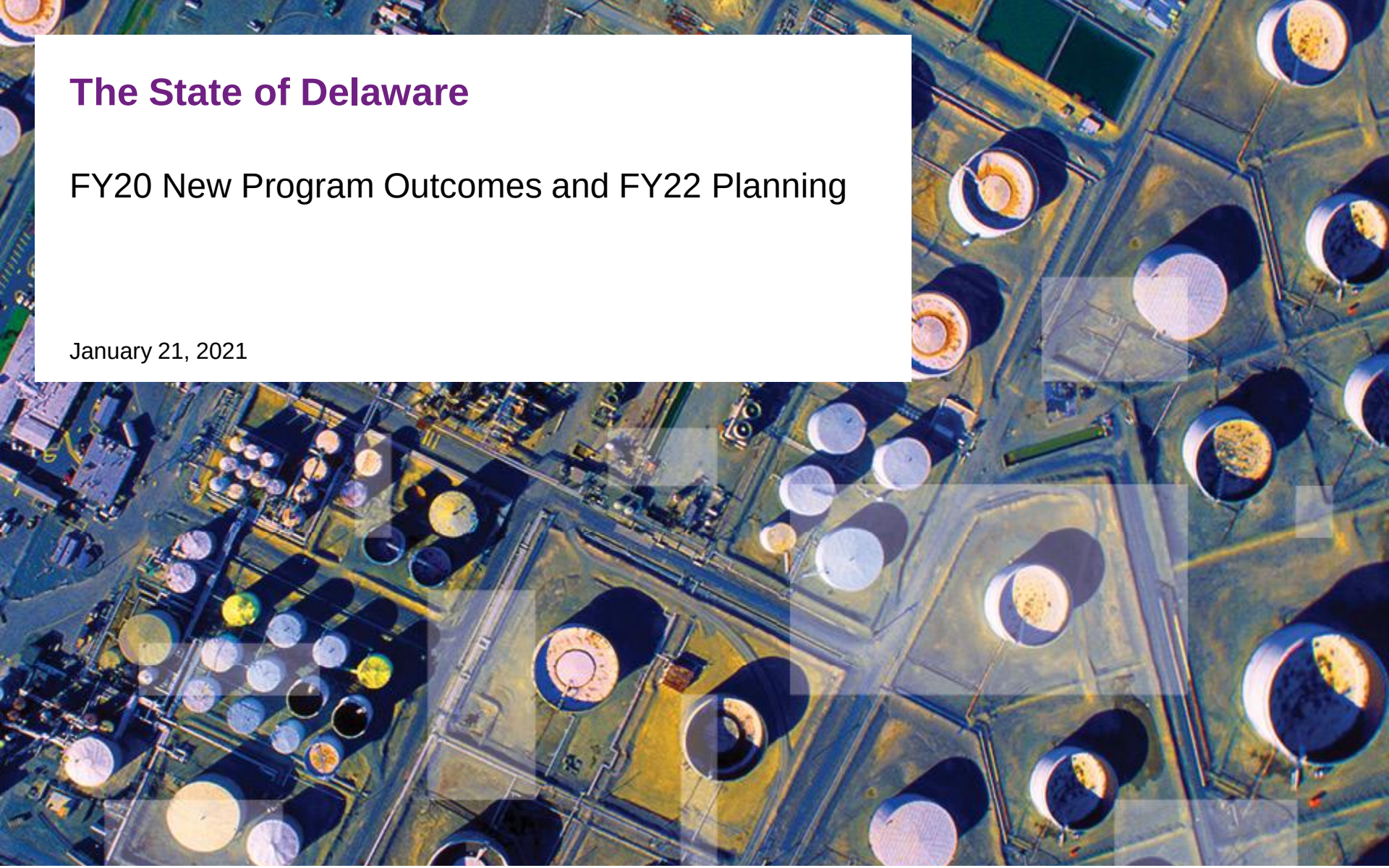

The State of Delaware

FY20 New Program Outcomes and FY22 Planning

January 21, 2021

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Today's discussion

- FY20 new program outcomes
- FY22 planning
  - Bariatric surgery carve-out considerations
  - Open Enrollment engagement considerations
  - 2021 Open Enrollment – SBO overview
- Next steps

