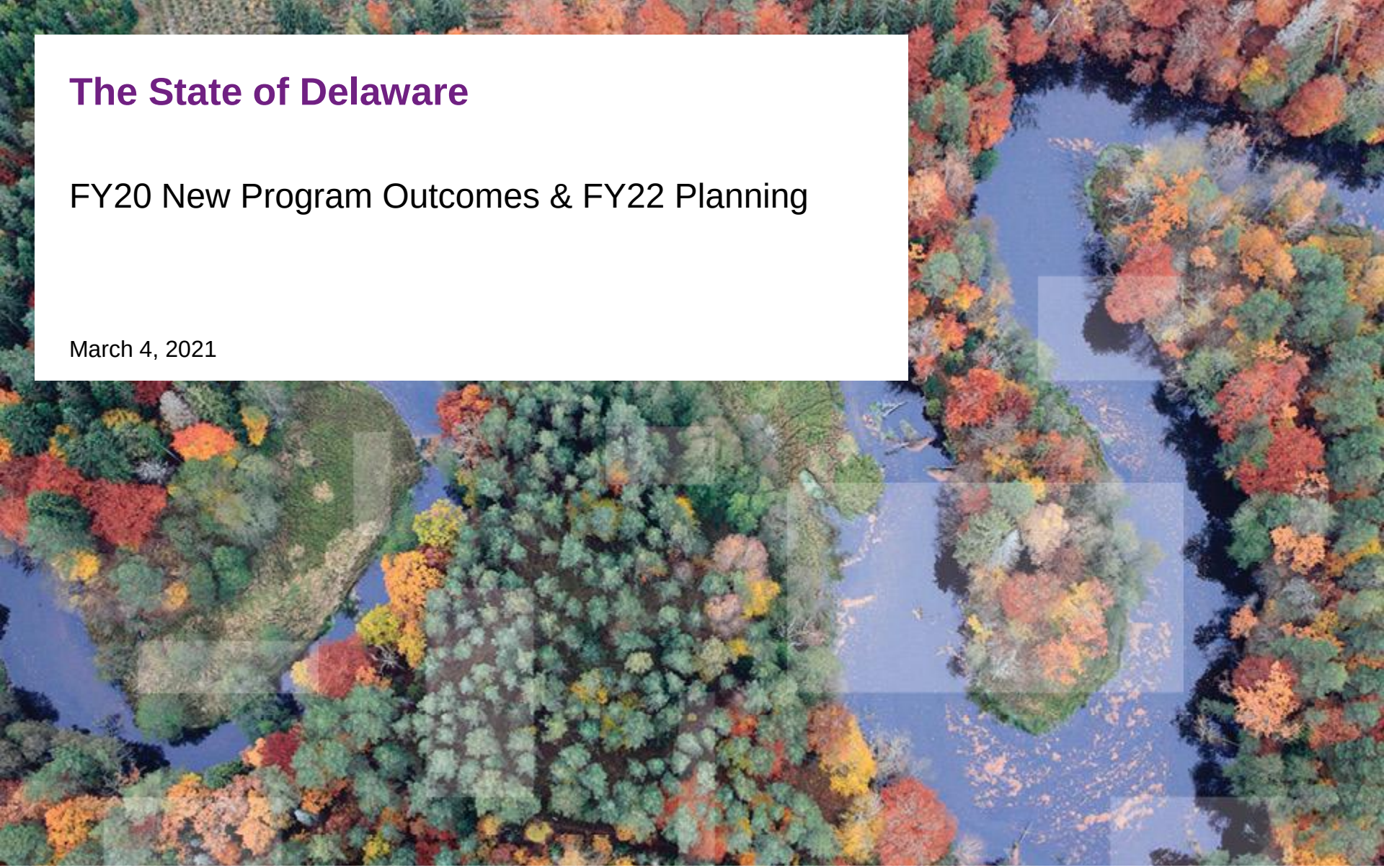
The State of Delaware

FY20 New Program Outcomes & FY22 Planning

March 4, 2021



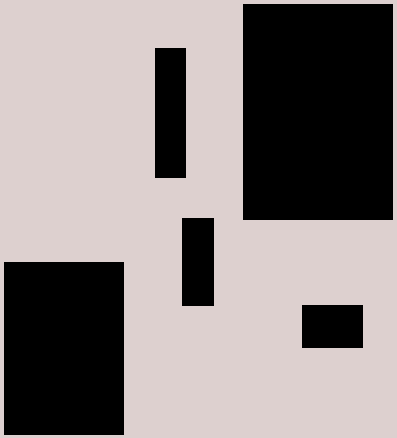
Willis Towers Watson

Today’s discussion

- Mental Health Parity & Addiction Equity Act (MHPAEA) required changes
- COVID-19 GHIP benefit plan adjustments – expanded coverage
- Rethink Family Support Benefit
- SurgeryPlus bariatric carve-out
- Next steps

- Appendix

Mental Health Parity & Addiction Equity Act (MHPAEA) required changes

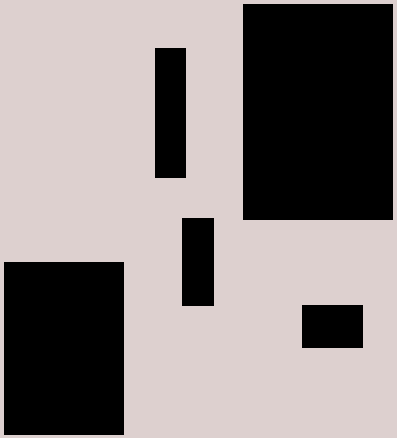


Mental Health Parity & Addiction Equity Act (MHPAEA)

Overview	▪ Requires health plans providing mental health/substance use disorder (MH/SUD) benefits to provide those benefits in parity with medical/surgical (M/S) benefits ▪ Health plans that impose financial requirements (e.g., deductibles, copayments) or quantitative treatment limitations (e.g., # visits, days of coverage) may not be applied more stringently to MH/SUD benefits than M/S benefits ▪ Non-quantitative treatment limitations (e.g., prior authorization, utilization review) may not be applied more stringently to MH/SUD benefits than M/S benefits ▪ Increased focus on financial requirements/quantitative treatment limits, and public inquiries related to MHPAEA are on the rise
Compliance obligations of the GHIP	▪ SPDs/plan document review of treatment limitation language ▪ Claims/audit review ▪ Review to ensure program structure does not violate quantitative/non-quantitative treatment limitation rules ▪ Appropriate disclosures to participants (medical necessity; benefit denials)

Outcome for FY22 medical plan	▪ Results of MHPAEA review: Medical plans are out of compliance and require the following changes:
