MINUTES FROM THE COMBINED MEETING OF THE FINANCIAL and HEALTH POLICY & PLANNING SUBCOMMITTEES TO THE STATE EMPLOYEE BENEFITS COMMITTEE
SEPTEMBER 9, 2021

The Health Policy & Planning ("HP&P") Subcommittee and the Financial Subcommittee to the State Employee Benefits Committee (the "Committee") met Thursday, September 9, 2021 in a combined meeting. The meeting was held at 97 Commerce Way, Suite 201, in Dover; however, in the interests of protecting the citizens of this State from the public health threat caused by COVID-19, this meeting was presented via WebEx and participants were encouraged to attend virtually.

Subcommittee Members Represented or in Attendance:

Director Faith Rentz, Statewide Benefits Office ("SBO"), Department of Human Resources (Appointee DHR Secretary Bonner), Chair
The Honorable Colleen Davis, State Treasurer, Office of the State Treasurer
Ms. Judy Anderson, Delaware State Education Association, (Appointee Mr. Taschner for DSEA)
Mr. Steven Costantino, Director Health Care Reform, Dept. of Health and Social Services ("DHSS") (Appointee DHSS Secretary Magarik)
Ms. Jeanette Hammon, Senior Fiscal & Policy Analyst, Office of Management & Budget ("OMB") (Appointee of OMB Director Cade)
Mr. William Oberle, Delaware State Trooper's Association (Appointee Mr. Taschner, DSEA)
Ms. Judi Schock, Deputy Principal Assistant, OMB (Appointee OMB Director Cade)
Mr. Bert Scoglietti, Deputy Controller General, Office of the Controller General ("OCG") (Appointee CG Jones)
Mr. Stuart Snyder, Chief of Staff, Department of Insurance (Appointee Commissioner Navarro)
Ms. Ashley Tucker, Deputy State Court Administrator, Administrative Office of the Courts (Appointee The Hon. Collins Seitz, Chief Justice, Delaware Supreme Court)

Subcommittee Members Not Represented or in Attendance:

Mr. Keith Warren, Chief of Staff, Office of the Lt. Governor (Appointee Lt. Governor Hall-Long)

Others in Attendance:

Dr. Jessilene Corbett, Deputy Secretary, DHR
Ms. Leighann Hinkle, Deputy Director, SBO, DHR
Mr. Chris Giovannello, Willis Towers Watson ("WTW")
Ms. Jaclyn Iglesias, WTW
Ms. Wendy Beck, Highmark Delaware
Ms. Julie Caynor, Aetna
Ms. Valeria Coverdale, Hamilton Goodman LLC
Ms. Sandy Hart, IBM Watson Health
Ms. Katherine Impellizzeri, Aetna
Ms. Lisa Mantegna, Highmark Delaware
Mr. Walter Mateja, IBM Watson Health
Ms. Louisa Phillips, Delaware Healthcare Association
Ms. Paula Roy, Roy & Associates
Mr. Aaron Schrader, HR Manager, SBO, DHR
Ms. Martha Sturtevant, Exec. Sec., SBO, DHR - Recorder, State Employee Benefits Committee and Subcommittees
Ms. Mary Kate McLaughlin, Barnes & Thornburg

CALLED TO ORDER – DEPUTY DIRECTOR LEIGHANN HINKLE

Deputy Director Hinkle called the meeting to order at 10:03 a.m.

APPROVAL OF MINUTES – DEPUTY DIRECTOR LEIGHANN HINKLE

A MOTION was made by Ms. Schock and seconded by Ms. Tucker to approve the Minutes from the Combined Subcommittee meeting on August 12, 2021.
1 Abstention – Mr. Costantino
MOTION ADOPTED

DIRECTOR'S REPORT – DIRECTOR FAITH RENTZ, CHAIR

Request for Proposal ("RFP") Updates

The Proposal Review Committee will meet beginning September 13, 2021, to review the bid proposals for the Health Third Party Administrator ("TPA") contract for an effective date of July 1, 2022.

Pharmacy Benefit Manager Services

The SBO continues to work through the implementation of Pharmacy Benefit Manager services through CVS, effective July 1, 2021. CVS sent member communications in June outlining the steps required by the member or their physician to transition prescriptions. Most calls to the SBO Customer Service Team ("CST") have been from members who did not complete the requested action. The SBO CST is working with members on a case-by-case basis. All questions regarding pharmacy coverage should be directed to SBO CST.

FY23 Planning

Following the August 16, 2021 Committee meeting, SBO leadership met with the Co-Chairs to review the projected FY23 deficit including the reimbursement of COVID-19 expenditures and the timing and receipt of $20.0M in one-time supplemental funding. The Subcommittee has been asked to review potential plan design options and to bring those recommendations to the Committee for consideration on December 13, 2021, for changes that would go into effect on July 1, 2022.

FINANCIALS – MR. CHRIS GIOVANNELLO, WTW

July Fund Report

Approved supplemental funding in the amount of $20.0M was not received in July as previously reported, but it is reflected in the July Fund Report in Other Revenues under July Budget. The request has been submitted to OMB and the CGO for approval, but the timing of the transfer is unknown.

