**MINUTES FROM THE COMBINED MEETING OF THE FINANCIAL and HEALTH POLICY & PLANNING SUBCOMMITTEES TO THE STATE EMPLOYEE BENEFITS COMMITTEE**
**FEBRUARY 18, 2021**

The Health Policy & Planning ("HP&P") Subcommittee and the Financial Subcommittee to the State Employee Benefits Committee (the "Committee") met Thursday, February 18, 2021 in a combined meeting. In accordance with the Proclamation Authorizing Public Bodies to Meet Electronically and in the interests of protecting the citizens of this State from the public health threat caused by COVID-19, this meeting was conducted via WebEx and without a physical location.

*Subcommittee Members Represented or in Attendance:*
Dir. Faith Rentz, SBO, Department of Human Resources ("DHR") (Appointee DHR Sec. Bonner), Chair
The Honorable Colleen Davis, State Treasurer, Office of the State Treasurer
Ms. Judy Anderson, DSEA, (Appointee Mr. Taschner for DSEA)
Mr. Steven Costantino, Dept. of Health and Social Services ("DHSS") (Appointee DHSS Sec. Magarik)
Deputy Secretary Tanesha Merced, DHSS (Appointee DHSS Sec. Magarik)
Ms. Emily Molinaro, OMB (Appointee of OMB Dir. Cade)
Ms. Judi Schock, Deputy Principal Assistant, Office of Management & Budget (Appointee OMB Dir. Cade)
Mr. Bert Scoglietti, Deputy Controller General, Office of the Controller General (Appointee CG Jones)
Mr. Stuart Snyder, Chief of Staff, Department of Insurance (Appointee Commissioner Navarro)
Ms. Ashley Tucker, Staff Attorney, Administrative Office of the Courts (Appointee The Hon. Collins Seitz, Chief Justice, Delaware Supreme Court)
Mr. Keith Warren, Chief of Staff, Office of the Lt. Governor (Appointee Lt. Governor Hall-Long)

*Subcommittee Members Not in Attendance:*
Ms. Victoria Brennan, Chief of Fiscal Policy, Office of the Controller General (Appointee CG Jones)
Mr. William Oberle, Delaware State Trooper's Association (Appointee Mr. Taschner, DSEA)

*Others in Attendance:*
Ms. Leighann Hinkle, Deputy Director, SBO, DHR
Mr. Chris Giovannello, Willis Towers Watson ("WTW")
Ms. Jaclyn Iglesias, WTW
Ms. Rebecca Warnken, WTW
Ms. Brooke Best, SurgeryPlus
Ms. Christina Bryan, Delaware Healthcare Association
Ms. Julie Caynor, Aetna
Ms. Cherie Dodge Biron, Deputy Principal Asst., DHR
Ms. Nina Figueroa, Health Policy Advisor, SBO, DHR
Ms. Deborah Hamilton, Hamilton Goodman Partners
Ms. Katherine Impellizzeri, Aetna
Ms. Lizzie Lewis, Hamilton Goodman Partners
Ms. Heather Johnson, Controller II, DHR
Mr. Walter Mateja, IBM Watson Health
Ms. Jennifer Mossman, Highmark Delaware
Ms. Paula Roy, Roy & Associates
Ms. Christine Schiltz, Parkowski, Guerke & Swayze
Mr. Aaron Schrader, HR Manager, DHR, SBO
Ms. Martha Sturtevant, Exec. Sec., SBO, DHR - Recorder, State Employee Benefits Committee and Subcommittees
Mr. John Zutter, SurgeryPlus

**CALLED TO ORDER**
Director Rentz called the meeting to order at 10:00 a.m.

**APPROVAL OF MINUTES –DIRECTOR FAITH RENTZ, CHAIR**

A MOTION was made by Mr. Constantino and seconded by Ms. Schock to approve the Minutes from the Combined Subcommittee meeting on January 21, 2021.
MOTION ADOPTED (1 Abstention – Mr. Scoglietti).

**DIRECTOR'S REPORT – DIRECTOR FAITH RENTZ, CHAIR**

*Rethink Family Support Benefits*

The free trial benefits for Rethink family support benefits have been extended. SBO is evaluating options related to this benefit including responses received to the Request for Information ("RFI") released in January as well as related benefits and services available through the GHIP and other avenues outside of the GHIP.

