MINUTES FROM THE MEETING OF THE STATE EMPLOYEE BENEFITS COMMITTEE
December 13, 2021

The State Employee Benefits Committee (the "Committee") met at 2:00 p.m. on December 13, 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"), SEBC Co-Chair
and Ms. Judi Schock, Deputy Principal Assistant, (OBO Director Cade)
Acting Secretary Jessilene Corbett, Department of Human Resources ("DHR"), Acting Co-Chair
The Honorable Colleen Davis, State Treasurer, Office of the State Treasurer ("OST")
The Honorable Chief Justice Collins Seitz, Delaware Supreme Court
Controller General Ruth Ann Jones, Office of the Controller General ("OCG")
Secretary Molly Magarik, Department of Health & Social Services ("DHSS")
Mr. Stuart Snyder, Chief of Staff, Department of Insurance ("DOI") (OBO The Honorable Trinidad Navarro, Insurance Commissioner)
Mr. Jeff Taschner, Executive Director, Delaware State Education Association ("DSEA") (Appointee of The Honorable John Carney, Governor)
Mr. Keith Warren, Chief of Staff, Office of the Lieutenant Governor (OBO The Honorable Bethany Hall-Long, Lieutenant 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")
Mr. Marc Gutstein, 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. Jennifer Bredemeier, University of Delaware
Ms. Rebecca Byrd, ByrdGomes
Ms. Julie Caynor, Aetna
Ms. Marian Coker, Information Resource Specialist, Department of State
Mr. Steven Costantino, Dir. Healthcare Reform, DHSS
Ms. Cherie Dodge Biron, Deputy Principal Asst., DHR
Ms. Sara Dunlevy, CVS Health
Mr. John Ficaro, Aetna
Ms. Nina Figueroa, Health Policy Advisor, DHR, SBO
Ms. Jacqueline Faulcon, READAA
Ms. Julie Greenwood, University of Delaware
Ms. Jeanette Hammon, Sr. Fiscal Policy Analyst, OMB
Ms. Sandy Hart, IBM Watson Health
Ms. Charlene Hrivnak, CVS Health
Ms. Katherine Impellizzeri, Aetna
Ms. Heather Johnson, Controller, DHR
Mr. Jamie Johnstone, Deputy Principal Assistant, Dept. of Finance ("DOF")
Mr. Adam Knox, Highmark Delaware
Ms. Lizzie Lewis, Hamilton Goodman Partners
Mr. Dan Madrid, Chief Operating Officer, OST
Ms. Lisa Mantegna, Highmark Delaware
Mr. Walt Mateja, IBM Watson Health
Mr. Sean McNeeley, Director of Bond Finance, DOF
Ms. Carole Mick, Administrative Specialist, DHR, SBO
Ms. Alexis Miller, Highmark
Mr. Paul Miller, BeneCare
Mr. Nick Moriello, Highmark
Ms. Kathy Nedelka, PHRST

Mr. Michael North, Aetna
Ms. Louisa Phillips, Delaware Healthcare Association
Ms. Paula Roy, Roy Associates
Ms. Elizabeth Sampo, Aetna
Ms. Carrie Schiavo, Delta Dental
Mr. Robert Scoglietti, Deputy Controller General, OCG
Mr. Charles Simons, Highmark Delaware
Ms. Martha Sturtevant, Exec. Sec., SBO, DHR – Recorder
Ms. Ashley Tucker, Deputy State Court Administrator, Admin Office of the Courts
Ms. Elizabeth Vogelsong, BeneCare

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

APPROVAL OF MINUTES – DIRECTOR FAITH RENTZ, DHR, SBO
A MOTION was made by Mr. Taschner and seconded by Controller General Jones to approve the minutes from the November 8, 2021, meeting of the State Employee Benefits Committee.
MOTION ADOPTED UNANIMOUSLY

DIRECTOR'S REPORT – DIRECTOR FAITH RENTZ, DHR, SBO
Proposal Review Committee Updates
The PRC was scheduled to make a formal recommendation to the Committee for the award of the Dental Plan Third Party Administrator ("TPA") Request for Proposal ("RFP"); however, the PRC has not concluded its work. The PRC is expected to present its recommendation on January 24, 2022.

