MINUTES FROM THE COMBINED MEETING OF THE FINANCIAL and HEALTH POLICY & PLANNING SUBCOMMITTEES TO THE STATE EMPLOYEE BENEFITS COMMITTEE
MAY 6, 2021

The Health Policy & Planning ("HP&P") Subcommittee and the Financial Subcommittee to the State Employee Benefits Committee (the "Committee") met Thursday, May 6, 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, Dir. Health Care Reform, Dept. of Health and Social Services ("DHSS") (Appointee DHSS Sec. Magarik)
Ms. Emily Molinaro, OMB (Appointee of OMB Dir. Cade)
Ms. Judi Schock, Deputy Principal Assistant, Office of Management & Budget ("OMB") (Appointee OMB Dir. Cade)
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)

Subcommittee Members Not Represented or 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)
Mr. Bert Scoglietti, Deputy Controller General, Office of the Controller General (Appointee CG Jones)
Mr. Keith Warren, Chief of Staff, Office of the Lt. Governor (Appointee Lt. Governor Hall-Long)

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. Wendy Beck, Highmark
Ms. Julie Caynor, Aetna
Ms. Nina Figueroa, Health Policy Advisor, SBO, DHR
Ms. Sandy Hart, IBM Watson Health
Ms. Katherine Impellizzeri, Aetna
Ms. Elizabeth Lewis, Hamilton Goodman Partners
Ms. Heather Johnson, Controller II, DHR
Mr. Walter Mateja, IBM Watson Health
Ms. Lisa Mantegna, Highmark Delaware
Ms. Mary Kate McLaughlin, Faegre Drinker Biddle Reath
Ms. Paula Roy, Roy & Associates
Ms. Martha Sturtevant, Exec. Sec., SBO, DHR - Recorder, State Employee Benefits Committee and Subcommittees

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 Ms. Schock and seconded by Ms. Tucker to approve the Minutes from the Combined Subcommittee meeting on March 4, 2021.
MOTION ADOPTED (1 Abstention: Ms. Molinaro)

DIRECTOR'S REPORT – DIRECTOR FAITH RENTZ, CHAIR

SEBC Updates

April 19, 2021, the Committee voted to increase the Dependent Care Flexible Spending Account maximum limit during the FY22 plan year to allow employees the opportunity to elect a maximum deduction of $8,000 for July 1 through December 31, 2021.

Mr. Costantino joined the meeting.

2021 Open Enrollment

Open Enrollment is open from May 3 to May 19, 2021. Call center volume and participation to date are comparable to 2020. SBO will send reminder emails to employees who have not actively engaged.

Legislative Updates

The Primary Care Reform Collaborative bill to increase reimbursements to primary care and cap total aggregate spend outside of primary care has been introduced as SB 120; the latest bill exempts the Group Health Insurance Plan ("GHIP"). It was released by the Senate Executive Committee and has been assigned to Senate Finance. Public comment at the Executive Committee was significant in both support and opposition of the bill.

Additionally, SB 120 seeks to balance the increases by limiting additional growth in healthcare spending. It is proposed that the bill would also legislate mandatory minimums for payment innovations, including alternative payment models that promote value-based care.

FINANCIALS – MR. CHRIS GIOVANNELLO, WTW

February Fund Report

February had $10.5M in commercial prescription drug rebates and another $7.8M in EGWP (Medicare Part D) prescription drug rebates which were in line with expectations.

Claims ran high at $79.9M and were $4.7M above budget; however, the YTD is in line with expectations. Other expenses included an extra Express Scripts payment for both the commercial and EGWP plans.

February had $6.4M in net income relative to an expectation of $12.0M. The YTD fund equity balance is $185.9M compared to $186.8M budgeted and is in line with expectations.

March Fund Report

March ran high with $91.0M in claims relative to $84.5 budgeted for a $6.7M or 0.95% YTD variance to the budget which brings the fund equity balance to $163.5M.

Ms. Anderson queried what the process was for releasing the COVID-19 reserve back into the fund. Mr. Giovannello responded that there was not a formal process but added that he would provide more details in the Long Term Projection Recast.

GHIP LONG-TERM PROJECTION RECAST – MR. CHRIS GIOVANNELLO

There were significant reductions in GHIP health care costs during CY20 due to the impact of deferred care that exceeded the costs related to the testing and treatment of COVID-19. The impact of the pandemic on the GHIP remains largely unknown and depends on many factors, including the level of care deferral that returns, the shift of vaccination costs to the state, service utilization (e.g., virtual care), the impact of missed preventive screenings, compounding mental health issues, and additional unknown health needs of COVID-19 survivors.

On July 27th, 2020, the SEBC approved a one-time COVID-19 reserve of $23.5M in FY21.

Through March, FY21 claims ran $6.7M above budget, and April medical claims exceeded budget by an additional $2.6M. May and June's claims are projected to trend above budget.

