MINUTES FROM THE COMBINED MEETING OF THE FINANCIAL and HEALTH POLICY & PLANNING SUBCOMMITTEES TO THE STATE EMPLOYEE BENEFITS COMMITTEE
OCTOBER 7, 2021

The Health Policy & Planning ("HP&P") Subcommittee and the Financial Subcommittee to the State Employee Benefits Committee (the "Committee") met Thursday, October 7, 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 of Acting Secretary Corbett), Chair
Ms. Judy Anderson, Delaware State Education Association, (Appointee of Mr. Taschner, Executive Director, DSEA)
Mr. Steven Costantino, Director Health Care Reform, Dept. of Health and Social Services ("DHSS") (Appointee of Secretary Magarik)
Ms. Darlene Cox, Administrative Manager, Office of the State Treasurer (Appointee of The Honorable Colleen Davis)
Ms. Jeanette Hammon, Senior Fiscal & Policy Analyst, Office of Management & Budget ("OMB") (Appointee of Director Cade)
Ms. Evelyn Nestlerode, Deputy State Court Administrator and Chief Financial Officer, Administrative Office of the Courts (Appointee of The Hon. Collins Seitz, Chief Justice, Delaware Supreme Court)
Mr. William Oberle, Delaware State Trooper's Association (Appointee of Mr. Taschner, Executive Director, 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 of CG Jones)

Subcommittee Members Not Represented or in Attendance:

Mr. Stuart Snyder, Chief of Staff, Department of Insurance (Appointee of Commissioner Navarro)
Mr. Keith Warren, Chief of Staff, Office of the Lt. Governor (Appointee of 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. Jen Manieri, WTW
Ms. Wendy Beck, Highmark Delaware
Ms. Alyssa Chandler, Admin Specialist, SBO, DHR
Ms. Carrie Cole, ByrdGomes Group
Ms. Valeria Coverdale, Hamilton Goodman LLC
Ms. Nina Figueroa, Health Policy Advisor, SBO, DHR
Ms. Sandy Hart, IBM Watson Health
Ms. Charlene Hrivnak, CVS Health
Ms. Katherine Impellizzeri, Aetna
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

CALLED TO ORDER – DIRECTOR FAITH RENTZ

Director Rentz called the meeting to order at 10:02 a.m.

APPROVAL OF MINUTES –DIRECTOR FAITH RENTZ, CHAIR

A MOTION was made by Ms. Anderson and seconded by Mr. Oberle to approve the Minutes from the Combined Subcommittee meeting on September 9, 2021.
1 Abstention – Ms. Nestlerode
MOTION ADOPTED

DIRECTOR'S REPORT – DIRECTOR FAITH RENTZ, CHAIR

Annual Medicare Open Enrollment and CVS Caremark/SilverScript Transition

The State of Delaware Special Medicfill Open Enrollment runs from October 4, 2021, to October 15, 2021. During this annual Open Enrollment, benefit-eligible State of Delaware Medicare pensioners may make changes, enroll, or disenroll in the Special Medicfill benefit (supplemental Medicare coverage) available with or without Medicare Part D prescription coverage.

CVS Caremark will replace Express Scripts as the prescription coverage benefits administrator for participants enrolling in the SilverScript prescription coverage option effective January 1, 2021. Participants will receive communications from CVS Caremark regarding the transition.

Mr. Scoglietti joined the meeting.

PRIMARY CARE DASHBOARD REPORTING – DEPUTY DIRECTOR LEIGHANN HINKLE, SBO

There was a review of the Primary Care Dashboard. The Dashboard included FY21 Primary Care Provider ("PCP") utilization data, Q1 FY22 network changes, and provider counts by county and by health plan administrator through September 30, 2021.

Monthly reporting provided by Highmark on network changes does not identify the cause of a provider's termination (e.g., voluntary, involuntary, or transitioned to a specialty) except for those providers moving to a concierge model. In Q1 FY22, Highmark reported 16 terminations with zero PCPs moving to concierge. Highmark reported 27 new PCPs in New Castle County ("NCC"), 5 in Kent County ("KC"), and 8 in Sussex County ("SC").

Aetna reported that 7 PCPs were terminated voluntarily, 4 involuntarily, and 5 transitioned to a specialty. Aetna reported 8 new PCPs in NCC, 3 in KC, and 10 in SC.

