MINUTES FROM THE MEETING OF THE STATE EMPLOYEE BENEFITS COMMITTEE
NOVEMBER 8, 2021

The State Employee Benefits Committee (the "Committee") met at 2:00 p.m. on November 8, 2021. The meeting was held at 97 Commerce Way, Suite 201, in Dover; however, in the interests of protecting the citizens of this State from the public health threat caused by COVID-19, this meeting was presented via WebEx and participants were encouraged to attend virtually.

Committee Members Represented or in Attendance:

Director Cerron Cade, Office of Management & Budget ("OMB"), Co-Chair
Acting Secretary Jessilene Corbett, Department of Human Resources ("DHR"), Acting Co-Chair
The Honorable Bethany Hall-Long, Lieutenant Governor and Ms. Laura Wisniewski, Constituent & Community Liaison, Office of the Lieutenant Governor
The Honorable Trinidad Navarro, Insurance Commissioner, Department of Insurance ("DOI")
The Honorable Chief Justice Collins Seitz, Delaware Supreme Court
Ms. Liza Davis, Deputy State Treasurer, Office of the State Treasurer ("OST") (OBO The Honorable Colleen Davis, State Treasurer)
Ms. Ruth Ann Jones, Controller General, Office of the Controller General ("OCG")
Secretary Molly Magarik, Department of Health & Social Services ("DHSS")
Mr. Jeff Taschner, Executive Director, Delaware State Education Association ("DSEA") (Appointee of The Honorable John Carney, Governor)

Others in Attendance

Director Faith Rentz, Statewide Benefits Office ("SBO"), DHR
Deputy Director Leighann Hinkle, SBO, DHR
Deputy Attorney General Adria Martinelli, Dept. of Justice, SEBC Legal Counsel
Mr. Chris Giovannello, Willis Towers Watson ("WTW")
Ms. Jaclyn Iglesias, WTW
Ms. Rebecca Warnken, WTW
Ms. Joanna Adams, Pension Administrator, Office of Pensions ("OPen")
Ms. Judy Anderson, DSEA
Ms. Wendy Beck, Highmark Delaware
Ms. Christina Bryan, Delaware Healthcare Association
Ms. Rebecca Byrd, ByrdGomes
Ms. Carla Cassell-Carter, Deputy Director, BPD, OMB
Ms. Julie Caynor, Aetna
Mr. Steven Costantino, Dir. Healthcare Reform, DHSS
Ms. Cherie Dodge Biron, Deputy Principal Asst., DHR
Mr. John Ficaro, Aetna
Ms. Nina Figueroa, Health Policy Advisor, DHR, SBO
Ms. Jacqueline Faulcon, READAA
Ms. Julie Greenwood, University of Delaware
Ms. Sandy Hart, IBM Watson Health
Mr. Patrick Heinrich, Teledoc Health
Ms. Charlene Hrivnak, CVS Health
Ms. Katherine Impellizzeri, Aetna
Mr. Kollin Jensen, Teledoc Health
Ms. Heather Johnson, Controller, DHR
Mr. Jamie Johnstone, Deputy Principal Assistant, Dept. of Finance ("DOF")
Mr. Adam Knox, Highmark Delaware
Ms. Lisa Mantegna, Highmark Delaware
Mr. Walt Mateja, IBM Watson Health
Mr. Sean McNeeley, Dir. Of Bond Finance, DOF
Ms. Kathy Nedelka, PHRST
Mr. Nick Moriello, Highmark
Ms. Evelyn Nestlerode, Deputy State Court Administrator and Chief Financial Officer, AOC
Mr. Michael North, Aetna
Mr. Matt Rosen, Policy Advisor, OST
Ms. Paula Roy, Roy Associates
Ms. Elizabeth Sampo, Aetna
Ms. Carrie Schiavo, Delta Dental
Ms. Christine Schiltz, Parkowski, Guerke, & Swayze
Ms. Judi Schock, Deputy Principal Asst., OMB

Mr. Aaron Schrader, HR Manager, SBO, DHR
Mr. Robert Scoglietti, Deputy Controller General, OCG
Mr. Mike Shipley, Highmark Delaware
Mr. Charles Simons, Highmark Delaware
Ms. Courtney Stewart, Deputy Director, OMB
Ms. Martha Sturtevant, Exec. Sec., SBO, DHR – Recorder
Ms. Ashley Tucker, Deputy State Court Administrator, Admin Office of the Courts
Ms. Joanne White, WIC Director, DHSS

CALLED TO ORDER
Director Rentz called the meeting to order at 2:00 p.m.