GHIP claims paid for COVID-19 testing and treatment totaled $23.0M through March 2021 including $18.7M in treatment claims for a total of 5,811 patients ($17.1M in claims for 786 admits), and $4.3 in testing claims (DNA RNA and antibody tests).

The projected FY21 budget of $899.2M has been revised up to $9.8M from FY21 Q2 and reflects actual operating expenses through March 2021, April 2021 claims, and estimated claim levels for May and June.

The FY21 and FY22 budgets reflect Other Revenues based on when revenues will be earned (received by the GHIP Fund) rather than when revenues will be incurred by the plan. FY21 Other Revenues reflect actual payment projections through Q4 and no longer captures anticipated true-up amounts to be earned in CY21 and CY22.

Budget projections have been revised. There is a projected $25.9M surplus projected for FY21 and does reflect the $23.5M COVID-19 reserve. A deficit of $47.0M is projected for FY22.

Mr. Costantino queried whether the projected deficit assumes a continuation or a release of the COVID-19 reserve. Mr. Giovannello confirmed that it assumes a release of the reserve.

Absent program changes or premium rate increases, the GHIP will deplete health fund surplus during FY22, even with the release of COVID-19 reserve.

On January 14th, 2019, the Financial Subcommittee recommended to the Committee to smooth available surplus over two years. This recommendation was intended to minimize the need for significant rate increases in years with poor claims experience and minimizes the volatility on year-over-year increases in member contributions. The Financial Subcommittee included a recommendation to revisit surplus smoothing methodology annually.

If no other program changes, target smoothing FY21 surplus ($25.9M) over 2 years requires a 14.2% rate increase effective January 1, 2022. If no other program changes, to target a $0.0 surplus by end of FY22 requires an 11.0% rate increase effective January 1, 2022.

The FY22 projected shortfall is $72.9M; this is projected by subtracting operating expenses from operating revenues and less any change in reserve (i.e., $991.6M - $1,083.6M – ($19.1M) = $72.9M) and is the amount needed to fund FY22 so that there is no change in surplus relative to FY21 (FY21 surplus of $25.9M + $47.0M deficit = $72.9M).

The shortage can be addressed through increased premium rates, adopting program changes to reduce operating expenses, or using some or all the available surplus from prior years.

The one-time COVID-19 reserve of $23.5M was intended to maintain the solvency of the Fund under adverse scenarios directly or indirectly related to COVID-19. It was recommended to review reserve levels more frequently (e.g., quarterly) until the pandemic has subsided and claim levels are stabilized.

Mr. Constantino queried whether there were indications that claims were stabilizing and if there were any changes to trend estimates. Mr. Giovannello responded that claim levels are running higher as deferred care returns, the longer-term impact remains uncertain, and the long-term trend remains at 5.7%.

Ms. Anderson queried how the short-term trend projections were impacted by the CVS Pharmacy Benefit Manager savings estimates. Ms. Warnken responded that the projected CVS savings estimates are highest in

FY22; there are modest incremental savings in years 2 and 3 of the contracts, but the bulk of the savings is reflected in the first year of the three-year contract.

Claims will be frequently monitored for emerging experience in addition to monitoring the emerging utilization and cost savings for GHIP initiatives adopted to date. The Financial Subcommittee will be tasked with recommending the timing and level of rate increase for FY22.

Ms. Anderson queried whether trends impact the projections for the minimum reserve and the claims liability reserve. Mr. Giovannello responded that the reserves generally increase at the same rate as the operating expenses with additional consideration to how quickly claims are processed.

MEDICAL THIRD-PARTY ADMINISTRATION REQUEST FOR PROPOSAL OVERVIEW – MS. JACLYN IGLESIAS

There was a review of market dynamics affecting the GHIP going into the FY16 Medical Third-Party Administration ("TPA") Request for Proposal ("RFP") including the passage of the Affordable Care Act ("ACA") in 2010 that began to shift accountability to the health care delivery system to better manage outcomes and led to a focus on value-based contracting with medical providers, the passage of House Bill 81 in 2011 specified the types of GHIP state-level medical plan options and established participant cost-sharing parameters, the Delaware Health Care Commission developed the Delaware Health Innovation Plan in 2013, which led to the establishment of the Delaware Center for Health Innovation in 2014 to focus on health care payment reform, and the State Employees Health Plan Task Force established in response to the FY15 Health Fund deficit.

The outcomes of the 2016 Medical TPA RFP were reviewed. The GHIP remained with Highmark Delaware and Aetna (a requirement for a single administrator for each type of plan resulted in the elimination of Highmark HMO and Highmark CDH Gold plans), adoption of value-based agreement with Aetna and Christiana Care for the HMO plan, and the adoption of enhanced care management for Aetna HMO ("CareVio") and Highmark PPO and First State Basic plans ("CCMU"). There were no changes to the Highmark Special Medicfill Medicare supplement plan.

Nationally there has been a shift toward consolidating TPAs and Pharmacy Benefit Managers ("PBM") and continued emphasis on payment for value when contracting with medical contractors. Additionally, the COVID-19 pandemic transformed the evolution of health care delivery.