Mr. Scoglietti queried whether the 16 terminations reported by Highmark were the same providers reported by Aetna. Ms. Hinkle responded that SBO will follow up with this detail.

There was a review of FY21 utilization data by quarter and by county (where the member resides) including the number of visits for preventive care, other PCP office visits, telehealth, urgent care, and walk-in retail. The number of visits reported was stable by quarter and across all counties; the average visits by county for FY21 were NCC: 57,385, KC: 30,460, and SC: 26,714.

It was noted that data was not yet available for the last month of Q4, but a refresh is expected to be available for the November 4, 2021 Subcommittee meetings. Moving forward the Primary Care Dashboard will be presented on a quarterly basis.

FINANCIALS – MR. CHRIS GIOVANNELLO, WTW

August Fund Report

Medicare/EGWP rebates are performing as expected notwithstanding the volume of claims received in August that resulted in rebates that reflect higher than the budgeted amount.

FY22 continues with favorable claims experience through August. Medical and prescription claims are $4.2M and $2.1M below the budgeted amount respectively. The YTD variance for Commercial prescription claims is $8.5M below the budgeted amount because of the transition from Express Scripts to CVS Caremark. EGWP prescription claims are on budget for the year.

The $18.3M projected YTD claims surplus is offset by the $20.0M in approved supplemental funding not received, bringing the YTD Fund Equity balance to $1M below the budgeted amount.

FY23 PLANNING – PLAN DESIGN CONSIDERATIONS – MS. JACLYN IGLESIAS, WTW

The Subcommittees reviewed FY23 opportunities for consideration presented at the Combined Subcommittee meeting on September 9, 2021, including the number of members that would be impacted, the estimated FY23 savings or cost avoidance, and the impact on the required 15.0% premium rate increase effective July 1, 2022.

Implementing a $50 single/$100 family or a $500 single/$1000 family deductible for the HMO and Comprehensive PPO populations on July 1, 2022, would impact 89,000 members and yield an estimated savings of $1.5M and $11.7M respectively that would result in a 0.2% to 1.4% reduction in the required premium rate increase.

Adding deductibles of $50 to $250 to the Medicfill population in addition to adding copays for office visits, emergency room visits, and hospital stays would impact 28,600 members and yield estimated savings ranging from $0.8 to $3.9M that would result in a 0.1% to 0.5% reduction in the required premium rate increase.

A 50% increase to the current prescription plan copay structure for the Commercial and EGWP populations (e.g., generic from $8 to $16, and brand from $12 to $24) would impact 102,100 and 28,000 members respectively, yield estimated savings totaling $6.2M that would result in a cumulative reduction of 0.7% to the required premium rate increase.

Reinstating copays for telehealth utilization in the commercial population would impact 102,100 members and yield an estimated savings of $4.0M that would result in a 0.5% reduction to the required premium rate increase.

Increased cost-sharing will yield savings for the Group Health Insurance Program (“GHIP”), but increased cost-sharing alone will have a minimal impact on reducing the required premium rate increase and result in significant member disruption.

The Subcommittees reviewed three optional pharmacy programs available through the GHIP’s prescription Pharmacy Benefit Manager, CVS Caremark.

The Drug Savings Review program reviews prescription utilization to ensure that the prescription and dosage follows evidence-based medical guidelines. Potential savings is dependent on the responsiveness of the provider community. CVS may outreach to physicians regarding patient safety and savings opportunities, but the provider retains discretion over the member’s prescriptions therapy.

There is a monthly administrative fee, but the program has a 3:1 minimum Return on Investment (“ROI”) guarantee. CVS estimates the program will yield an estimated gross savings of $1.1M to $3.0M (includes savings for members). The Drug Savings Review program can be implemented for an effective date of January 1, 2022, if CVS is notified by October 15, 2021.

Ms. Anderson requested the estimated net savings of the program. Ms. Iglesias responded that the estimated gross savings are inclusive of the administrative fees, but she will follow up regarding the estimated savings net of member cost-share.

The PrudentRx specialty copay card program is an independent third-party organization that CVS Caremark has partnered with to leverage savings from manufacturer copay cards for specialty medications that could produce savings but would require members to enroll and would increase member out-of-pocket costs for individuals who do not enroll. The program is offered to the Commercial population only; the EGWP population is not eligible.