APPROVAL OF MINUTES – DIRECTOR FAITH RENTZ, SBO
A MOTION was made by Director Cade and seconded by Lt. Gov Hall-Long to approve the minutes from the October 11, 2021, meeting of the State Employee Benefits Committee.
MOTION ADOPTED UNANIMOUSLY

DIRECTOR'S REPORT – DIRECTOR FAITH RENTZ, SBO
Legislative Updates
Secretary Geisenberger, of the Department of Finance, presented to the Committee on October 11, 2021, on the work of the Retirement Benefit Study Committee ("RBSC") in response to EO 51. The RBSC released the first report to Governor Carney and the General Assembly on November 1, 2021, that includes recommendations for the Committee to explore Medicare retiree plan options and a short-term recommendation regarding a communication and education strategy to stakeholders and retirees regarding the unfunded Other Post-Employment Benefits liability specifically as it pertains to retiree healthcare funding and plan design. OPen, SBO, and DOF will meet in November to discuss and an update will be provided to the Committee on December 13, 2021.

The Department of Insurance released a bulletin on November 3, 2021, regarding the approval of SS 1 for SB 120 related to primary care services. The bulletin outlines the implementation plan and puts health carriers on notice of their requirements to comply with the Bill. Commissioner Navarro added that the Bill intends to increase the percentage of spending on primary care to maintain primary care providers in Delaware and limit the number of providers transitioning to a concierge service platform as well as to lower the overall cost of primary care.

Request for Proposal Updates
The Proposal Review Committee ("PRC") has concluded their review and recommendations for the Health Third-Party Administrator Request for Proposal ("RFP") that will be presented during today's agenda for the Committee's consideration.

The Dental Plan Administration RFP released in September has received five bidders. The PRC will conduct interviews on November 15, 2021, and a contract award recommendation is expected to be provided to the Committee on December 13, 2021.

The Consulting/Actuarial Services RFP is scheduled for advertisement in early January for a contract effective date of July 1, 2021. Committee members were encouraged to contact Director Rentz to review and provide feedback during the RFP drafting process.

November Subcommittee Meeting
The Subcommittees met on November 4, 2021, to review FY23 plan design options and Health RFP contract award recommendations that will be shared with the Committee today.

FINANCIALS – MR. CHRIS GIOVANNELLO, WTW

September Fund Report

Revenues are running $19.5M under budget for the year attributable to the $20.0M in supplemental funding that was approved and budgeted but has not yet been received. Director Cade added that the funding should be received the week of November 8, 2021.

As a result of a favorable quarter, medical and prescription claims are running $22.6M below budget attributable to one less invoice. Claims are projected to run higher in Q2 – Q4 to align with the budget.

The Fund Equity Balance is $148.4M through September 30, 2021, with a YTD surplus of $63.1M.

FY22 Q1 UPDATE and FY23 GHIP PROJECTIONS – MS. JACLYN IGLESIAS, WTW and MR. GIOVANNELLO, WTW

Long-term projections have been updated to include an updated headcount, FY22 revenue items, claims experience through Q1 FY22, and the projected operating expenses for FY23. A year-end surplus for FY22 is projected at $17.6M attributable to favorable claim experience and removing the first CVS invoice from the budget due to invoice timing. The FY23 projected deficit has been revised to $119.1M.