HEALTH TPA RFP CONTRACT AWARD RECOMMENDATIONS – MS. JACLYN IGLESIAS, WTW
There was a recap of the Medical TPA RFP recommendation from the Proposal Review Committee ("PRC"):

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.

Secretary Magarik joined the meeting.

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.

A MOTION was made by Treasurer Davis and seconded by Acting Secretary, Dr. Corbett to award the Medical Third-Party Administrator Request for Proposal to Highmark Delaware and Aetna as recommended by the Proposal Review Committee for an effective contract date of July 1, 2022.
1 Abstention – Mr. Stuart Snyder
MOTION ADOPTED

FINANCIALS – MR. CHRIS GIOVANNELLO, WTW

October Fund Report

October premium fund contributions were lower than budgeted attributable to the timing of receipts for non-payroll groups. The GHIP supplemental bill funding will post in December.

October claims came in $4.3M favorable to the budgeted amount, and $26.9M for the year for medical and pharmacy claims combined. The net impact of October to the GHIP is a $1.9M improvement in the projected deficit and a YTD variance of $4.5M.

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

The FY 22 Q1 report is on an incurred basis (i.e., not cash) and compares FY22 YTD medical and pharmacy claims to FY21 YTD as reported by Aetna, Highmark, CVS, and ESI. On a gross claim performance FY22 is slightly more favorable than FY21, with FY22 coming in at 2.0% less PEPY, and 1.3% less than FY21 PMPY attributable to improved commercial pharmacy rebates.

The report compared the FY22 actual budget to the budget approved in August 2021. It was noted that there is one less invoice received than what was budgeted in both medical and pharmacy claims resulting in the appearance of claims being largely under budget.

Due to the timing of suppressed care, utilization of services is generally higher than the prior period. There was an increase in well care and preventive visits: 1.8% and 14.1% respectively. There was an increase in screening rates for colon, breast cancer, cervical cancer, and cholesterol.

There was a 0.3% decrease in inpatient admits with a 9.9% increase in length of stay and a 14.0% increase in cost per admit.

The projected FY23 budget has been revised down $15.2M to $963.7M driven by claims experience and builds in the PRC award recommendation for Medical TPA RFP and the Subcommittee recommendations most likely to be adopted by the Committee: reinstatement of member cost-sharing for telehealth visits with community providers, implementation of the CVS Drug Savings Review Program, and the CVS Transform Diabetes Care Program.

An update to Other Revenues reflects a reduction attributable to the increase in monthly federal reinsurance payments for the EGWP program: $48.52 per retiree in 2021 to $65.68 in 2022.

Final FY23 budget projections and FY23 rate impact will be presented in February 2022.

The $119.1M projected deficit for FY23 has been reduced to $103.2M; the FY22 projected surplus remains at $17.6M.

The latest FY23 projected deficit must be solved through a combination of premium rate increases and other levers that can generate substantial plan savings. Assuming no other program changes, a 12.2% increase will be needed on July 1, 2022: a $75M increase in state-share revenue (90%) and a $9M increase to the active and pre-65 populations.

If the rate increase was smoothed over two years and targeted a $0 deficit for FY25, a 7.5% increase would be needed for FY23, FY24, and FY25 consecutively. In this scenario, the GHIP would end FY23 and FY24 in a deficit position after reserves.

Mr. Taschner queried what the amount of rate action would be needed in FY23 and FY24 if starting with 12.2% in FY23 and the target remained the same for FY25. Mr. Giovannello estimated a rate increase that coincides with the trend: 5-7%.

A 12.2% rate increase effective July 1, 2022, equals a $3.40 - $33.29 per employee per month increase ($40.80 - $399.48 per year) and a State subsidy increase of $81.43 - $219.72 per employee per month ($977.16 - $2,636.64 per employee per year) depending on plan and coverage tier.

The current projection includes a $23.3M COVID-19 expense reimbursement payment received in June 2021 for claims paid through March.

A revised reporting of COVID-19 indicates the potential for an additional $15.8M in COVID-19 expense reimbursements that could hit the fund in FY22 or FY23; this could reduce the FY23 deficit to $86.3M.

If received, and assuming no other program changes, a 10.2% premium increase will be needed on July 1, 2022, to solve the projected FY23 deficit.