*Health Care Stakeholder RFI*

SBO and WTW are evaluating 19 responses received from the RFI that closed December 1, 2020. There will be no contract awards from this RFI; however, findings will be used as key inputs for the upcoming medical Third Party Administrator Request for Proposal scheduled for release in Spring 2021. SBO intends to update all respondents by March 1, 2021.

*New Benefits for 2021 Open Enrollment*

Open Enrollment is scheduled for May 3 – 19, 2021. SBO is implementing a second EyeMed Vision offering and the transition from Express Scripts to CVS Caremark for pharmacy benefits, both effective July 1, 2021. The transition to CVS for the Medicare population will occur on January 1, 2022.

*Legislative Updates*

The Primary Care Reform Collaborative met January 25, 2021 to discuss potential legislation that would set a primary care target spend of 11.5%, increase primary care spending 1.5% annually thru 2025, and include an increase in primary care reimbursement in CY21 to 150% of Medicare spend. SBO has provided comments and estimates for the fiscal impact to the GHIP range from $8.9M to $15.0M for FY22. A draft bill is expected in advance of the next meeting scheduled for March 8, 2021.

Mr. Costantino added that members of the Collaborative were asked to provide feedback on the proposed legislation and additional edits may be forthcoming.

Mr. Scoglietti queried the estimate on the annualized cost with full implementation. Dir. Rentz responded that the increase expected in FY22 would depend upon the effect date of an increase, but annualized estimates were not projected out thru 2025. Mr. Costantino added that legislation does not aim to redistribute the total spend and not increase the total cost of care.

*Treasurer Davis joined the meeting*.

*State Employee Benefits Committee Updates*

The Committee did not meet in January but will meet in February and March to discuss any plan design modifications, updated financials that include the CVS pharmacy contract, COVID-19 expenditures, and revised projections through FY22. Input from the Subcommittees will be important to the Committee as they consider and evaluate the financials and any potential changes impacting Open Enrollment. The Committee will meet February 22, 2021 to review financials and an updated forecast and meet in Executive Session to review a Level III disability appeal. The Subcommittees will hold a combined meeting on March 4, 2021.

*Subcommittee Tracking Log*

SBO is revising the format of the Subcommittee tracking log; members were encouraged to provide feedback on if continuing to receive this log is helpful.

**FINANCIALS**

*January 2021 Fund Equity Report – Mr. Giovannello, WTW*

A year-end prescription true up reconciliation payment of $9.5M was received for CY19, compared to last year's CY18 payment of $5.2M. The higher payment is because of increased pharmacy spend. Also received was a $5.7M Medicare Part D coverage gap discount payment.

January claims generated a surplus of $1.5M with a YTD claims surplus of $4.4M with a $4.8M variance to budget. The fund equity balance is $179.6M.

Mr. Costantino queried what assumptions might be made from the lower utilization of services in January. Mr. Giovannello responded that overall claims are running close to budget and varies weekly.

Mr. Scoglietti queried the YTD budget on projected operating expenses. Mr. Giovannello responded that he would review in the long-term projections presentation. Ms. Rentz added that she will send Mr. Scoglietti the FY21 budget approved by the Committee in August.

*FY21 Q2 Financial Reporting – Mr. Giovannello, WTW*

A review of FY21 claims through December reflects gross claims up 1.5% and aligns with the increase in average members. On a per-employee and per-member per-year basis medical claims reflect an increase of 1.3% to 1.7% and pharmacy reflects a decrease of 3.4% to 4.4% resulting from the timing of invoice payments; there were 12 ESI invoices in FY21 (commercial and EGWP) compared to 13 invoices in FY20 and if corrected for, pharmacy claims would reflect an increase of 5-6%.

Mr. Costantino asked to confirm that the prescription spend did not include rebates. Mr. Giovannello responded that the gross claims are prescription only, but the net costs and fees are reflected in the total program costs.

When comparing FY21 actual to FY21 budget (approved August 2020), medical claims are down 5%, but January claims were closer to budget; this is the result of the timing and the number of claims received.

Reductions were noted in the utilization and spend in preventive care, screenings, in-patient and emergency room admissions. Pharmacy increased 18.5% in utilization with specialty mediations at 46% of pharmacy spend.

A reconciliation of operating expenses versus operating revenues between the WTW Financial Report and the Fund Equity Report noted that WTW reports what is expected to be earned in FY21 compared to the Fund report that reflects what was received in FY21.