Director Cade queried whether the supplemental bill funding was included in Other Revenues. Mr. Giovannello confirmed that a one-time revenue for FY22 is included. Director Cade noted the growing increase in Other Revenues that was projected passed FY22. Mr. Giovannello responded that the increase is attributable to the savings associated with the new CVS Caremark rebate items.

Chief Justice Seitz queried whether the impact of COVID-19 was included in the projections, and, if so, how was it calculated. Mr. Giovannello responded that updated claim experience was normalized and used to calculate projections for FY22 and beyond; therefore, the projections do not account for COVID-19 related expenses that are not already included in the experience period (e.g., the longer-term impact of missed appointments that lead to delayed treatments).

Director Cade queried whether weekly reporting provided by Aetna and Highmark differentiated claims on the testing and treatment of COVID-19. Mr. Giovannello confirmed, adding that he will follow up with the total expenses.

Secretary Magarik recognized that it is difficult to quantify but queried whether there was a methodology to project the long-term impact of COVID-19. Mr. Giovannello responded that actuaries are actively gathering data, but no guidance has been shared at this time.

Director Cade noted that he expects that a portion of the American Rescue Plan Act (“ARPA”) and the Coronavirus Aid, Relief, and Economic Security Act (‘‘CARES Act’’) may continue to be utilized for eligible reimbursable expenses related to COVID-19. Chief Justice Seitz responded that care attributable to treatment that is a direct result of deferred care (e.g., missed appointments/diagnosis) could be attributable to COVID-19, and therefore reimbursable.

There are positive utilization trends because of COVID-19 that have the potential to lower costs for the Group Health Insurance Plan (“GHIP”) long-term (e.g., lower utilization of emergency rooms, and increased telehealth utilization) that add to the difficulty in quantifying the long-term impact to the GHIP.

Assuming no other program changes, and to fully solve for the $119.1M projected deficit, a 14.0% premium rate increase will be needed on July 1, 2022 ($86.0M increase in state share and a $10.0M increase in revenue paid by the active/pre-65 retiree populations); this is an increase of $3.90 to $38.20 per employee per month ($46.80 to $458.40 per year) depending on plan and coverage tier and a state subsidy increase of $93.45 to $252.13 per employee per month ($1,121.40 to $3,025.56 per year).

FY23 PLANNING CONSIDERATIONS – MS. JACLYN IGLESIAS, WTW

Opportunities to offset the required premium rate increase needed to solve for the projected deficit include but are not limited to Medical Third-Party Administrator Request for Proposal initiatives, plan design changes for active/pre-65 and Medicfill programs, adoption of proposed CVS Health pharmacy programs, adoption of mandatory bariatric carve-out and incentive modifications with SurgeryPlus.

Mr. Taschner noted that some of the program changes have the potential to reduce the total cost of care, and therefore increases are shared by the state and employees (90% and 10% respectively) while other program changes shift the cost to the plan participant.

There was a review of program changes for consideration.

Implementing an annual deductible of $50 single/$100 family or a $500 single/$1000 family for the HMO and Comprehensive PPO populations only on July 1, 2022, would yield an estimated savings of $1.5M and $11.7M respectively that would result in a 0.2% to 1.4% reduction in the required premium rate increase. This option does not apply to First State Basic and CDH Gold plans that already have a deductible.

Adding deductibles of $50 to $250 to the Medicfill population, separately or in addition to adding copays for office visits, emergency room visits, and hospital stays would yield estimated savings ranging from $0.8 to $3.9M for each individual change with a maximum of $10.3M that would result in a 0.1% to 0.5% reduction in the required premium rate increase for each individual change with a maximum reduction of 1.2%.

A 50% increase to the current prescription plan copay structure for the Commercial and EGWP populations would yield estimated savings totaling $6.2M that would result in a reduction of 0.7% to the required premium rate increase.

Reinstating copays for telehealth utilization in the commercial population for care provided by community medical providers only (i.e., copays for third-party preferred telemedicine providers would remain at $0) would yield an estimated savings of $4.0M that would result in a 0.5% reduction to the required premium rate increase. This option resonated the most with the Subcommittees.