Targeting a $0 deficit by the end of FY25 would require an annual premium rate increase of 7.2% in FY23, FY24, and FY25 consecutively. In this scenario, the GHIP would end FY23 and FY24 in a deficit position after reserves. A 7.2% increase yields approximately a $44M increase in state-share revenue (90%) and a $5M increase to the active and pre-65 populations.

A 10.2% rate increase effective July 1, 2022, equals a $2.84 - $27.83 per employee per month increase ($34.08 - $333.96 per year) and a State subsidy increase of $68.09 - $183.70 per employee per month ($817.08 - $2,204.40 per employee per year) depending on plan and coverage tier.

FY21 UTILIZATION UPDATE – MR. CHRIS GIOVANELLO, WTW

There was a review of the utilization analysis provided by IBM Watson Health. There will be ongoing analysis to evaluate the impact of COVID-19 on the GHIP long-term cost projections. The impact of the pandemic on the GHIP in FY22 and beyond remains largely unknown and will depend on many factors including the level of care deferral, ongoing vaccination costs, change in service mix (e.g., sustained shift to virtual care), the downstream impacts from missed preventive visits, compounding mental health issues, and unknown health needs of COVID-19 survivors, and a potential new wave of infection.

There was a total of $39.1M paid for COVID-19 testing, treatment, and vaccinations from the onset of the pandemic through October 2021. The GHIP received $23.3M in COVID-19 expense reimbursements based on expenses paid through March 2021. The GHIP could receive an additional $15.8 in reimbursement in FY22 or FY23.

Utilization varied depending on visit type. Preventive visits were above pre-pandemic levels for adult preventive, well-child, and mammograms, but were lower in other areas such as well-baby and other cancer screenings.

Utilization reached the highest levels since the start of the pandemic during FY21 Q4, exceeding the baseline year in many instances, but a dip in utilization was observed in FY22 Q1.

Imaging for outpatient hospital settings decreased 15.8% from baseline, freestanding utilization decreased 4.7% from baseline.

Emergency room utilization remains below the baseline period for most top conditions.

Outpatient mental health visits increased 11.4% above baseline which may be attributable to increased access. Substance abuse visits have been below baseline levels in all quarters except FY21 Q1 and in the most recent quarter, down 31.0% when compared to the baseline period.

Inpatient mental health admissions have been below baseline; in the most recent quarter, admissions were 17.4% below baseline. Inpatient substance abuse admissions increased by 90.4% from FY20 Q4 to FY21 Q4.

Admissions for substance abuse during FY22 Q1 were 24.3% above baseline. Increased utilization of outpatient mental health services, including virtual behavioral health visits, likely contributing to a reduction in inpatient admissions.

Utilization remains below baseline for most top clinical conditions. The top outpatient surgical procedures reached the highest level in FY21 Q4. Utilization for the top elective surgical procedures remains consistently below the baseline, except for the insertion of a stent for a blocked artery in the heart during FY21 Q1 & Q4. Elective procedures remain below baseline.

In FY21 the average paid per visit for traditional telemedicine provided by Amwell, Doctor on Demand, and Teladoc is less expensive ($56), but not meaningfully different than PCP providers ($79). Other telemedicine providers are more expensive ($84), but not meaningfully different; the difference may be attributable to individual provider contracts.

Total emergency room (“ER”) visits decreased from July 2019 through June 2021 (data excludes Medicare population); however, there was no reduction in the percent of steerable visits. It is estimated that there is $13.2M in potential cost avoidance for non-emergent ER visits. Emergency room visits that result in admission are excluded from outpatient hospital data.

When reviewing the top 5 non-emergent diagnoses in emergency rooms compared to their costs in urgent care, there was $2.6M in potential cost avoidance.

There was a decrease in high-tech imaging from FY19 to FY20 (excludes PET Scans), but then an increase from FY20 to FY21. High-tech imaging visits in an outpatient hospital setting accounted for 58.3% during FY19; only 55.4% were performed in the same setting during FY21. While some high-tech imaging needs to be performed in an inpatient hospital setting, there was $11-12M in potential cost avoidance if all high-tech imaging services were performed at a freestanding facility.

The cost for basic imaging in a hospital setting is 97% more than at a freestanding facility. Basic imaging visits in an outpatient hospital setting accounted for 43.5% during FY19; only 39.7% were performed in the same setting during FY21. While some basic imaging needs to be performed in an outpatient hospital setting, there was $3-4M in potential cost avoidance if all basic imaging services were performed at a freestanding facility.