*GHIP Long Term Projection Recast & COVID-19 Cost Reporting and Utilization Analysis – Mr. Giovannello, WTW*

Uncertainty around the pandemic continues. The impact will depend on many factors including the effectiveness of policies to mitigate spread and timing of easement of social distancing measures, the level of care deferral that returns in FY21 and FY22, the potential care deferral that emerges in FY21, the cost effectiveness of the vaccine or therapeutic agents, the potential for new waves of infection, and the downstream impact from missed preventive screenings/immunizations, compounding mental health issues, and the unknown health needs of COVID-19 survivors.

Vaccine costs are currently covered by the Federal Government and the State is responsible for the administration costs. Claims are being tracked on a weekly basis to analyze trends and to support premium rate recommendations. The $23.5M one-time COVID-19 reserve is still included in projections.

Claims for FY20 Q4 came in $47.1M below budget, claims for FY21 Q1 came in $11.2M below budget and FY21 Q2 came in $8.3M above budget driven by the return of deferred care. February, March, and April claims will be closely evaluated to determine the need for potential rate action in FY22. Q3 Financials will be available in May.

The YTD cost of COVID-19 testing and treatment claims for Highmark totals $10.7M for confirmed members and Aetna totals $2.7M. Highmark totals $9.6M in paid testing claims and Aetna totals $1.0M.

Mr. Costantino noted testing is free and queried what costs are included in testing paid claims. Mr. Giovannello responded that it likely includes required testing in advance of procedures as well as claims for procedure codes associated with someone who had a (negative) test.

Ms. Anderson queried the explanation for the cost disparity between Highmark and Aetna claims on a per-member basis. Mr. Giovannello responded that it cannot be confirmed that the claims are attributed to the same procedure codes and that provider billing is still evolving.

Aetna non-COVID-19 telemedicine claims continue to increase and total $57K with $4.0M in attributable claims. From January 1, 2020 Highmark had a total of $14.0M in claims attributable to telemedicine.

Mr. Costantino queried whether telemedicine spend could breakout claims associated with behavioral health. Mr. Giovannello confirmed and WTW will update the data to include the breakout.

The CVS commercial contract savings has been included in the long-term projections. The new contract is expected to reduce allowable pharmacy claims by $7.6M and increase rebates by $14.3M. The EGWP contract begins January 1, 2022; the savings for remaining 6 months of FY22 is expected to reduce allowable pharmacy claims by $13.2M and increase rebates by $16.5M.

Updated projections include spreading the return of deferred care into FY22, the increase in claims and premiums due to the growth in enrollment, and a cost of $160K for Aetna's essential health benefit changes related to accidental dental coverage.

Updated projections do not account for any future rate action or FY22 program or legislative changes including the proposed primary care legislation estimated at an increase of $10.0M, copay changes for mental health parity analysis estimated at an increase of $370K, and a bariatric surgery carve-out to SurgeryPlus estimated at $355K -$1.4M in cost avoidance.

A rate increase in FY21 is not possible; however, the Financial Subcommittee will be asked to review and recommend the timing and level of a rate increase in FY22.

*Treasurer Davis left the meeting*.

A $46.5M projected surplus through end of FY21 includes a $23.5M COVID-19 reserve and a $9.5M CY19 EGWP true-up payment received January 2021.

The projected operating expenses for FY21 is $1.019B factoring in deferred care. Without a premium increase or other savings initiatives, a deficit of $31.4M is projected through end of FY22. To smooth FY21 surplus over two years will require a 6.4% premium increase effective July 1, 2021, or a 7.8% increase without the COVID-19 reserve.

Emerging experience will continue to be tracked on a weekly basis to support a discussion around timing and level of potential rate action.

Mr. Scoglietti queried clarification on the calculations of the claims liability and the minimum reserve. Mr. Giovannello responded that claims liability is incurred claims that are not yet paid and are based on lag factors provided by Aetna and Highmark with the next update due in March, and the minimum reserve amount is the minimum cushion amount needed for a year outside the 97% confidence interval. Mr. Giovannello will share the associated documentation with Mr. Scoglietti.

Mr. Costantino queried whether the reserve was sufficient for a catastrophic year. Mr. Giovannello responded that the reserve is not sufficient to cushion events such as the pandemic. Ms. Warnken added that it represents a 1-2% swing in the confidence interval based on claims and demographics of the current population.