- Appendix
  - Section 23 FY18 budget epilogue – open enrollment

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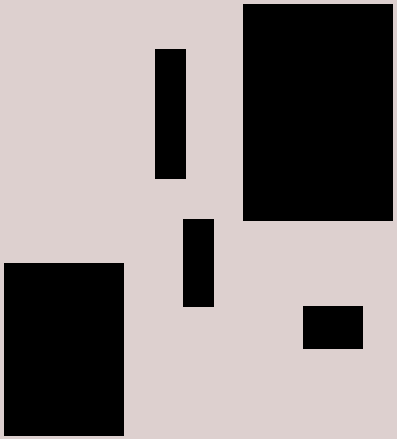
FY20 new program outcomes



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SurgeryPlus

Overview

- SEBC voted to adopt SurgeryPlus as a third-party administrator of Centers of Excellence (COEs) in October 2018
  - A COE is a medical facility and/or professional that has been identified as delivering high quality services and superior outcomes for specific procedures or conditions
  - Prior to then, access to COEs was available to GHIP participants through Highmark and Aetna, although there are differences between their COE offerings in terms of the scope of COE-eligible procedures and specific COE providers
- In June 2019, the SEBC voted to adopt a “carve-out” COE program design, communication and engagement strategy, incentive plan, and scope of covered services proposed by SurgeryPlus and developed with input from the Health Policy & Planning Subcommittee
  - Program design provided GHIP participants with the following choice of COE providers for a broad set of elective (non-emergency) procedures: plan participants could access a COE provider designated by their medical plan or they could access a SurgeryPlus COE provider
  - Use of SurgeryPlus COEs included additional incentives for the plan participant, including concierge member services to coordinate care on the plan participant’s behalf, travel benefits (hotel accommodation, mileage reimbursement, etc.) and a financial incentive (e.g., $2,000 for bariatric surgery)

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SurgeryPlus

FY20 savings – actual vs. estimated

- FY20 budget included an estimated $500,000 in net savings associated with implementing the carve-out program design and incentive plan proposed by SurgeryPlus
- Actual FY20 experience reflects a net savings of approximately $370,000
  - Data below reflects completed procedures only; does not reflect procedures that were scheduled but not yet completed prior to the end of FY20
- Key drivers of differences between estimated and actual savings from FY20:
  - Actual number of lower cost procedures were completed in FY20 than estimated (examples: colonoscopies, endoscopies)
  - Greater variety and cost variation among the scope of procedures actually offered vs. estimated
    - Estimated scope only included a subset of the COE-eligible procedures offered to the GHIP today (i.e., knee/hip replacements and spine surgery)
  - Incentive design was developed after the FY20 budget was finalized and was not factored into the estimated savings

SurgeryPlus FY20 experience	Estimated	Actual
Total number of procedures by participating providers	53	81
Gross Savings		
Estimated medical carrier claims cost	$1,881,000	$1,182,000
SurgeryPlus claim cost	$1,027,000	$509,000
Gross savings from SurgeryPlus	**$854,000**	**$673,000**
Admin Fees and Other Expenses		
SurgeryPlus administrative fees	$334,000	$196,000
Financial incentives	$0	$95,000
Travel benefits	$0	$13,000
Net savings to the State	**$520,000**	**$369,000**
FY20 budgeted savings[1]	**$500,000**	
Difference with FY20 budget		($131,000)

1. $500,000 savings also is net of estimated member cost share (approx. $20,000), which assumed members would pay the same out-of-pocket cost for using SurgeryPlus providers as they would to use the COEs available through the medical carriers.

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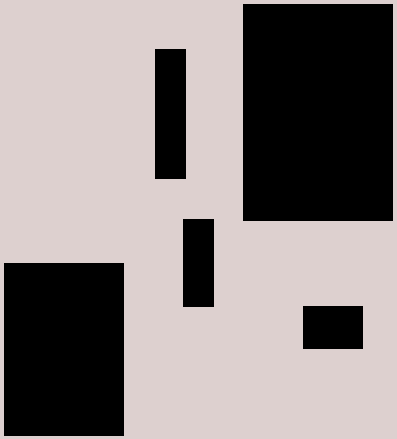
FY22 planning