There were no copay changes for imaging services in FY21.

In FY21 the average paid per visit for preferred lab services was 60.1% less than those performed in hospital outpatient labs, even after the average paid per visit increased 18.9% from FY20 to FY21. While some lab services need to be performed in an outpatient hospital setting, there was $3-4M in potential cost avoidance if all lab services were performed at a preferred lab.

The next steps will include ongoing monitoring for emerging plan experience related to COVID-19 testing and treatment, care deferral by type of care, as well as the cost savings for the GHIP initiatives adopted to date.

Additionally, there is an opportunity for potential plan design changes to promote the utilization of preferred sites of care, and there will be ongoing discussions regarding the timing and level of future rate action.

Secretary Magarik noted the challenge of communicating to members so that they understand their choices, stay healthy, and save costs. She advocated for additional support as needed for the Statewide Benefits Office.

FY23 PLANNING CONSIDERATIONS – MS. JACLYN IGLESIAS, WTW
The Committee reviewed several FY23 savings opportunities recently reviewed by the Subcommittees that aim to reduce the anticipated FY23 premium rate increase needed to solve the projected deficit.

Savings opportunities can come from but are not limited to, Medical TPA RFP initiatives, plan design changes for active/pre-65 and Medicfill programs, adoption of proposed CVS Health pharmacy programs, and adoption of mandatory bariatric carve-out and incentive modifications with SurgeryPlus.

The following three opportunities have been recommended by the Subcommittees for further evaluation and consideration by the Committees:

- Reinstating copays for telehealth utilization in the commercial population would yield an estimated cost avoidance of $4.0M that would result in a 0.5% reduction to the required premium rate increase. Additional discussion is needed regarding the treatment of behavioral health telemedicine visit copays with community providers, which have $15 and $20 copays in the HMO and PPO plans respectively. Maintaining $0 copays for behavioral health virtual visits with community providers would reduce the cost avoidance to $2M for FY23.

- The CVS Drug Savings Review program reviews prescription utilization to ensure that the prescription and dosage follow evidence-based medical guidelines. The cost avoidance 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 Next Generation Transform Diabetes Care ("ngTDC") program engages members with diabetes on actionable steps to address gaps in care, evaluate medical needs, and facilitate overall wellness. This program would impact all diabetic members and the net cost avoidance is estimated at $1.9M would result in a reduction of 0.2% to the required premium rate increase. This 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. The ngTDC program was approved for the Medicfill Plan at the SEBC meeting on October 11, 2021.

These recommendations have been built into the revised projections.

Additional savings opportunities that the Subcommittees would like to consider further before making a recommendation include:

- The CVS PrudentRx specialty copay card program to leverage savings from manufacturer copay cards for specialty medications that could produce savings but would require members to enroll and would increase member out-of-pocket costs 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 would result in a reduction of 0.8% to 0.9% to the required premium rate increase.

- Program changes for consideration include mandating the use of the SurgeryPlus benefit for bariatric surgery. Based on current utilization program savings are estimated at $1.2M which would result in a reduction of 0.1% to the required premium rate increase.

Savings opportunities where the Subcommittees have requested further study will continue to be evaluated and any additional recommendations will be presented to the Committee as appropriate.

There was no motion made from the Committee on the recommendations as presented.

CVS IMPLEMENTATION UPDATE – DIRECTOR RENTZ, DHR, SBO

The commercial population transitioned to CVS Health for pharmacy benefits on July 1, 2021. The transition has been smooth overall with 411,849 total prescription claims filled for 101,055 members.

Director Cade joined the meeting.

All performance guarantees have been met or exceeded by CVS Caremark. Member satisfaction is at 2% over the member service target of 90%.

SBO is working through escalated member transition issues on a case-by-case basis to reach a resolution. Calls into CVS Customer Care continue to decrease; there have been 14,285 total calls since implementation, with an average of 2.5 seconds to answer each call.

The primary reasons for calls into CVS Customer Care pertain to denial of claims and prior authorizations. Appeal denials have not been higher than 0.05% of paid claims. Denials represented 0.69% of all claims in July and have steadily decreased to 0.3% of all claims in October.