Mr. Taschner asked to confirm that the cost differential to the GHIP between an in-person visit versus telemedicine would be meaningful and not negate the increase in copay. Mr. Giovannello responded that the cost of a telemedicine visit is lower than an in-person visit, and additional utilization analysis will be provided at the next Committee meeting on December 13, 2021.

Mr. Taschner noted that all program changes discussed thus far would shift the cost to the plan participant in the form of a deductible and do not bring down the overall cost to the GHIP.

Additionally, CVS Caremark brought forth several recommendations for prescription savings programs.

The Drug Savings Review program reviews prescription utilization to ensure that the prescription and dosage follow evidence-based medical guidelines. CVS outreach is made to physicians directly but would be seamless from a member perspective. This program would impact the Commercial population only, and program savings is estimated at $1.0M to $2.8M (includes savings for members) that would result in a reduction of 0.1% to 0.3% to the required premium rate increase; the estimated savings is dependent on the responsiveness of the provider community.

The PrudentRx specialty copay card program is an independent third-party organization that CVS Caremark has partnered with to leverage manufacturer copay assistance programs for specialty medications. This program would require members to enroll and would increase member out-of-pocket costs (a 30% copay on specialty medications) for individuals who do not enroll. This program would impact members who are taking specialty medications and

savings are estimated at $6.9M to $7.7M that would result in a reduction of 0.8% to 0.9% to the required premium rate increase. This option requires further exploration by the subcommittees when they meet again on December 9, 2021.

The final CVS Caremark savings program discussed at the Subcommittee level is the Next Generation Transform Diabetes Care ("ngTDC") program that engages members with diabetes on actionable steps to address gaps in care, evaluate medical needs, and facilitate overall wellness. The ngTDC program was approved for the EGWP Medicare retiree population at the SEBC meeting on October 11, 2021 and is a potential replacement for Livongo for active and non-Medicare health plan members when the State's current third-party administrator contracts with Aetna and Highmark Delaware end on June 30, 2022. This program would impact all diabetic members and savings are estimated at $1.9M that would result in a reduction of 0.2% to the required premium rate increase.

Finally, other program changes considered by the Subcommittees include mandating the use of the SurgeryPlus benefit for bariatric surgery and making changes to the incentive structure for SurgeryPlus for the Commercial population.

Mandating the use of SurgeryPlus for bariatric surgery would yield an estimated savings of $1.2M and result in a reduction of 0.1% to the required premium rate increase. Members have no out-of-pocket costs when utilizing the SurgeryPlus program, so there would be no cost-shifting to the member for this option.

Modifying the incentive structure for SurgeryPlus would yield an estimated savings of 0.1M that would result in a negligible reduction to the required premium rate increase. Subcommittees expressed a limited amount of interest in this option because it does not meaningfully reduce overall costs for the GHIP.

The maximum annual savings opportunity if all program changes were adopted for FY23 is $24.0M - $45.0M and would reduce the projected $119.1M deficit to $74.0M - $95.0M and would still require a 9-11% premium rate increase to solve for the remaining deficit.

Chief Justice Seitz queried whether there was any benefit to the states included in the portion of the Build Back Better Bill related to prescription medications. Secretary Magarik responded that some relate to prescriptions but added that the GHIP is a quasi-ERISA plan, and the federal government has not yet included self-insured plans in larger policy changes.

There was a discussion regarding the disruption to members that would result from implementing the program changes in addition to premium rate increases.

Commissioner Navarro queried what the difference would be in dollars between a 9% premium rate increase and a 14% increase, adding that he had concerns regarding the impact of added deductibles on lower-income earners. Mr. Giovannello responded that in the example of the Comprehensive PPO Family Plan the annual premium rate increase for 9% is $295, and for 14% is $458.

Members discussed the inflation of healthcare costs and the need for a long-term solution.

Mr. Taschner would like to continue previous discussions on the high cost of healthcare/hospitalizations in Delaware as compared to neighboring states.