PrudentRx would contact members on a specialty medication that is exclusively filled by the CVS specialty pharmacy to enroll. Members would pay $0 out-of-pocket for medications on the GHIP's exclusive specialty drug list dispensed by CVS Specialty, regardless of whether a copay card is available. If a copay card is available (estimated at 96%), then copay assistance provided by the drug manufacturer is used to offset the GHIP share of the specialty drug cost.

Any member who does not take action to enroll in PrudentRx would be subject to a 30% coinsurance on specialty medications dispensed by the CVS Specialty pharmacy. Currently, members with a new specialty medication can fill their prescriptions one time outside of the CVS Specialty pharmacy. This option would be removed with the implementation of PrudentRx; therefore, requiring members to utilize the CVS Specialty pharmacy exclusively for these prescriptions.

The PrudentRx program is dependent upon the continuation of drug manufacturer copay assistance programs. There are no upfront administrative costs but realized savings are shared with PrudentRx (25%). CVS has estimated the annual net savings to the GHIP to be $6.9M, or $7.7M with an expanded list of specialty pharmacy (net of the shared savings).

Mr. Scoglietti queried the percent of total spend for Specialty pharmacy. Ms. Iglesias responded that on average 1 to 2% of the population is prescribed a specialty prescription, but the percentage of total GHIP spend is much higher. WTW will follow up with an updated percent of total spending.

Mr. Scoglietti asked to clarify how members would access CVS Specialty pharmacy. Ms. Iglesias responded that CVS Specialty pharmacy requires that members fill prescriptions via mail order and not a brick-and-mortar store.

Ms. Anderson expressed concern regarding the timing of implementing the proposed changes while members are transitioning from filling their prescriptions with Express Scripts to CVS Caremark. Director Rentz agreed that disruption to members and providers should be considered when considering whether to adopt any of the optional pharmacy programs.

The Next Generation Transform Diabetes Care ("ngTDC") 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 Medicfill plan participants effective December 31, 2021.

Mr. Costantino joined the meeting.

While Livongo provides all enrolled participants with a "connected meter" that uses wireless technology to transmit test results to Livongo coaches, who will contact members with abnormally high or low glucose levels, the ngTDC program uses a connected meter exclusively for members at high risk of abnormal glucose values; all other ngTDC enrolled participants will be offered another meter available from the CVS formulary. Unlike participants enrolled in the Livongo program, all ngTDC participants are eligible for diabetes coaching from nurses, nutrition counseling, and in-person support at CVS pharmacies.

The estimated annual cost of ngTDC for the Medicfill population is $115,000 more than the cost of Livongo; however, ngTDC offers a 2:1 guaranteed ROI.

The ngTDC program could have been implemented for an effective date of January 1, 2022, if CVS received notification by October 1, 2021; however, SBO obtained conditional approval from the SEBC co-chairs to begin implementation of this program with CVS but is seeking final approval from the Committee at the October 11, 2021 meeting. If the Committee does not provide final approval to implement this program, CVS has agreed to terminate the implementation process at no cost to the State and with no impact to members.

Subcommittee members will be asked to consider whether the ngTDC program should be adopted for active employees and non-Medicare pensioners and assess the value of this program against other diabetes offerings available through the medical Third-Party Administrators ("TPA"). CVS estimates that the adoption of ngTDC for this population would yield an estimated gross savings of $1.9M to the GHIP.

Mr. Scoglietti asked to clarify whether the 30% coinsurance on medications for members using the PrudentRx program would be in addition to copays they are already responsible for. Ms. Iglesias responded that members currently have a flat copay and there would be an additional coinsurance on medications for members over what they pay today. Mr. Scoglietti requested that in addition to the GHIP spend on specialty medications, he would like more data on the potential impact on members.

Mr. Oberle queried whether participation in the Transform Diabetes Care Program would be mandatory. Ms. Iglesias responded that participation would not be mandated. Mr. Oberle asked to clarify what assumptions were made in calculating the savings estimates. Ms. Iglesias responded that estimates were based on the current EGWP participation in the Livongo diabetes care management program.

Director Rentz encouraged the Subcommittee members to continue to share their feedback related to the proposed pharmacy changes. Follow-ups will be provided in advance of the November meeting to allow sufficient time for the Subcommittee members to prepare for their recommendations to the SEBC.

Updates to the prior analysis of the cost and estimated savings associated with a mandatory bariatric carve-out (with incentive modifications) with SurgeryPlus is ongoing with results expected to be shared at the Subcommittee meetings on November 4, 2021. Updates will include recent feedback from members who have used the benefit as well as a discussion regarding incentive plan modifications.