	  ▪ Reduction in behavioral health office visit copays for Aetna HMO plan from $25 to $15 per visit (total cost increase: $370,000 annually)
	  ▪ Reduction in behavioral health telemedicine copays for Teladoc (Aetna) and Amwell (Highmark) to $0 per visit (total estimated cost increase: $150,000 annually for Aetna and Highmark plans)

COVID-19 GHIP benefit plan adjustments – expanded coverage



COVID-19 benefit plan changes

Modified end date recommendations

Benefit Plan	Change	Optional / Legislation	Cost *(per 3-month extension)*	Approval Date for Change	Start Date	Initial End Date	2nd Extended End Date	Recommended Extension?
Medical	No member cost share for in-network, inpatient services related to treatment of COVID-19 or associated complications	Optional	$0.2m-$0.3m[1]	4/2/2020	4/2/2020	5/31/2020 - Highmark 6/1/2020 - Aetna	3/31/2021 – Highmark & Aetna	Yes (1)
EAP	Coverage for all SOD employees	Optional	$16,800	3/18/2020	3/19/2020	6/30/2020	3/31/2021	Yes (2)
Medical	No member cost share for office visits (PCP, urgent care, ER) that result in either order or administration of COVID-19 test or for treatment of COVID-19 or associated health complications	FFCRA[2]	—[3]	3/18/2020	3/18/2020	End of federal mandate	3/31/2021 – Aetna & Highmark	Yes (3)
Medical	No member cost share for any telehealth visits	Optional	$25,000 - $37,000 (est.)	3/20/2020	3/20/2020	6/4/2020 – Aetna 6/15/2020 – Highmark	3/31/2021 – Aetna & Highmark	Yes (4)

1) Recommend extending for all members, across both Aetna and Highmark, for no more than 30 days following the end of the national public health emergency. Highmark has announced extension through 3/31/2021 for fully insured business. Aetna discontinued its extension on 2/28/21.

