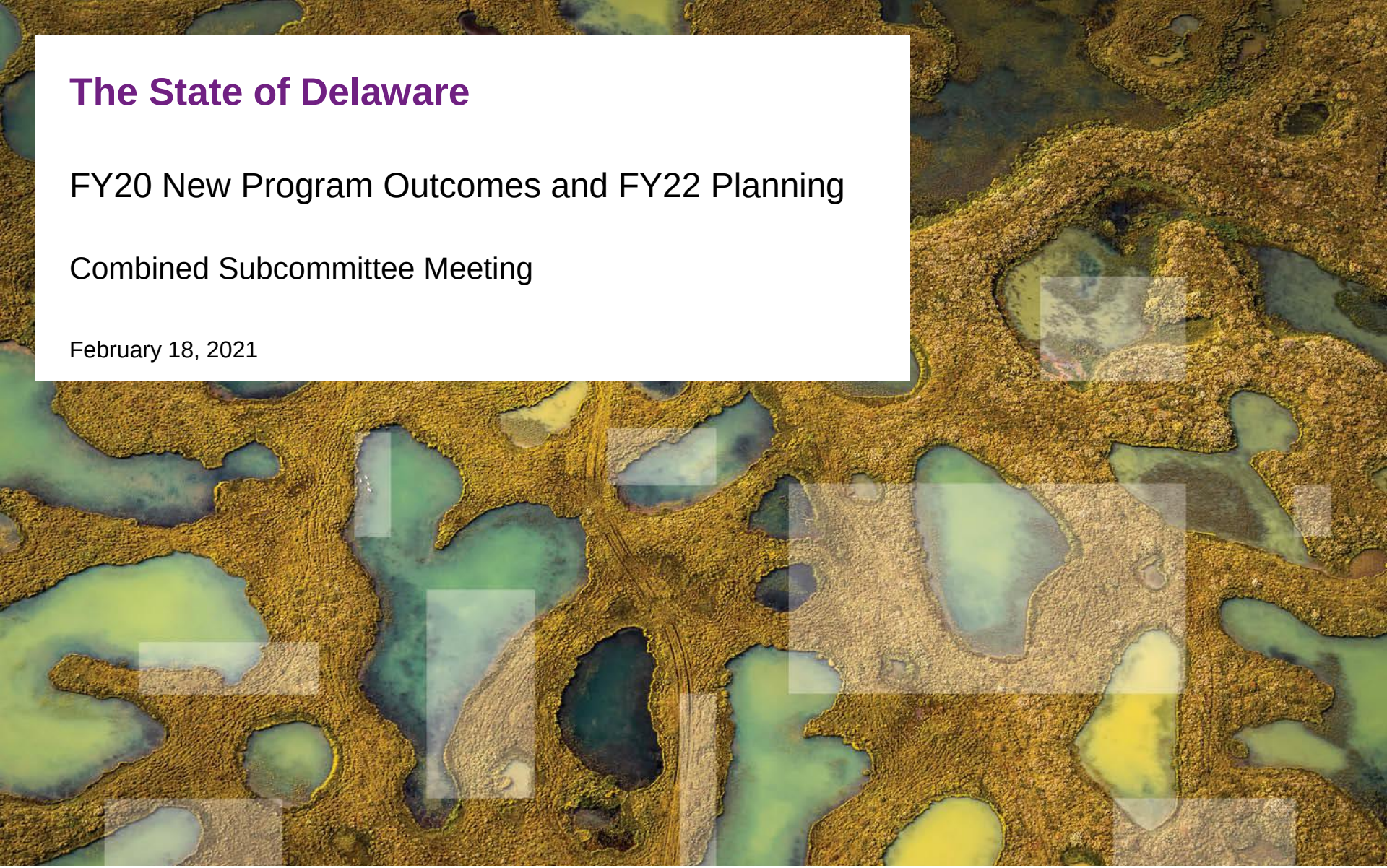
# The State of Delaware

## FY20 New Program Outcomes and FY22 Planning

Combined Subcommittee Meeting

February 18, 2021









Willis Towers Watson

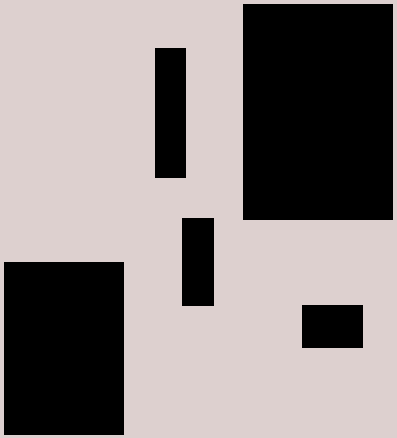
# Today's discussion

- FY22 planning
  - Open Enrollment engagement considerations
  - Bariatric surgery carve-out considerations