Bariatric surgery carve-out considerations



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FY22 planning

Bariatric surgery

- One opportunity for consideration is mandating the use of the SurgeryPlus network for bariatric surgeries
- Currently, GHIP members who want to obtain these procedures have the choice to use their medical plan's provider network (i.e., through Highmark or Aetna) or obtain the surgery through the SurgeryPlus program
- There is potential for significantly different member experiences when seeking this surgery through the medical plan vs. the SurgeryPlus program in terms of:
  - Concierge support for locating a provider, scheduling an appointment, coordination of follow-up care with the member's PCP, etc.
  - Availability of participating providers
  - Health outcomes associated with the selected surgical provider
  - Claim billing and adjudication process
  - Travel benefits associated with using a provider of excellence
- The medical carriers have had challenges with administering this benefit for the State in the past, such as not applying the 25% coinsurance to members using non-COE facilities

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FY22 planning

Bariatric surgery

- SurgeryPlus has indicated that some plan sponsors within its book of business are starting to mandate use of the SurgeryPlus program for a limited set of procedures
  - Bariatric surgery is the most popular procedure to "carve-out" entirely to SurgeryPlus
- There are several potential benefits to GHIP participants and the plan if the State were to do this:
  - Travel requirements for plan participants would be limited
    - SurgeryPlus now has participating providers in Delaware who will perform bariatric surgery on an inpatient or outpatient basis
  - This procedure requires a lengthy coordination process with patients prior to surgery, and the SurgeryPlus program could support patients through this process via the concierge services offered through the program
  - Potential for members to share in the potential savings realized through steering members to SurgeryPlus providers
- The SEBC has discretion in how to offer coverage for this benefit -- bariatric benefits are not an ACA Essential Health Benefit; therefore, not required to be covered at all

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Bariatric surgery

Potential cost avoidance

- SurgeryPlus calculated the potential cost avoidance associated with carving out bariatric surgery and several other types of procedures
- Based on claims incurred in CY2019, SurgeryPlus estimated gross savings of approximately $2.2m if the 132 bariatric surgeries conducted during that time all delivered through SurgeryPlus providers
  - SurgeryPlus estimates that approximately 0.1% of the total enrolled population had bariatric surgery

						% of Total	
	Procedure	Total Spend		Total Savings [2]		SurgeryPlus	Total
Procedure Category	Count	Carrier	SurgeryPlus [1]	$	%	Spend	Medical Spend
Bariatrics	132	$4,253,033	$2,092,244	$2,160,789	50.8%	5.0%	1.2%
Joint Replacement	191	5,948,837	2,740,673	3,208,164	53.9%	7.0%	1.7%
Spine	152	6,224,260	2,586,234	3,638,026	58.4%	7.3%	1.7%
Inpatient GYN	50	904,785	517,207	387,578	42.8%	1.1%	0.3%
Other Orthopedics	1,477	15,721,519	7,072,755	8,648,764	55.0%	18.5%	4.4%
Other GYN	2,188	12,391,874	7,322,384	5,069,490	40.9%	14.6%	3.5%
Cardiac	42	1,703,283	891,419	811,864	47.7%	2.0%	0.5%
ENT	754	4,145,799	1,628,866	2,516,933	60.7%	4.9%	1.2%
General	754	8,714,896	3,470,734	5,244,162	60.2%	10.3%	2.4%
GI / Other Minor Procedures [3]	19,095	24,793,120	12,124,029	12,669,090	51.1%	29.2%	7.0%
Carve-Out Total	**475**	**$16,426,130**	**$7,419,151**	**$9,006,980**	**54.8%**	**19.4%**	**4.6%**
Total	**24,835**	**84,801,406**	**40,446,544**	**44,354,862**	**52.3%**	**100.0%**	**23.8%**

Source: SurgeryPlus

Note: Reflects SurgeryPlus manageable procedures observed in State of Delaware claims data for the 12-month period ending December 31, 2019.

(1) Implied by historic SurgeryPlus book of business savings percent savings for each category.

(2) Reflects historic SurgeryPlus book of business savings percent savings for each category.

(3) Other Minor Procedures includes high frequency, low cost and low acuity procedures such as biopsies & excision of masses.

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Bariatric surgery

Other considerations

- Today, the State provides plan participants with financial incentives for choosing a COE provider
  - Through the medical carrier networks: members in the PPO and HMO plans will pay up to $200 for inpatient or $0 (no cost) for outpatient surgery at a COE vs. 25% of the total cost of surgery at a non-COE provider (regardless of their status as a participating provider in the medical network)
  - Through SurgeryPlus:
    - $0 (no cost) for inpatient or outpatient surgery, plus
    - Financial incentive of $2,000 for bariatric surgery
- If coverage for bariatric surgery was only available through the SurgeryPlus program, should the financial incentive continue?