2) Recommend extending for all State employees for no more than 30 days following the end of the national public health emergency ($16,800 per 3 months).

3) Recommend extending for all members, across both Aetna and Highmark, for no more than 30 days following the end of the national public health emergency. Highmark has announced extension through 3/31/2021. Aetna has extended through duration of the federal mandate.

4) Recommend extending for all members, across both Aetna and Highmark, for all services (not only behavioral and mental health visits), for no more than 30 days following the end of the national public health emergency. Highmark has announced extension through 3/31/2021 for fully insured business. Aetna discontinued telehealth (except for behavioral health visits) on 6/4/2020.

1 Based on estimated annual cost of $0.7m - $1.2m calculated for all medical plans, adjusted for 3 months of FY20.
2 FFCRA = Families First Coronavirus Response Act.
3 Not valued separately – cost included in medical estimate for expanding in-network inpatient treatment of COVID-19 shown in recommendation 1 above.

The content on this slide has been updated by SBO based on content originally prepared by WTW and presented to the SEBC on 6/8/2020, 9/14/20 and 12/14/20.

COVID-19 benefit plan changes

Coverage for COVID-19 vaccines

- Currently, the federal government is funding the ingredient cost of COVID-19 vaccines
- Employer-sponsored health insurance, including the GHIP, is responsible for the cost of vaccine administration
  - The Coronavirus Aid, Relief and Economic Security (CARES) Act requires full coverage of COVID vaccines without cost share regardless of when it is administered
  - Group health plans should also not impose cost sharing for visits where the vaccination is the primary visit purpose
  - First dollar coverage for qualifying coronavirus preventive services must be provided regardless of whether such services are provided by an in- or out-of-network provider
  - All providers participating in the CDC's COVID vaccination program must agree not to seek any reimbursement from the member through balance billing
- SBO has authorized GHIP medical and Rx vendors to cover the cost of vaccine administration starting in December 2020 and when these vaccines started to become available
  - CDC's Advisory Committee on Immunization Practices (ACIP) issued an interim recommendation for use of the Pfizer vaccine on December 12, 2020; group health plans must cover the vaccine by January 5, 2021
  - Moderna's vaccine received a recommendation on December 18, 2020 and must be covered by January 12, 2021
  - Johnson & Johnson's vaccine received a recommendation on February 28, 2021 and must be covered by March 19, 2021

COVID-19 benefit plan changes

FSA deadlines for the 2019, 2020 and 2021 plan years

- Due to the COVID-19 pandemic, the IRS loosened some of the rules governing flexible spending accounts (FSAs) to help people receive the full value of their elections
  - Changes address midyear elections and claim/grace periods (both applicable to the State's plan); also address carryover provisions (not applicable to the State's plan)
  - IRS clearly states that making any of these changes is entirely up to the discretion of the plan sponsor

- **2019 plan year (1/1/2019 – 12/31/2019) is closed:** claim/grace periods were previously extended; however, deadline to submit claims for reimbursement was March 1, 2021

- **2020 "short" plan year (1/1/2020 – 6/30/2020)**
  - In May 2020, deadline to incur claims for reimbursement was extended from 9/15/2020 to 12/31/2020 as permitted under IRS Notice 2020-29
  - Deadline to submit claims for reimbursement has not been determined or communicated to participants
  - **SBO recommendation:** Allow participants to submit claims for reimbursement through 6/30/2021
    - Extends claim submission period by 3.5 months beyond the 2.5-month grace period typically allowed by the Plan
    - Allows this plan year to be "closed out" prior to the beginning of the 2021 plan year