- Appendix
  - Section 23 FY18 budget epilogue – open enrollment

# FY22 planning

## Open Enrollment engagement considerations



# 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

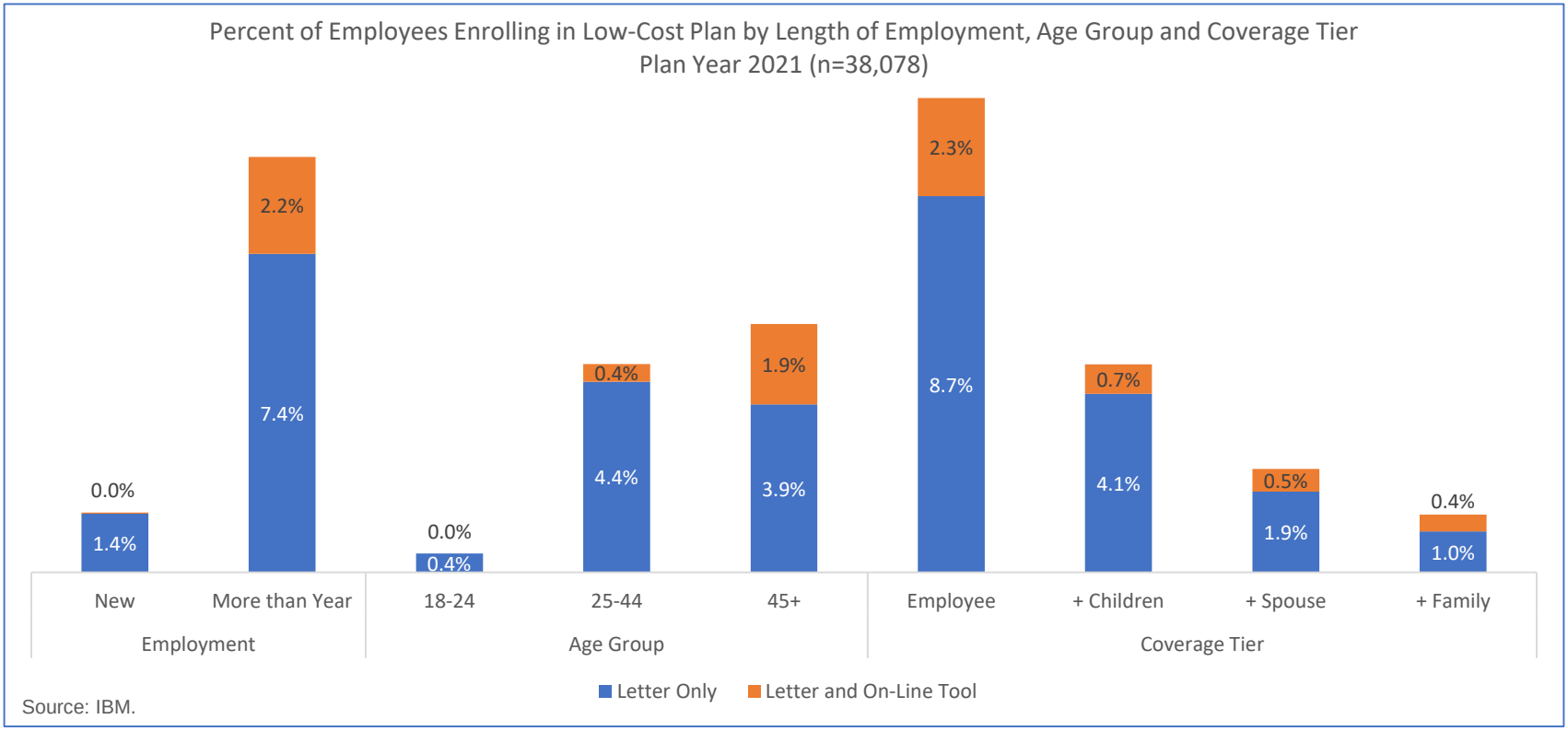
| OE Period | State Agency Average | State Average |
|---|---|---|
| 2020 OE (for FY21) | 85.8% | 83.4% |
| 2019 OE (for FY20) | 85.8% | 84.7% |
| 2018 OE (for FY19) | 84.9% | 81.8% |
| 2017 OE (for FY18) | 60.1% | 54.1% |

# 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)
  - Utilization rate among employees and non-Medicare pensioners continues to increase each year
    - 2020 OE (for FY21): 27%
    - 2019 OE (for FY20): 22%
    - 2018 OE (for FY19): 20%
  - 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
    - Only 8.4% of users selected 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 for them

# State employee utilization of enrollment decision support tool

- At the January Combined Subcommittee meeting, details related to employee/non-Medicare pensioner utilization of the myBenefitsMentor tool were reviewed
- As a follow-up from that discussion, additional information about how the employee population segments into various user groups has been provided below



# For discussion

- What are Subcommittee members' perspectives on requiring vs. encouraging engagement in the Open Enrollment process?
- Is there consensus around a recommendation that can be shared with the SEBC?