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Bariatric surgery

Other considerations (continued)

- Member-facing considerations:
  - Carve-out would require member communications and updates to plan documents and benefits summaries describing this change, along with procedures for claim denials and appeals
    - Opportunity to leverage communications for the upcoming OE period to communicate this change; would require SEBC approval by March 2021 to meet printer deadlines for FY22 OE
    - Members would need to understand any differences between current bariatric surgery clinical policy guidelines through Highmark and Aetna and SurgeryPlus
  - Description of benefits and restrictions would need to be added to plan summaries
  - Grace period may be necessary for members who are scheduled to have bariatric surgery with a non-SurgeryPlus provider within a given period of time following the effective date of the carve-out

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Bariatric surgery

Other considerations (continued)

- Medical carrier considerations
  - Coverage for specific procedure codes associated with bariatric surgery would need to be "turned off"
  - Scripting required for carrier customer service and care management teams to ensure consistent messaging about this change; also, referral protocols should be established and tracked
  - Discussion of claim denials and appeals process would be necessary
  - Online provider portals and member websites would need to be updated to reflect carve-out arrangement (i.e., non-coverage of bariatric surgery through Highmark and Aetna plans and coverage only through SurgeryPlus)
  - Clinical policy guidelines for SurgeryPlus bariatric surgery program are currently under review against medical carrier guidelines to determine any material differences in the member experience

Question for Subcommittee members:

Do you have any initial feedback on the potential opportunity to carve out bariatric procedures to the SurgeryPlus program?

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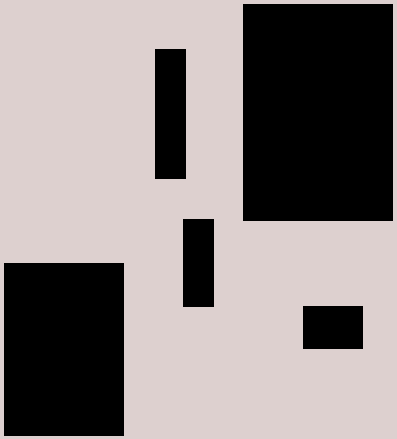
FY22 planning

Open Enrollment engagement considerations



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Open enrollment engagement

- In 2017, the budget epilogue language was updated to allow the SEBC to implement an active enrollment each year (see appendix slide)
  - Active enrollment encourages more employees to review the options available and make an optimal plan choice for their situation, whether the default plan or something else, driving savings for the State
- Since that time, the SEBC has opted to strongly encourage employees and non-Medicare pensioners to actively engage in open enrollment, but have opted against implementing an active enrollment process
- State employee engagement in open enrollment has increased in recent years

OE Period	State Agency Average	State Average
2020 OE (for FY21)	85.8%	83.4%
2019 OE (for FY20)	85.8%	84.7%
2018 OE (for FY19)	84.9%	81.8%
2017 OE (for FY18)	60.1%	54.1%

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Open enrollment engagement

- The State provides employees with an enrollment decision support tool to aid in medical plan selection each year: IBM Watson's myBenefitsMentor tool
  - myBenefitsMentor tool provides employees and non-Medicare pensioners with recommendations for the lowest cost medical plan option based on the employee's or pensioner's historical medical costs (including their covered dependent costs, if applicable)
  - While the myBenefitsMentor tool was used by nearly 27% of employees and non-Medicare pensioners during FY21 Open Enrollment, a relatively small percentage selected the recommended plan (see next page)
  - Utilization rate among employees and non-Medicare pensioners continues to increase each year
    - 2019 OE (for FY20): 22%
    - 2018 OE (for FY19): 20%

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State employee utilization of enrollment decision support tool

FY21 open enrollment

Distribution of Contracts by Plan Choice for FY21 by Lowest Cost Plan ("Recommended Plan") and Use of Watson Benefits Mentor Tool

43,546 letters with medical plan options, estimated cost information and projected low-cost plan were sent to benefit eligible employees and early retirees.

38,364 employees were enrolled in medical plans in FY20 and included in the letter distribution.

