The State of Delaware

Federal and State Policy Impacting the GHIP

May 23, 2022

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Contents

- Federal legislation impacting the GHIP
- State policy impacting the GHIP

Overview of the Transparency in Coverage Final Rule and CAA legislation

Transparency in Coverage (TiC) Final Rule

- President Trump's Executive Order 13877 ("Improving Price and Quality Transparency")
- Final Rule on transparency in health coverage requirements of §1311 of the Affordable Care Act (ACA) issued November 2020
- Requirements
  - **2022: *Negotiated Prices** (delayed until July 1, 2022):** Public release of negotiated rates via machine readable files
  - **2023/2024 Cost-sharing Information:** Disclosure of cost-sharing estimates by group health plans and health insurance issuers at enrollee request (via online tool or paper)

Currently in effect for the GHIP

Effective 7/1/2022 for the GHIP

Consolidated Appropriations Act (CAA)

Legislation passed in late 2020 includes:

No Surprises Act (Title I)

- ***Surprise medical billing protections***
- ***In-network deductible / OOPM on ID card***
- ***Continuity of care***
- ***Accuracy of provider directories***
- Price comparison tool
- Advance EOB

Transparency (Title II)

- ***Removal of plan / provider gag clauses***
- ***MHPAEA NQTL** comparative analysis requirement***
- ***Broker / consultant fee disclosure***
- Reporting on pharmacy benefits / costs

Self-insured plans including the GHIP will need to rely on the medical TPAs/PBMs to support full compliance as only these vendors will have the data and systems needed to meet these requirements

*Complements a similar hospital transparency rule issued by HHS (effective January 2021) that requires hospitals to post standard charge amounts based on negotiated rates for common or shoppable items or services.

**MHPAEA NQTL = Mental Health Parity and Addiction Equity Act (MHPAEA) Non-Quantitative Treatment Limitations (NQTLs)

Transparency in Coverage Final Rule requirements: negotiated prices

- The Transparency Final Rule requires plans to **make available to the public** (including consumers, researchers, employers, and other third-parties) **three separate machine-readable files** that include detailed negotiated prices related to:

In-network information	Out-of-network information	Prescription drug information
Disclosure of negotiated rates for all covered items and services between the plan or issuer and in-network providers	**Disclosure of historical allowed amounts and billed charges from out-of-network providers**	**Disclosure of in-network negotiated rates and historical net prices (after rebates) for all covered prescription drugs at the drug and pharmacy location level**

- The files must be
  - **Updated monthly**
  - Posted on the **insurer's or plan's website**
  - And provided **free of charge**

Upcoming requirement

Price disclosure via machine-readable files for in-network and out-of-network medical

July 1, 2022

Future state and timing TBD

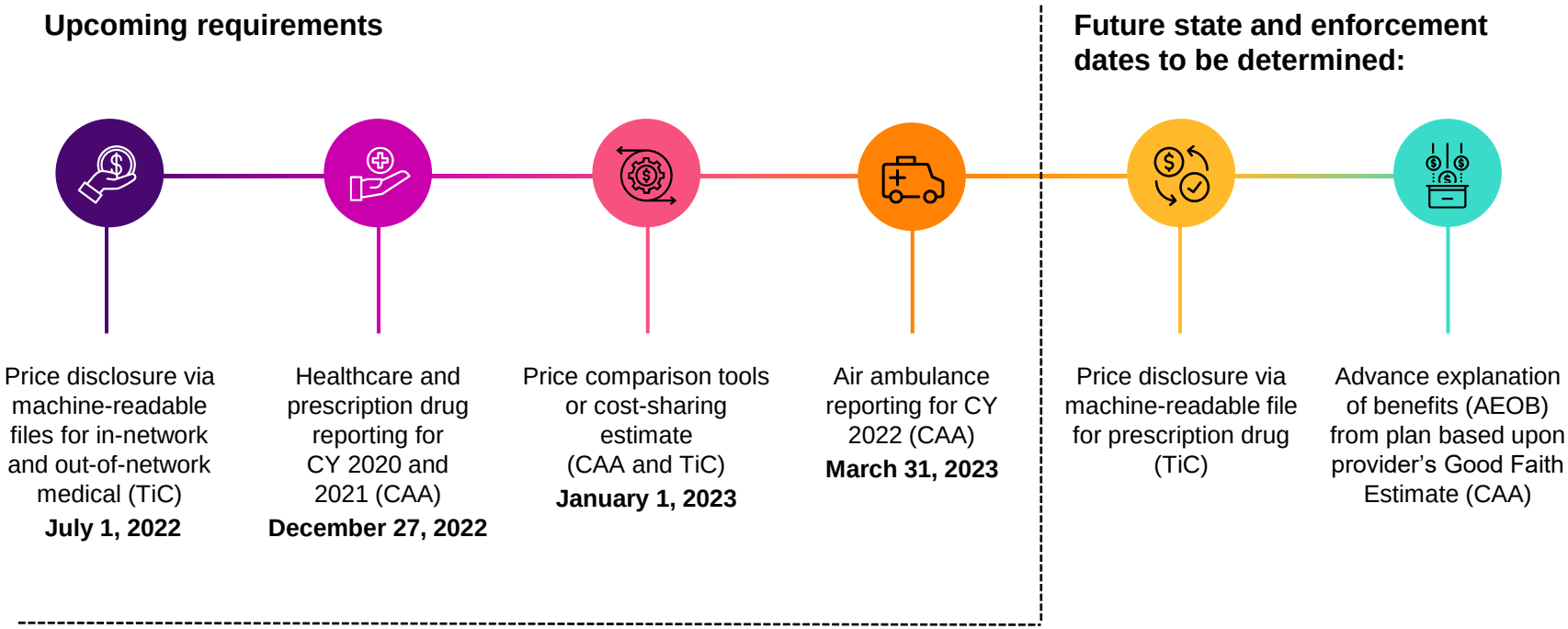
Price disclosure via machine-readable file for prescription drug