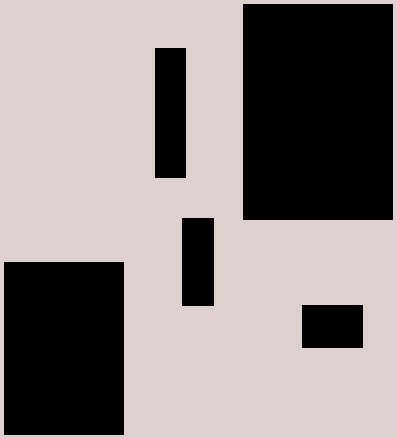
Regardless of whether engagement in Open Enrollment is required or encouraged, employees and non-Medicare pensioners would benefit from continued use of the myBenefitsMentor tool, which supports a goal within the GHIP Strategic Framework:

- *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*

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.

# FY22 planning

Bariatric surgery carve-out considerations



# Bariatric surgery

## Overview of provider options

- Currently, GHIP members who want to obtain bariatric surgery 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

# Bariatric surgery

## Carve-out opportunity for FY22

- 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

# Bariatric surgery

## Range of potential cost avoidance for FY22

- Potential cost avoidance associated with carving out bariatric surgery is highly dependent upon the number of procedures that will be conducted during FY22
- Several factors can impact number of procedures, including:
  - Continued impact of COVID-19 on deferral of elective procedures, and
  - 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
- Number of procedures noted below are based on a range leading up to the average annual number of bariatric surgery procedures in the two years prior to the COVID-19 pandemic (Calendar Years 2018-2019)
- Estimate below also assumes financial incentive for using SurgeryPlus program is discontinued, given that GHIP coverage of bariatric procedures would only be available through the SurgeryPlus program in this scenario

| Estimated FY22 cost avoidance | per procedure |
|---|---|
| **Gross Cost Avoidance** | |
| Estimated medical carrier claims cost | $37,000 |
| SurgeryPlus claims cost | $18,000 |
| **Gross Cost Avoidance from SurgeryPlus** | **$19,000** |
| **Administrative Fee and Other Expenses** | |
| SurgeryPlus administrative fee | $7,000 |
| Financial incentive | $0 |
| Travel benefits | $175 |
| **Net Cost Avoidance to the State** | **$11,825** |

| | 1/4 pre-COVID average | 1/2 pre-COVID average | Pre-COVID average |
|---|---|---|---|
| Annual number of procedures | 30 | 60 | 120 |
| **Total Estimated FY22 Cost Avoidance to the State** | **$355,000** | **$710,000** | **$1,419,000** |

# Bariatric surgery

## Other considerations with carve-out opportunity

- 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
- 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

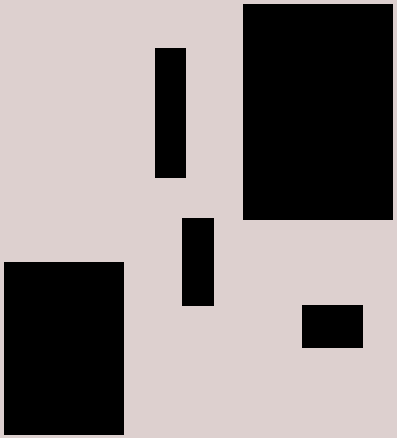
# Next steps

- Subcommittee members to provide feedback on the potential opportunity to carve out bariatric procedures to the SurgeryPlus program
- 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
- The SEBC will be asked to determine whether coverage of bariatric surgery will be carved out to the SurgeryPlus program effective 7/1/21, or if plan participants will continue to have a choice of surgery providers
  - Item will be presented for a vote at the March 8, 2021 SEBC meeting

***For discussion today and at the March 4 Subcommittee meeting:***

- What are Subcommittee members' perspectives on carving-out bariatric surgery to the SurgeryPlus program?
- Is there consensus around a recommendation that can be shared with the SEBC?

# Appendix



# 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.