Lowest Cost Plan:[1]

- Aetna CDH: 16,303 (37.2%)
- Aetna HMO: 9,537 (21.8%)
- First State Basic: 17,706 (41.0%)

10,359 employees / early retirees utilized the Benefits Mentor tool (26.9% of those enrolled in a health plan prior to Open Enrollment).

[1]More than one plan may be the projected lowest cost option for some letter recipients.

Source: IBM.

2021 Plan Choice Employees (% of Enrollment among Letter Recipients)	Used Tool (Y/N)	Tool Utilization Distribution by Plan Employees (% of Plan Enrollment among Letter Recipients Enrolled in a Plan in FY20)
Aetna CDH 2,849 (5.5%)	Y	451 (18.8%)
	N	1,947 (81.2%)
Aetna HMO 10,773 (19.4%)	Y	2,333 (27.6%)
	N	6,107 (72.4%)
Highmark FSB 2,879 (5.9%)	Y	313 (12.2%)
	N	2,253 (87.8%)
Highmark PPO 31,542	Y	7,119 (29.1%)
	N	17,304 (70.9%)
Medicfill 623	Y	86 (16.0%)
	N	451 (84.0%)
No Plan Enrollment in FY20 5,182 (11.9%)		

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State employee utilization of enrollment decision support tool

FY21 open enrollment (continued)

Letter Recipients Enrolled in a Health Plan Who Used Tool (10,359)

Lowest Cost Plan	Plan Choice[1]		% of Enrolled Active Employees and Early Retirees Choosing Recommended Plan
Aetna CDHP (n=4,884)	**Aetna CDHP**	**227**	**4.7%**
	Aetna HMO	1,053	
	Highmark FSB	122	
	Highmark PPO	3,406	
Aetna HMO (n=2,915)	Aetna CDHP	69	**17.9%**
	Aetna HMO	**513**	
	Highmark FSB	64	
	Highmark PPO	2,214	
Highmark FSB (n=2,668)	Aetna CDHP	155	**4.8%**
	Aetna HMO	774	
	Highmark FSB	**127**	
	Highmark PPO	1,598	
Total			**8.4%**

Letter Recipients Enrolled in a Health Plan Who Did Not Use Tool (28,103)

Lowest Cost Plan	Plan Choice[1]		% of Enrolled Active Employees and Early Retirees Choosing Recommended Plan
Aetna CDHP (n=11,074)	**Aetna CDHP**	**718**	**6.5%**
	Aetna HMO	2,329	
	Highmark FSB	612	
	Highmark PPO	7,086	
Aetna HMO (n=6,591)	Aetna CDHP	266	**18.7%**
	Aetna HMO	**1,230**	
	Highmark FSB	252	
	Highmark PPO	4,591	
Highmark FSB (n=10,603)	Aetna CDHP	966	**13.1%**
	Aetna HMO	2,565	
	Highmark FSB	**1,392**	
	Highmark PPO	5,760	
Total			**12.0%**

Source: IBM.

[1]Excludes those not enrolled in a Medical Plan in FY20 and Medicfill enrollees in FY21.

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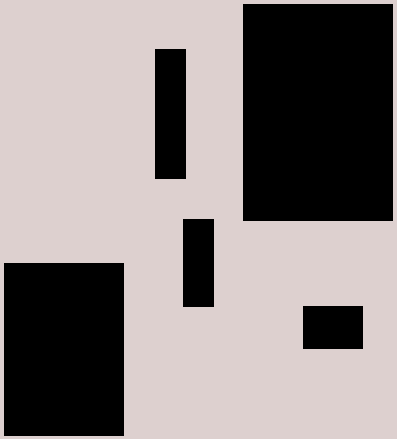
FY22 planning

2021 Open Enrollment – SBO overview



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2021 Open Enrollment

- Open Enrollment for all groups will start **Monday, May 3, 2021 and run through Wednesday, May 19, 2021.**

- Given the current COVID-19 pandemic, SBO will not hold health fairs. Instead, we are working with our benefit vendors to create short informational videos that will be posted on the Open Enrollment page of the SBO website for employees to access while preparing for Open Enrollment.