**GHIP FY20 NEW PROGRAM OUTCOMES & FY22 PLANNING – MS. JACYLN IGLESIAS**

The 2017 epilogue language allows the Committee to either roll over an existing election to the following plan year or implement an active enrollment that would require employees to participate in OE or be defaulted into a designated plan option. The Committee has opted to use strong messaging to encourage, but not require, participants to actively participate. Engagement in open enrollment has increased from 54.1% in 2017 to 83.4% in 2020 because of this strong messaging.

To support employee decision making the State provides the myBenefitsMentor tool by IBM Watson to help employees identify the lowest cost plan recommendation based on their historic medical costs including applicable dependents. This tool was used by 27% of active employees and non-Medicare pensioners during 2020 OE (FY21); however, only 8.4% switched to the recommended plan, compared to 12.0% of those who did not use the tool but still selected the lowest cost plan that would have been recommended.

Employees employed for more than a year were more likely to select the recommended plan. The older the employee, the more likely they were to select the recommended plan. Employees without dependents were much more likely to select the recommended plan.

There was a discussion regarding possible conclusions, past survey results, and the potential benefit of having an employee focus group to better understand why employees would not choose the lowest cost plan.

There was a discussion regarding the mandatory use of enrollment decision support for active employees who utilize the PHRST platform. Members discussed the liability of defaulting an employee into a plan. The Subcommittee did not express interest in requiring vs. encouraging active enrollment.

Mr. Costantino queried what data is available to evaluate the tool's recommendations; what percent of employees would have/not have benefited the following year by having the recommended plan. Dir. Rentz responded that she will follow up.

Currently GHIP members have the choice to use their medical plan or obtain bariatric surgery through the SurgeryPlus program. There is an opportunity in FY22 to mandate bariatric surgery through SurgeryPlus.

SurgeryPlus has participating providers in Delaware who will perform bariatric surgery on an inpatient or outpatient basis. SurgeryPlus has no out-of-pocket cost sharing for members and can benefit members in terms of health outcomes, claim billing and adjudication, and concierge support to locate providers, schedule appointments, limit travel requirements, coordinate follow-up care, and more.

The medical carriers have had challenges with administering this benefit in the past, such as not applying the 25% coinsurance to members using non-Center of Excellence facilities.

Bariatric benefits are not an ACA Essential Health Benefit; therefore, the Committee has discretion in how to offer coverage for this benefit.

The net cost avoidance per procedure is estimated at $12K with a range of potential cost avoidance for FY22 estimated between $355K (at 1/4 of pre-COVID average) and $1.4M (at pre-COVID average) to be determined by the number of procedures, and the length of any grace period offered 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. Estimate also assumes that the financial incentive for using SurgeryPlus for this procedure is discontinued.

Other considerations include communications and updates to plan documents and benefit summaries, including procedures for claim denials and appeals, as well as communicating the differences in clinical policy guidelines through Highmark, Aetna and SurgeryPlus.

Medical carrier considerations would include disabling coverage for specific procedure codes associated with bariatric surgery, scripting for carrier customer service and care management teams to ensure consistent messaging about this change, discussion of claims denials and appeal process, and updating online provider portals and member websites to reflect the carve-out arrangement. Additionally, the 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.

There was a discussion regarding routinely reviewing estimates for cost avoidance against realized savings. The experience in the first year of offering SurgeryPlus resulted in more surgeries than expected, but fewer high-cost surgeries than expected.

Ms. Anderson requested a summary of SurgeryPlus member satisfaction surveys specific to GHIP member utilization. Ms. Best responded that SurgeryPlus will follow up.

**OTHER BUSINESS**
Mr. Costantino announced that the federal Health Insurance Marketplace is open for enrollment by Executive Order from February 15 to May 15, 2021.

**PUBLIC COMMENT**
No public comment

**EXECUTIVE SESSION**
A MOTION was made by Mr. Constantino and seconded by Mr. Scoglietti to move into Executive Session at 11:45 a.m.
MOTION ADOPTED UNANIMOUSLY.

**ADJOURNMENT**
A MOTION was made by Mr. Scoglietti and seconded by Ms. Schock to adjourn the meeting at 12:26 p.m.
MOTION ADOPTED UNANIMOUSLY.

Respectfully submitted,

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