Subcommittee members expressed interest in a further evaluation of:

- Increasing variable copay changes to preferred sites of care (e.g., freestanding radiology and independent laboratories)
- Medical plan design changes for the Medicfill population (earliest effective date January 1, 2022)
- Prescription plan design changes for the Medicfill population (earliest effective date January 1, 2022)

- The Drug Savings Review Program
- The Transform Diabetes Care program

Subcommittee members expressed limited support of:

- Adding deductibles to the Commercial and HMO plans; savings did not compensate for the disruption
- Changes to the SurgeryPlus incentive design

Subcommittee members expressed interest in additional information and follow up of:

- The bariatric carve-out option
- The PrudentRx prescription savings program

Subcommittee members discussed balancing program changes and premium increases, with some members expressing a preference for a higher premium increase, which would spread over all plan participants, in lieu of plan changes such as adding deductibles which would have a greater impact on members who are using the plan.

There was also a discussion regarding the need for a further review and continued evaluation of quantifying the cost impact of deferred care on the GHIP.

Chief Justice Seitz would like to see more recommendations for tangible low-cost benefit enhancements to the plan that might offset premium rate increases such as care coordination. Ms. Iglesias responded that the Drug Savings Review program is one program that would provide prescription savings for members while ensuring that the prescription and dosage follow evidence-based medical guidelines, and the bariatric carve-out certifies that members are utilizing Centers of Excellence that support best outcomes. She added that there may be additional enhancements because of the Medical TPA RFP.

Commissioner Navarro queried the impact on the deficit projection assuming the adoption of a 14% premium rate increase. Mr. Giovannello responded that a 14% rate increase would not eliminate the need for future rate increases, but future increases would be more closely aligned with the trend of 5% or 6% annually.

There was a discussion regarding the value of healthcare and whether the cost is supported by healthier outcomes that justify the investment of the employees, the state, and the taxpayers.

The Subcommittee will meet again on December 9, 2021, for further discussion of the program savings opportunities and to finalize any recommendations to the Committee for presentation and consideration on December 13, 2021.

HEALTH TPA RFP CONTRACT AWARD RECOMMENDATIONS – MS. JACLYN IGLESIAS, WTW

The Committee reviewed the outcomes of the Medical TPA RFP and the recommendations of the Proposal Review Committee.

The GHIP provides medical and prescription drug benefits to approximately 129,000 active and retired employees of the State of Delaware and their dependents, including approximately 16,000 employees, retirees, and their dependents from non-State groups that can participate.

There are four medical plan options for active employees and non-Medicare pensioners including the Comprehensive PPO and First State Basic plans administered by Highmark Delaware, and the HMO and CDH Gold plans administered by Aetna.

The Special Medicare Medicfill plan for Medicare pensioners is also administered by Highmark Delaware.

The State's contracts with both TPAs expire on June 30, 2022, for the non-Medicare plans and on December 31, 2022, for the Medicare supplement plan.

The goals of the RFP were to identify Medical TPAs that could support the goals of the GHIP Strategic Framework, including an increased proportion of spending through advanced alternative payment models, reducing per-member cost for diabetic members, limiting the total cost of care inflation, and offer and increase engagement in decision support tools.

There was a heavy focus on whether bidders could provide competitive financial terms including provider reimbursement rates and administrative fees, service level guarantees including accountability for supporting the GHIP Strategic Framework goals, and solutions that uphold and support investment in primary care and support the Affordability Targets of the Delaware Department of Insurance's Office of Value-Based Health Care Delivery.

Medical TPAs should be able to support the GHIP's programs and plan offerings and deliver on the core functions of a medical TPA while also supporting the greater strategic goals and objectives.

There was a review of the timeline for the Medical TPA RFP.

There were two bidders: Aetna, and Highmark Delaware.

The PRC interviewed both finalists and met several times to review scoring considerations before finalizing recommendations to present to the Committee at today's meeting.