July was a favorable claims month. Total claims were $12.4M under budget resulting from invoice timing of prescription claims.

FY23 PLANNING – MR. CHRIS GIOVANNELLO and MS. JACLYN IGLESIAS, WTW

FY22 is projected to end with a surplus of $9.3M. Assuming no premium rate action or program changes, FY23 is projected to end with a $127.3M deficit to be solved through premium rate increases and potentially other levers that can yield substantial savings.

The Financial Subcommittee will recommend the timing and level of rate increase required in FY23. If no other program changes, a 15.0% premium increase will be needed on July 1, 2022, to solve the projected deficit. Per Delaware Code, the State pays approximately 90% ($93.0M) of premium rates and increases, and the remaining 10% ($11.0M) is paid by the employee/pensioner for the active/pre-65 retiree population.

Potential savings opportunities include the Medical TPA RFP, plan design changes (for active/pre-65 and Medicfill programs), and program changes including the adoption of the proposed CVS Health pharmacy programs, and adoption of mandatory bariatric carve-out and incentive modifications with SurgeryPlus.

The Subcommittee reviewed opportunities for managing health outcomes and costs for participants and the GHIP to be evaluated through the Medical TPA RFP. The most immediate opportunities to impact FY23 plan costs will arise from the Committee's decisions related to provider network selection, value-based contracting,

and Medicare plan funding arrangements. While care management, wellness, and performance guarantees will also be evaluated during the RFP process, the timeline for realized savings is longer-term.

The Subcommittees reviewed deductible modeling for the HMO and Comprehensive PPO plans. Implementing a $50 single/$100 family deductible on July 1, 2022, would yield a savings of $1.5M, a $500 single/$1000 family deductible would yield a savings of $11.7M. Adding deductibles will have minimal impact on the overall deficit and a premium increase will still be needed to solve for the remaining deficit, creating two layers of member disruption.

A 15.0% premium increase increases the annual employee/pensioner contributions by $85 – $223 for the HMO plan, and $189 – $491 for the Comprehensive PPO plan.

Medicare retirees have minimal cost-sharing for medical under the current Medicfill plan. The State can achieve savings through increased cost-sharing for the Medicfill plan in the form of deductibles and/or copays on specific services.

Adding deductibles to the Medicfill plan would yield minimal cost savings while creating significant member disruption (e.g., a $50 deductible would yield a savings of $0.8M, and a $250 deductible would yield a savings of $3.9M).

Adding copays for office, emergency department, and/or inpatient visits can more effectively achieve savings while mitigating member disruption (e.g., a $10 office visit copay is estimated to yield a savings of $3.4M).

Adding deductibles and copays to the Medicfill plan will have a minimal impact on the overall deficit and a premium increase will still be needed to solve for the remaining deficit, creating three layers of member disruption for Medicare retirees.

A 1% premium increase equates to approximately $9.0M. Said another way, for every $9.0M in plan design changes, the premium rate increase required to solve for the projected deficit would be reduced by 1%.

WTW reviewed benchmarking information from its Benefit Data Source database to evaluate potential copay changes to prescription plan design. The benchmarking reflects 272 organizations with 10K+ employees. Most organizations offer copays for generic drugs (retail and mail-order), and coinsurance for brand drugs (preferred and non-preferred, retail, and mail-order).

A 50% increase to the current prescription plan copay structure (e.g., generic from $8 to $16, and brand from $12 to $24) would yield a savings of approximately $3.9M for commercial plans and $2.3M for Medicfill plans. The savings are meaningful but do solve for the projected $127.3M deficit.

Since the onset of COVID-19, the GHIP has continued to evaluate and extend certain benefit enhancements related to the pandemic, including Employee Assistance Program (“EAP”) coverage for all State employees (including casual/seasonal and part-time), and no member cost-sharing for any telehealth visit. Benefit enhancements are currently extended for no more than thirty days following the end of the national public health emergency. The FY21 cost impact to the GHIP for extending EAP coverage was $70K.

There were substantial increases in telehealth utilization with “other” telehealth providers, including PCP’s and specialists. In FY21, the GHIP paid approximately $19.0M in telehealth claims associated with these “other” providers with no member cost-sharing; these visits would have had a copay attached to them. Based on cost-sharing for pre-pandemic telehealth claims, the GHIP could save $4.0M by waiving the extension of no member cost-sharing for any telehealth visit.

Ms. Anderson queried the cost impact of shifting "other" telehealth visits to in-person visits. Mr. Giovannello responded that more analysis would be needed but added that it is more convenient to have a telehealth visit, and total visits may be reduced if visits were exclusively in-person.

The SEBC has adopted a variety of initiatives to improve health outcomes and reduce the total cost of care for members and the GHIP. WTW is in the process of refreshing data on utilization and outcomes that will be shared with the Subcommittee at an upcoming meeting.

Mr. Costantino queried whether the site of care steerage had resulted in behavior changes. Ms. Iglesias responded that utilization patterns are being evaluated and additional analysis was forthcoming.

The Subcommittees reviewed three program options presented by CVS Health that could yield savings for the GHIP.