Transparency-related provisions of the Consolidated Appropriations Act

Currently or soon-to-be in effect for the GHIP

Requirement	Effective Date for the GHIP	Rule or Requirement
Removal of plan/provider gag clauses	Effective when enacted	Plans may not enter into any agreement regarding access to a network of providers that would restrict the plan from providing provider-specific cost or quality of care information, accessing de-identified information or data, or sharing such information with a business associate. Annual attestation of compliance required.
MHP NQTL Comparative Analysis	February 10, 2021	Requires group health plans to conduct comparative analyses of the nonquantitative treatment limitations (NQTLs) used for medical and surgical benefits as compared to mental health and substance use disorder benefits.
Disclosure of direct and indirect compensation for brokers and consultants	December 27, 2021	Requires disclosure by health benefit brokers and consultants to plan sponsors regarding, at the time of contracting, their reasonably expected direct and indirect compensation for referral of services to group health plans.
Surprise medical billing protections	July 1, 2022	Prohibits some, but not all, surprise medical billing starting in 2022. Member out-of-pocket cost is based on in-network rates and benefits (i.e., member held harmless). Plan and out-of-network provider have 30 days to negotiate final rates that will be covered under the plan. Disputed charges between plan and out-of-network provider ultimately resolved through binding arbitration (independent dispute resolution) on a loser-pays basis.
Revision of insurance ID cards	July 1, 2022	Requires insurance ID cards to include in- and out-of-network deductible amounts and out-of-pocket maximums.
Continuity of care	July 1, 2022	Requires certain participants to receive up to 90 days of continued coverage at in-network cost-sharing rates when their provider moves out-of-network.
Accuracy of provider directories	July 1, 2022	Requires group health plans and issuers to provide participants up-to-date provider directories, and participants who rely on incorrect information received will only be liable for in-network cost-sharing amounts.

Transparency in coverage and Consolidated Appropriation Act – 2022 and 2023 effective dates



COVID-19 benefit plan changes

Recap and updates following the April 25, 2022 SEBC meeting

- The SEBC has previously opted to elect several benefits enhancements to support members during the COVID-19 pandemic
- The duration of these benefit enhancements have been tied to either regulatory requirements (such as the IRS loosening some of the rules governing flexible spending accounts in 2020 and 2021) or the end of the national public health emergency period
- During the COVID-19 pandemic, there are two separate “emergency” events that expire at different times and impact employee benefit plans differently, and the GHIP has benefit enhancements that are tied to each separate emergency event
  - ***National Emergency Declaration***
    - Issued by the President, can remain in effect for one year (unless the President rescinds it earlier), and was recently extended by President Biden to April 1, 2023
  - ***Public Health Emergency***
    - Issued by the Department of Health and Human Services in 90-day increments; recently extended to July 15, 2022

COVID-19 benefit plan changes

Recap and updates following the April 25, 2022 SEBC meeting (continued)

- During the April 25, 2022 SEBC meeting, the Committee reviewed the GHIP benefit enhancements aligned to the emergency declaration with the earlier end date (“Public Health Emergency”) and discussed the implications for extending the end date to match the emergency declaration with the later end date (“National Emergency Declaration”)
  - Committee requested information on how other states are handling COVID-related benefit enhancements tied to the Public Health Emergency period
- So far, outreach to other states and large employers about this issue has indicated that those plan sponsors who are still maintaining COVID-related benefit enhancements including waived copays and deductibles for COVID-19 testing and treatment have not communicated a specific deadline to plan participants
  - WTW is continuing to conduct outreach and will provide an additional update to the SEBC in June
- Further discussion with the SEBC will take place at the June 2022 meeting to review and confirm the timing for any future extensions of the COVID-19 benefit enhancements currently tied to the Public Health Emergency period which ends on July 15, 2022