COVID-19 benefit plan changes

FSA deadlines for the 2019, 2020 and 2021 plan years (continued)

- **2021 plan year (7/1/2020 – 6/30/2021)**
  - Plan year ends on 6/30/2021
  - Grace period extends through 9/15/2021 (deadline to incur claims for 2021 plan year)
  - Deadline to submit claims for reimbursement is 30 days after end of grace period (i.e., 10/15/2021)
  - **SBO recommendation:** No changes to these dates for 2021 plan year
    - Plan participants have previously been given ample time and notice to plan how and if they will avail themselves of the additional flexibility to incur and submit FSA-reimbursable claims
    - Administratively burdensome to maintain multiple plan years with extended deadlines for claim/grace periods

COVID-19 benefit plan changes

Pre-tax commuter (PTC) benefit

- Claim deadlines have been removed due to the pandemic as most employees are no longer traveling to/from their work location and aren't incurring commuter expenses such as transit fees and parking
- A participant in the PTC benefit would need to re-start contributions in order to incur expenses when they start commuting again
- Some employees currently have unused PTC funds, which the State would be able to allow those participants to use for services incurred after their contributions stop (provided that all PTC participants have the same opportunity to do so)
- This would allow employees to utilize any unused funds to date and may lessen any employee concerns should the State wish to reinstate a claim submission deadline

- **SBO recommendation**: Allow all plan participants to access unused PTC funds to pay for services incurred prior to restarting contributions, continuing until at least 30 days following the end of the national public health emergency and further evaluated at that point to consider the status/impact of the I-95 corridor project
  - Mitigates adverse impact to employees who stopped contributions abruptly to COVID-19 and have unused PTC funds
  - Provides more flexibility for employees due to the uncertainty currently with the I-95 corridor project and its impact on commuting into the City of Wilmington

COVID-19 benefit plan changes

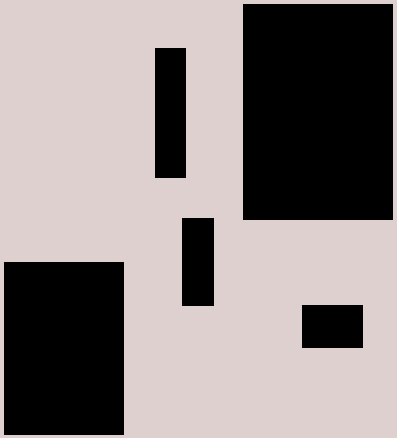
COVID-19 rider to the State's Critical Illness insurance

- Last week, Securian offered to add a COVID-19 rider to the State's Critical Illness coverage with no impact to 5-year rate guarantee currently in place through 6/30/2025
  - No change in the premiums that employees pay for coverage
  - Benefit rider pays 10% of full benefit[1] if there is a 5-day hospital stay due to COVID-19 diagnosis
  - Rider is currently approved in Delaware but not yet approved in several states[2], including New Jersey, so State employees residing in those states who purchase the State's Critical Illness coverage won't be eligible for this benefit until their state of residence approves this benefit filing

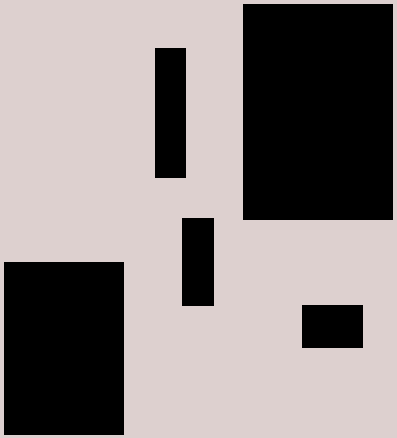
- **SBO recommendation:** Adopt the COVID-19 rider
  - Rider can be added without any changes to premium rates that employees pay for coverage

1 $15,000 or $30,000 for employees; $7,500 or $15,000 for spouses; for children, 50% of the employee amount.
2 California, Colorado, Idaho, Indiana, New Jersey, and Washington have not yet approved Securian's filing for this benefits rider.