CVS' Drug Savings Review program reviews prescription utilization to ensure that the prescription/dosage follows evidence-based medical guidelines. The savings potential is dependent on the responsiveness of the medical provider community, as CVS would be reaching out to physicians regarding patient safety and savings opportunities and a monthly administrative fee would apply.

CVS' Next Generation Transform Diabetes Care program engages members with diabetes on actionable steps to address gaps in care, evaluate medical needs, and facilitate overall wellness. This is a potential replacement for Livongo, which will be discontinued for participants in the Aetna and Medicfill plans effective June 30, 2022 and December 31, 2021, respectively. Medical and prescription data would be utilized to make a personalized glucose meter recommendation. There would be member disruption through moving members away from their current meters (including those currently engaged with Livongo), and although less than the current fee for Livongo, a monthly administrative fee would apply.

CVS' PrudentRx program leverages manufacturer assistance with specialty medications (a class of medications that are tailored to a specific medical condition, are often emerging drugs in the marketplace without competition, or that require injections or infusions to administer) that could produce savings but would require significant engagement from members. There is no upfront administrative fee, and the savings are shared with the program administrator.

Members discussed their concerns with potentially duplicating existing programs available through medical TPAs and the healthcare system partners. Ms. Iglesias responded that using an electronically connected glucose meter to provide real-time feedback to a care management program is different than what is offered through the TPAs. Potential duplication will be a consideration as the Proposal Review Committee completes its review of the medical TPA RFP.

The Subcommittees requested additional detail on the estimates associated with the proposed programs. Ms. Iglesias responded that initial cost-avoidance estimates had been provided by CVS and additional analysis to validate the savings estimates and any potential member impact is forthcoming.

The Subcommittees reviewed the option to access surgical Centers of Excellence ("COE") through SurgeryPlus. Participants' utilization of SurgeryPlus has gradually increased since the program's inception on July 1, 2019. GHIP members can still access the same services through the medical TPAs (without the same level of incentives to do so), so utilization of the program for certain types of surgeries is still low.

The SurgeryPlus program produced a net savings of approximately $370K. While more procedures were completed than expected, net savings were $130K less than expected due to differences in the variety and cost variation among the procedures performed over what was anticipated, and that the incentive design was developed after the FY20 budget was finalized (not factored into the savings estimate).

The Subcommittees were considering the implications of mandating the use of the SurgeryPlus benefit for bariatric surgery. No action was taken at the time given concerns about the bariatric provider network under a carve-out approach. Since then, SBO and WTW have continued to monitor outcomes of the SurgeryPlus benefit and are preparing a summary of FY21 outcomes for an upcoming Subcommittee meeting.

SurgeryPlus has made progress addressing the Subcommittee's concerns about the bariatric provider network. Prior savings estimates for carving out bariatric surgery ranged from $355K to $1.4M, depending on the number of procedures performed during the plan year. Further analysis would be required to update the estimated savings and quantify the cost of bariatric surgery through the medical carriers.

The Subcommittees could also consider expanding the scope of surgeries beyond bariatric, such as joint replacements and spine surgery. There is also an opportunity to refresh the incentive amounts paid to members who utilize the program. Incentives would not be necessary for mandated services.

The Subcommittees expressed interest in learning more about the savings opportunities related to SurgeryPlus, but they requested an analysis of the bariatric provider network. Ms. Iglesias responded that the refreshed savings analysis would include an update on the provider network.

Action relating to any program changes must be made by the Committee in December for an effective date of July 1, 2022.

There was a discussion regarding the flexibility of reversing an adopted program change. As a self-insured Plan the SEBC has authority to make changes at any time to out-of-pocket costs; however, mid-year changes would not be swift administratively and should be weighed against the member disruption. Program changes that are contracted with vendors (e.g., pharmacy savings program and SurgeryPlus) would be in place for the term of the contract.

The Subcommittees discussed weighing the potential impact to members against the potential savings of the proposed program changes versus rate action alone. Estimates for program savings assume that members will utilize the program changes. A significant change in plan design will require the GHIP to offer employees the opportunity to change plans.

The was a discussion regarding the variation of the trend reported in the long-term projections. The FY20 trend reflects the impact of the pandemic and corresponding care deferral. The 5.7% composite trend is adjusted for a projected 5% medical and 8% pharmacy trend.

There was consensus among the Subcommittees that the $127.3M deficit could not be resolved with program changes alone. Several Subcommittee members expressed a preference for a combination of contract negotiations, program changes, out-of-pocket costs, and rate increases. The Subcommittees also queried whether member disruption might outweigh the potential savings that may result from program changes and out-of-pocket costs while not meaningfully reducing the necessary rate action.

The Subcommittees will continue discussions regarding the timing and level of future rate action as emerging utilization and cost savings for the GHIP initiatives continue to be monitored.

The Subcommittees will meet again on October 7, 2021.

OTHER BUSINESS

No other business was presented.

PUBLIC COMMENT
No public comment was provided.

ADJOURNMENT
A MOTION was made by Mr. Costantino and seconded by Mr. Scoglietti to adjourn the meeting at 11:38 a.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