State policy impacting the GHIP

Bill	Summary	Status as of 5/20/22
HB 248 – Equitable Reimbursement of Certain Pensioners' Spousal Healthcare Expenses	Introduced in mid-June 2021. Would require the State to reimburse healthcare expenses incurred by eligible pensioner spouses on Medicare who are required to enroll in their former employer's healthcare coverage and their former employer's coverage pays less that the State's coverage would pay. The Pension Office completed a fiscal note estimating impacts to the State/Pension Office to provide coverage as outlined in the bill to range from $6.9M to $13.8M annually. May be impacted by modifications to the State's SCOB Policy which are currently under review with the Subcommittees and is targeted for discussion/vote by the SEBC in August 2022.	Tabled in House Administration due to the fiscal note
HB 303 – Behavioral Health Well Checks	Introduced in 2020 as HB 307. Would mandate coverage for an annual behavioral health preventive well visit with a licensed mental health provider. Estimated annual fiscal impact to the GHIP is $2.4M. The bill if passed, would become effective on 1/1/2024.	Out of the House Appropriations Committee on 5/19/22, placed on Ready List
HB 400 – Sensitive Health Services	Introduced on 4/28/22 and replaces HB 261. Would require insurance carriers and the GHIP to use a common summary of payment form or explanation of benefits (EOB) for defined sensitive health care services. SBO and the GHIP carriers do not have any concerns with the bill.	Out of the House Committee on 5/3/22, placed on Ready List

State policy impacting the GHIP (continued)

Bill	Summary	Status as of 5/20/22
TBD – Chiropractic Maintenance Care	Senator Hansen has convened various stakeholders for discussion related to draft legislation that would require insurers and the GHIP to provide supportive/maintenance chiropractic care. Highmark and Aetna estimated annual fiscal impacts to the GHIP are less than $100K. Senator Hansen circulated another draft bill and requested comments by end of day on 5/6/22. SBO and the GHIP TPAs have reviewed and have no concerns or changes to the estimated fiscal impacts.	Not formally introduced yet
HB 219 – Pharmacy Benefit Managers	This Act is designed to provide enhanced oversight and transparency as it relates to PBMs. CVS, the GHIP Pharmacy Benefit Manager reported to SBO in April 2022 that retail brand claims will be excluded from the retail discount guarantee and instead be guaranteed at national average drug acquisition cost (NADAC). Estimated annual costs to the State of Delaware based on actual GHIP claims from October 2021 to April 2022 would be $1.8M. CVS presented a contract amendment to SBO on 5/11/22 reflecting brand claims guaranteed at NADAC and attaching pricing to the benefit plan; amendment is currently under review. Once the updated pricing is attached to the benefit plan, the Reverse and Reprocess (R&R) to pharmacies can take place. R&R – turn-around times could be anywhere from 30 – 60 days. CVS will keep the State of Delaware updated on the status of the progress.	Enacted without signature by the Governor and effective on January 1, 2022

Other state policy being tracked by the SBO

Bill	Summary	Status as of 5/20/22
SB 267 – Fairness in Cost Sharing	Senate Bill 265, Fairness in Copays was introduced and assigned to Senate Banking, Business & Insurance on 4/13/22. The bill requires that third-party cost-sharing assistance utilized by patients is applied toward the individual's deductibles and out-of-pocket limits. The intent of the bill is to ensure that the copay accumulator programs being used by insurers to claw back manufacturer copay assistance that would otherwise benefit the individual as opposed to the plan/insurer, is applied to the individual's deductible and OOP plan year maximums. **The bill excludes the GHIP** and SBO has confirmed no concerns from Highmark, Aetna or CVS.	Passed in Senate, sent to House for consideration
SS 1 for SB 120 – Primary Care Investments and Sustainability	The Primary Care Reform Collaborative (PCRC) bill passed and signed by the Governor will increase investments in primary care. In addition to the increases in primary care reimbursements, the bill sets caps on total aggregate spend in areas outside of primary care to balance increases by limiting additional growth in healthcare spend and establish through regulation, mandatory minimums for payment innovations, including alternative payment models and provider price increases. The bill does not apply to the GHIP; therefore, there was not a fiscal note from DHR.	Signed by the Governor on 10/1/21
SS 1 for SB 222	Bill would amend Title 18 of the Delaware Code relating to rates. Clarifies the definition of Core CPI, clarifies that the Insurance Commissioner will use the bimonthly indices developed by the United States Bureau of Labor Statistics ending with the bimonthly index issued in January of the applicable rate filing year. (3) By setting, in Section 2 of this Act, the Core CPI for rate filing year 2022 at 2.7%. As a result, under § 2503(a)(12)a.1. of Title 18 of the Delaware Code, the allowable aggregate unit price growth for rate filing year 2022 is 3.7%, which is the Core CPI, or 2.7%, plus 1%.	Passed in Senate, sent to House for consideration