The Subcommittees reviewed an update on the utilization of services with variable copays by the site of care and the outcomes associated with a variety of initiatives adopted since FY16 to improve health outcomes and support management of cost for members and the GHIP including clinical management programs, and SurgeryPlus.

IBM Watson Health and WTW compared incurred claims experience from April 2020 to March 2021 to the prior two years to evaluate changes that occurred during the first year of the pandemic.

Key findings revealed that visits to emergency rooms, urgent care, and primary care for similar conditions decreased by about 30% compared to the prior 12-month period; however, the proportion of visits to emergency rooms, urgent care, and primary care providers as a percent of total remained relatively consistent (e.g., visits to emergency rooms represented 6% of total visits to these types of providers).

Visits for high-tech radiology services on an outpatient basis decreased by 13.5% overall during the most recent 12-month period (decreases of 15.6% at hospitals and 10.6% at freestanding facilities). The proportion of visits to freestanding facilities for high-tech radiology services increased by one percentage point each year (from 42% of total visits to 44%). Visits for basic imaging services on an outpatient basis at hospitals decreased by 17.7% whereas visits to freestanding facilities for the same types of service decreased only 8.7%; however, visits for mammograms at freestanding facilities increased by 0.1%.

Finally, visits for lab services on an outpatient basis increased at hospitals (3.1%) and preferred labs (5.4%); there were notable increases in utilization of microbiology services at both outpatient hospital labs (96.4%) and independent labs (30.4%) attributable to COVID-19 testing.

There continues to be a reduction in utilization of most services with variable copays by the site of care, except for outpatient labs, which have increased at both hospitals and preferred labs (driven by COVID-19 testing) and likely stems from the combined impact of the pandemic and changes in behavior driven by copay differentials.

Prior to COVID-19, the GHIP experience would show a reduction in utilization of nonpreferred sites of care in the plan years coinciding with copay changes, but in years with no changes, utilization of non-preferred sites of care would revert to higher levels. As a result of the pandemic changing utilization patterns across virtually all types of care, it is necessary to establish a new baseline for GHIP experience with the site of care utilization and continue to monitor to determine whether these behavior changes are sustainable. At this time no changes to FY23 copay differentials are recommended.

Mr. Costantino queried whether there had been any year-to-year inpatient hospitalization comparisons and how the analysis aligns with plan expenditures. Mr. Giovannello responded that paid claims through FY21 show inpatient length of stay were up 10% while utilization remained flat. WTW will follow up with additional information. He added that while total claims were $47.0M below budget in April-June 2020, the GHIP ran above budget in FY21 with the return of differed care. FY21 data is needed to determine whether claims experience has reached a new normal in which to compare moving forward.

Mr. Costantino queried whether a drop in some service areas caused an increase in others. Mr. Giovannello responded that WTW will explore further.

Utilization and engagement rates for clinical management programs are based on the most recent data that coincides with the peak of the pandemic and data trends may not be indicative of true program experience. For a consistent and detailed evaluation between similar programs, a continued effort to standardize the metrics across programs is recommended and an analysis based on defined metrics and outcomes from the vendor partners for purposes of comparison.

A key challenge with these programs is the administrative effort of the SBO and the GHIP vendor partners in administering the program and removing the duplication of services. Additionally, it is difficult to report which vendor is credited for health improvements, risk reductions, and savings (e.g., coordination of care management between SurgeryPlus and other care management programs, and the impact of care management programs vs. Livongo in improving diabetic member health outcomes).

The Livongo Diabetes Care Management and Prevention Program was first implemented in July 2019. There are two components to the program: the diabetes prevention program, and the diabetes care management program that utilizes a connected glucose meter to monitor members at high risk and provides 24/7 real-time interventions with certified diabetes education specialists.

The Livongo Diabetes Prevention program is currently available to members enrolled in Highmark; Livongo was discontinued for Aetna plan participants on December 31, 2020 and will discontinue for GHIP Aetna members effective July 1, 2022. Reporting is limited, and enrollment is lower than expected for the eligible population.

Livongo has an enrollment that is lower than expected (15%) but once enrolled, those that activate the meter (95%), have a decrease in A1c of greater than 1% at the 6-month milestone (target of 0.9% decrease).

The recommendation is to continue to explore targeted strategies to increase enrollment for the Livongo Diabetes Prevention and the Diabetes Care Management programs and to evaluate the referral protocol from care management to the Livongo programs to ensure program integration.