The PRC agrees that both finalists were qualified to administer both a Special Medicfill Medicare Supplement plan and a group Medicare Advantage product to the Medicare pensioner population, with Highmark Delaware's Medicare Advantage product being slightly more favorable than Aetna's product based on the results of the scoring.

The PRC agrees that while Highmark Delaware's score was higher than Aetna's across all the non-Medicare plan options, there were concerns about the impact of consolidating all non-Medicare plan options with one bidder, given that this would have on competition among medical TPAs and providers in Delaware. There were also concerns about the limited transparency into the joint venture between Highmark Delaware and Christiana Care and its potential impact on the GHIP, as well as concerns about the possibility of forgoing potential benefits to the GHIP and plan participants provided within Aetna's proposal.

The PRC agrees that there is potential value in considering the new programs and value-added services proposed by both Highmark Delaware and Aetna for their respective awarded plans including the disease and care management program options for each vendor, the type of HMO plan offered by Aetna (i.e., with or without a "PCP gatekeeper"), and a recommendation on the Everside Health primary care model for the Aetna CDH Gold and HMO plans. The PRC recommends that the Financial and Health Policy & Planning Subcommittees discuss and evaluate these options and bring a recommendation to the Committee at the meeting on February 28, 2022, for an effective date of July 1, 2022.

The PRC recommends continued evaluation of these Medicare plan options following the recommendations from the Retirement Benefits Study Committee (released on November 1, 2021), with no immediate contract award of a Medicare product at this time. A decision on the administration of a Medicare plan for CY23 should be made no later than March 31, 2022, to provide sufficient time for implementation and communication of that plan option before the current Special Medicfill Medicare Supplement plan contract terminates on December 31, 2022. If the Committee elects to offer the Special Medicfill Medicare Supplement plan beyond December 31, 2022, the Committee could award the contract to Highmark Delaware based on the scoring results by the PRC.

The PRC recommends a contract award of the HMO and CDH Gold plans to Aetna for an initial three-year term effective July 1, 2022, through June 30, 2025, with two optional one-year period extensions. Such award shall be subject to the approval of the Department of Technology and Information and Department of Insurance and a finalized contract which shall include performance guarantees.

The PRC recommends a contract award of the Comprehensive PPO and First State Basic plans to Highmark Delaware for an initial three-year term effective July 1, 2022, through June 30, 2025, with two optional one-year period extensions. Such award shall be subject to the approval of the Department of Technology and Information and Department of Insurance and a finalized contract which shall include performance guarantees.

The PRC recommends continued evaluation and discussion by both the Financial and Health Policy & Planning Subcommittees, with recommendations brought to the SEBC in February 2022, for the disease and care management options for each vendor, the type of HMO plan for Aetna, and a recommendation on the Everside Health primary care model for the Aetna CDH Gold and HMO plans.

The Committee did not act on the recommendation.

OTHER BUSINESS
No new business was presented.

PUBLIC COMMENT
Christina Bryan, representing the Delaware Healthcare Association remarked that costs are higher in Delaware due to the age and chronic disease of the population. She added that outcomes are not exclusively tied to medical care, but also social factors.

Nick Moriello, representing Highmark Delaware expressed disappointment regarding the recommendations of the PRC. He stated that the Highmark Delaware bid proposal addressed ways to improve cost savings and health outcomes.

Lt. Gov Hall-Long left the meeting at 3:29 and delegated Wisniewski as her representative.

EXECUTIVE SESSION
A MOTION was made by Secretary Magarik and seconded by Commissioner Navarro to move into Executive Session at 3:31 p.m.
MOTION ADOPTED UNANIMOUSLY

ADJOURNMENT
A MOTION was made by Secretary Magarik and seconded by Commissioner Navarro to adjourn the meeting at 04:57p.m.
MOTION ADOPTED UNANIMOUSLY

Respectfully submitted,

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Martha Sturtevant, Executive Secretary, Statewide Benefits Office, Department of Human Resources
Recorder, State Employee Benefits Committee, and Subcommittees