A member who is receiving a denial pertaining to a prior authorization is primarily a result of timeframes built into the plan design to ensure that members are monitored and taking the most appropriate medications for their condition and/or diagnosis.

Another pain-point for members has been related to prescriptions written by providers to be dispensed as written ("DAW"). If the medication is not listed on the CVS formulary, or if there is a generic equivalent of the medication, and no prior written support has been submitted indicating why that member requires the brand medication, the Choice Program applies. Through the Choice Program, the member will receive a penalty at the point-of-sale by paying a non-preferred copay plus the difference between the cost of the generic and the brand medication. However, this represents 0.27% of claims and continues to decrease as members transition to generic medications as the plan intends.

SBO meets with CVS monthly to review key utilization metrics. Of the 101,055 eligible members per month, the average utilization of members is 36.7% for a total gross cost of $69.0M with the GHIP paying $64.9M, for a member cost-share of 5.9%.

The generic dispensing rate is 77.7% and the generic substitution rate is 97.5%. More outreach is needed to educate members and providers on available generic substitution.

Through November, specialty medications represent $27.0M and 39.4% of the GHIP's total gross costs, but only 1.2% of total prescriptions. For the members who are paying for specialty medications, their cost-share is 1.0%.

The formulary is not managed by the GHIP and therefore is not managed by the Committee. The formulary is evaluated regularly and varies across PBMs.

Effective utilization management strategy is key for cost containment and quality oversight. The Pharmacy Benefit Manager ("PBM") monitors marketplace trends to ensure member access to clinically appropriate and cost-effective medications.

The PBM contract includes utilization management where prior authorization may be required (e.g., step therapy, member education, Diabetic One copay program, and the Choice Program) when lower-cost generic/brand medications are available, when the medication is known to have side effects and/or be misused, or when additional steps (e.g., testing) are needed to ensure the medication will be effective.

There was a review of prior authorization trends by month for approved and denied claims by specialty and non-specialty formulary and clinical medications. July was the highest denial month with 0.69% and trended downward to 0.33% in November as members learn to use their benefits.

Members who wish to appeal a prescription claim denial have two levels of appeals with CVS Health, one with the SBO, and a final appeal option to the Committee. Level one and two appeals to CVS peaked in August with a sharp decline in September that continued through November.

In the first five months of the contract, there were 930 claims where members were charged a copay as part of the Choice program to fill DAW prescriptions where a generic equivalent was available. In most cases the pharmacy will contact the provider, at the member's request, with a generic option; however, there are some instances where members choose to pay the penalty.

Penalties for DAW prescriptions have decreased each month, but SBO is working with CVS to identify members for additional education and outreach regarding available options to eliminate that penalty.

SBO will continue to serve as the point of contact for escalated issues. Where appropriate, SBO and CVS are applying lessons learned to the EGWP Medicare implementation. SBO will continue to communicate and provide regular updates.

RETIREMENT BENEFIT STUDY UPDATE – DIRECTOR RENTZ, DHR, SBO

Committee members reviewed the Retirement Benefits Study Committee ("RBSC") report delivered at the RBSC meeting on November 29, 2021. The meeting focused on the 2021 OPEB actuarial valuation and the corresponding updates to funding, eligibility, and benefit options previously presented. The updates did not include savings projections associated with the Committee's adoption of any Medicare Advantage program pending the award of the Health TPA RFP.

The RBSC and the Committee's PRC recommend that the Committee continue to review plan options and Medicare exchange options for the Medicare population.

The recommendation is for a decision on the administration of a Medicare Plan for CY23 be made not later than March 2022 to allow 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 or Aetna based on the scoring results by the PRC.

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.

Further consideration and evaluation will be delegated to the Subcommittees.

OTHER BUSINESS

No new business was presented.

PUBLIC COMMENT
The public did not present further comment.

EXECUTIVE SESSION
A MOTION was made by Secretary Magarik and seconded by Mr. Taschner to move into Executive Session at 3:56 p.m.
MOTION ADOPTED UNANIMOUSLY

ADJOURNMENT
A MOTION was made by Mr. Taschner and seconded by Dr. Corbett to adjourn the meeting at 4:27 p.m.
MOTION ADOPTED UNANIMOUSLY

Respectfully submitted,

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