At a state-level, independent practices continue to consolidate with larger health care systems, Delaware established the Health Care Spending Benchmark, and several working groups have focused on broader state healthcare considerations including primary care, delivery system transformation, prescription drug purchasing, and the state's liability for retiree medical expenses.

Key changes to the GHIP design and offerings include the adoption of a Strategic Framework in December 2016 (updated February 2020), adoption of plan design differentials to encourage site of care steerage for select services, the addition of SurgeryPlus surgeons of excellence program, and a PBM change from Express Scripts to CVS Health.

There was a review of the goals outlined in the 2021 Medical TPA RFP.

Bidders will be asked to support the goals of the Strategic Framework by increasing the proportion of spend through advanced alternative payment models, reducing per-member cost for diabetic members, limiting total cost of care inflation, and offering and increasing employee engagement with decision support tools.

Bidders should provide competitive financial terms including provider reimbursement rates and administrative fees, performance guarantees, investments in primary care, and uphold the affordability targets as defined by the Delaware Department of Insurance's Office of Value-Based Health Care Delivery.

Bidders should support the GHIP's programs and plan offerings by administering current plans, support plan provisions that optimize the effectiveness of GHIP benefit offerings, integrate with other programs and vendors supporting the GHIP, maintain a provider network that meets current and future state goals of the GHIP, provide supplemental coverage to Medicare-eligible retirees and their Medicare-eligible dependents, and support other state-level health care initiatives.

Bidders should be able to deliver on core functions of a medical TPA including claims administration, provider network, care management, member services, care navigation support, online tools and resources, communications support, account management, reporting, participation in the DHIN, and the ability to coordinate with Delaware community health resources.

Bidders will be expected to articulate how they can meet the goals of the GHIP Strategic Framework that will require a transformational level of change that may not be possible under the requirements of the Delaware Code (HB 81 in 2011), which outlines a fixed cost share for each medical plan option for both employer and employee share, and the State requirement to offer at least four medical plan options to active employees and non-Medicare pensioners.

Subcommittee members may wish to consider whether the goals of HB 81 still align with the changes in the healthcare marketplace and the goals of the Strategic Framework. Possible implications if these requirements remain in place include the potential for low-enrollment plans to adversely impact efforts to align with value-based arrangements at the plan level, and that a fixed cost share will limit the Committee's ability to solve for the projected FY22 budget shortfall.

Maintaining the existing Code requirements limits the Committee's ability to drive meaningful change towards offering fewer but more meaningfully different medical plan choices that steer participants to high-quality, cost-efficient providers.

Mr. Costantino clarified that deviating from the current Code would require legislative action and queried whether the expectation was for that action to be taken before June 30, 2021. Ms. Iglesias responded that bidders have been asked to comment on how they would support the plans with the current rules that are in place today, and they have been asked to articulate what could be possible without the current restrictions.

The Medical TPA RFP was posted to Delaware's Bid Solicitation Directory on April 26, 2021, with the Intent to Bid deadline on April 30, 2021.

Several organizations have indicated an interest in submitting proposals, including Highmark and Aetna. There was a mandatory conference call with bidders on May 5, 2021. Questions from bidders are due May 14, 2021, and responses to bidder questions are targeted for release on May 28, 2021. The bid deadline for RFP participants is June 18, 2021.

The analysis of proposals will be conducted between June and August 2021 and will include an evaluation of how bidders will support the GHIP as designed today and how they could achieve the goals of the Strategic Framework without the current limitations in place. In addition, there would be an analysis of Medicare options to determine any financial benefits to the GHIP including member communication considerations if a decision were made to move away from the current Medicare supplement offering.

Finalist interviews are scheduled for August 23 and 24, 2021. The Proposal Review Committee recommendation to the SEBC will be presented in late 2021.

Effective dates for contract awards through this RFP process are July 1, 2022, for active employees and non-Medicare pensioner plan options, and January 1, 2023, for the Medicare retiree plan option.

Mr. Costantino queried how value-based solutions will be evaluated to ensure the anticipated savings. Ms. Iglesias responded that the market is demanding accountability and bidders understand that they will be expected to provide examples. There will be further dialog among the Proposal Review Committee.

Ms. Anderson asked if there was any expectation for legislative action. Director Rentz responded that there was no expectation for any legislative action in 2021 and any change would likely be a transitional approach. Ms. Anderson added that she does not see the requirements of HB 81 as limitations to achieving the Strategic Goals but rather that the cost-share provisions committing both the employer and employee to known rate increases has been an improvement.

A similar update will be provided to the Committee on May 10, 2021. Director Rentz invited participation by the Subcommittees in the RFP review process.

OTHER BUSINESS
No new business was presented.

PUBLIC COMMENT
No public comment was provided.

ADJOURNMENT
A MOTION was made by Mr. Costantino and Seconded by Ms. Molinaro to adjourn the meeting at 11:25 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