There are two other diabetes prevention programs, Solera, and the YMCA Diabetes Prevention Program.

Solera is an Aetna partner administering their National Diabetes Prevention Program to Aetna plan participants via online or virtual modalities with an in-person and telephonic option also available. The program launched January 1, 2021; therefore, the data is too immature for evaluation beyond early engagement numbers. Six-month reporting indicates positive program enrollment (22%) but seeing over a 50% drop-out between enrollment and completion of two sessions.

The recommendation is to continue program promotion and monitoring of enrollment, engagement, and ongoing engagement.

The YMCA Diabetes Prevention Program is a partner of Aetna and Highmark administering their National Diabetes Prevention via in-person and on-site modalities. The program has low enrollment making it difficult to evaluate program effectiveness and impact year-over-year. Engagement is at 70% for 9 sessions and GHIP participants are achieving 5% weight loss exceeding the program expectations.

Mr. Scoglietti queried whether the eligibility program requirements were similar across all diabetes prevention programs and whether members could self-enroll. Ms. Iglesias responded that the program requirements are similar, and many may self-enroll through a process to determine eligibility and the appropriateness of the program, but most participants are enrolled through the member's PCP or other care management programs.

The Subcommittees were asked whether there were additional data points that could be provided or questions that could be answered to help them think whether the Livongo Diabetes Care Management Program should be expanded where its possible to do so, or whether to expand the ngTDC across the broader population entirely through the CVS Caremark benefit. The Subcommittees had no questions and no comment.

The SurgeryPlus Surgical Centers of Excellence (COE) program launched July 1, 2019. The Committee approved a "carve-out" COE program design, communication and engagement strategy, incentive plan, and scope of covered services. GHIP participants have the option of using a medical plan COE provider or a SurgeryPlus COE provider. Using a SurgeryPlus COE includes a concierge service, travel benefits, and a financial incentive (e.g., $2,000 for bariatric surgery).

Despite a decline in elective procedures following the pandemic, utilization has returned and has resulted in a net plan savings of approximately $2.2M in FY21. Orthopedic surgeries (e.g., joint or spine) prove the greatest opportunity for program savings and members engagement based on the frequency of occurrence and potential for cost variation.

The recommendation is to consider a review of the State's tiered benefit for voluntary use of SurgeryPlus or mandating the use of SurgeryPlus by targeted procedures (e.g., bariatric, joint replacement).

Hinge Health is another recommendation to provide virtual physical therapy to address chronic and acute non-surgical needs. Virtual physical therapy helps optimize recovery time, employee productivity, and return to work. SurgeryPlus customers receive preferred pricing from Hinge Health, an ROI performance guarantee, and substantial fees at risk, which support the continuation and expansion of the program.

The CareVio Care Management Program available to members enrolled in an Aetna HMO Plan and offers comprehensive condition management and intensive case management for higher risk plan participants. Low engagement rates limit the ability to determine savings estimates or program impact, but there has been an increase in preventive care utilization among the HMO population.

The recommendation is to evaluate engagement protocols and to consider other reporting enhancements that capture local provider efforts to support population health.

The Aetna Case and Disease Management Program launched July 1, 2015 for the CDH Gold population. Again, low engagement rates limit the ability to determine savings estimates or program impact.

The recommendation is to evaluate engagement protocols and explore other Aetna care management models that may increase engagement and integration between clinical and non-clinical interactions.

The Highmark Custom Care Management Unit is offered to Highmark PPO and First State Basic Plan members and is designed to identify high-cost members and intervene to mitigate costs before costs are incurred. The program

has reasonably high levels of engagement with clinical nurses and health coaches and non-clinical member support services.

The recommendation is to evaluate engagement protocols and opportunities to promote preferred sites of care where it is appropriate to do so based on evidence-based guidelines for chronic conditions.

The next steps include continued discussions regarding savings opportunities to explore further, continued monitoring of emerging utilization and cost savings for the GHIP initiatives adopted to date, and continued discussions regarding the timing and level of future rate action.

OTHER BUSINESS
Mr. Scoglietti acknowledged WTW for the depth of the materials presented.

PUBLIC COMMENT
No public comment was provided.

ADJOURNMENT
A MOTION was made by Mr. Scoglietti and seconded by Ms. Anderson to adjourn the meeting at 12:00 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