- Assignment of online courses:
  - SBO will assign one online course to HR/Benefit Representatives on April 6, 2021 titled ***"HR/Benefit Rep Responsibilities For Open Enrollment"*** that reviews their responsibilities prior to, during and after Open Enrollment to best support their employees.
  - SBO will assign one online course to benefit-eligible employees on April 7, 2021 titled ***"Navigating Open Enrollment"*** that reviews the steps they need to take prior to, during and after Open Enrollment, as well as any changes that will occur for the plan year beginning July 1, 2021.
  - Activities and questions within the online courses will be streamlined this year.
  - Online courses will be available and tracked in the Delaware Learning Center (DLC) and via a separate website link (for those who do not have access to the DLC).
  - Completion due date for the online courses is April 30, 2021.

2021 Open Enrollment

- SBO will offer virtual “Question & Answer” sessions for HR/Benefit Representatives to participate in prior to Open Enrollment.
- SBO will streamline Open Enrollment communications, including content and messaging.
- The Double State Share (DSS) Form for eligible employees does not have to be completed until after Open Enrollment ends; however, employees can complete the DSS Form during Open Enrollment if they wish.

2021 Open Enrollment

- All benefit-eligible employees are **required to actively participate** in the Open Enrollment process each year.

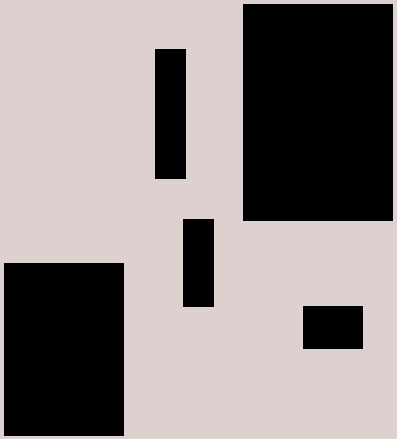
Actively participate between **May 3 - 19, 2021**
by completing these three simple steps:

- ***STEP ONE:*** Log in to State of Delaware Employee Self-Service (employeeselfservice.omb.delaware.gov) to enroll, confirm or waive your health, dental and/or vision coverage.

- ***STEP TWO:*** Complete the online Spousal Coordination of Benefits Form only if you will be covering your spouse under a Highmark Delaware or Aetna Health Plan as of July 1, 2021.

- ***STEP THREE:*** Check out the additional benefits available, including the Flexible Spending Account (FSA) Plan, Accident & Critical Illness Insurance and Group Universal Life (GUL) Insurance.

Next steps



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Next steps

- Subcommittee members to provide feedback on the potential opportunity to carve out bariatric procedures to the SurgeryPlus program
- The SEBC will be asked to determine whether an active enrollment process is required for FY22, or if it will continue to strongly encourage active participation among State employees and non-Medicare retirees
  - Item will be presented for a vote at either the February or March 2021 SEBC meeting
- Either decision would benefit from continued use of the myBenefitsMentor tool, which supports a goal within the GHIP Strategic Framework:
  - In light of the GHIP's changing demographic profile, strive for an incremental increase in unique users utilizing a specific point-of-enrollment and/or point-of-care engagement platform/consumerism tool[1] by at least 5% annually
- Subcommittee members are encouraged to discuss this with your SEBC member and reach out to the SBO with any questions or requests for additional information

1 Through FY2021, this tool will continue to be administered under the purview of the SBO. Post-FY2021, selection of a specific engagement platform / consumerism tool will be at the discretion of the SEBC.

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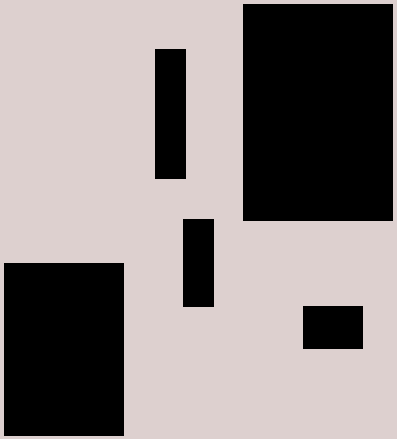
Appendix



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Section 23 FY18 budget epilogue – open enrollment

Employees of the State of Delaware who are enrolled in a health insurance benefit plan must actively participate in the open enrollment process each year by selecting a health plan or waiving coverage. Should such employee(s) neglect to enroll in a plan of their choice during the open enrollment period or waive coverage, said employee(s) and any spouse or dependents enrolled at the time will be enrolled into the default health plan(s) as determined by the State Employee Benefits Committee.

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