Rethink Family Support Benefit



SurgeryPlus bariatric surgery carve-out opportunity



Bariatric surgery

Carve-out opportunity for FY22

- Previously discussed the opportunity to consider carving out bariatric surgery coverage to the SurgeryPlus program
- Potential benefits include:
  - Steerage to high quality providers evaluated by rigorous quality criteria
  - More consistent member experience with concierge support to coordinate care over lengthy pre-surgical period
  - Limited travel requirements for inpatient and outpatient bariatric surgery
  - Potential shared savings for members and the GHIP
- Potential cost avoidance estimate ranges from $355,000 to $1.4m, depending upon number of procedures performed during FY22
- Change would require updates to plan documents and additional member communications about this change, in addition to administrative coordination with Highmark and Aetna

Bariatric surgery

Carve-out opportunity for FY22 (continued)

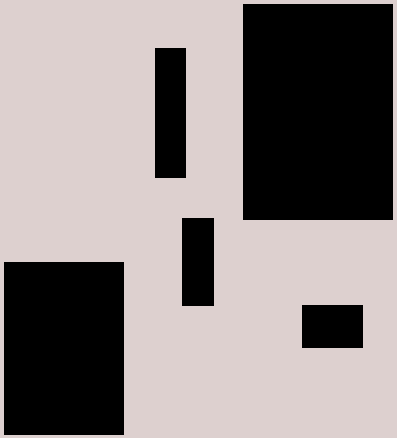
- At the last Combined Subcommittee meeting on February 18, further details were requested on member satisfaction with the SurgeryPlus program so far
- Every plan participant who completes a surgery through this program is prompted to complete a satisfaction survey when their surgical episode of case concludes
  - Members are given the opportunity to rate how likely they are to recommend the SurgeryPlus program and its providers to friends and family and how they would rank the performance of their SurgeryPlus care advocate and provider
  - The program and its providers consistently achieved high satisfaction ratings from members (ranging, on average, 4.8 – 4.9 out of 5, with 5 being the most satisfied)

- Another question from the prior meeting was regarding whether the FY20 actual vs. expected cost avoidance has been reviewed, which was discussed at the January 21 Combined Subcommittee meeting (see appendix for results)

For discussion today:

- 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?

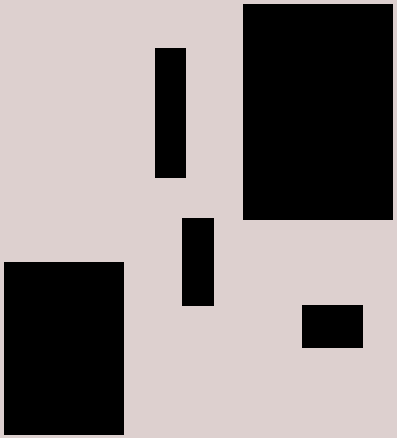
Next steps



Next steps

- SEBC to vote on extension and/or adoption of recommended FY22 changes at the March 8, 2021 meeting
- Recommended changes:
  - Extend EAP coverage for all State employees for no more than 30 days following the end of the national public health emergency
  - Extend no member cost share for IP/OP admissions related to COVID-19, or office visits (PCP, urgent care, ER) that result in order or administration of COVID-19 test for all members for no more than 30 days following the end of the national public health emergency
  - Extend no member cost share for any telehealth visits for no more than 30 days following the end of the national public health emergency
  - Extend no member cost share for in-network, inpatient services related to COVID-19 for no more than 30 days following the end of the national public health emergency
  - Allow participants to submit claims for FSA reimbursement under the 2020 “short” plan year through 6/30/2021
  - Allow all plan participants to access unused PTC funds to pay for services incurred prior to restarting contributions, continuing until at least 30 days following the end of the national public health emergency and further evaluated at that point to consider the status/impact of I-95 project
  - Adopt COVID-19 rider for Securian Critical Illness coverage

Appendix



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.