MINUTES FROM THE COMBINED MEETING OF THE FINANCIAL and HEALTH POLICY & PLANNING SUBCOMMITTEES TO THE STATE EMPLOYEE BENEFITS COMMITTEE
NOVEMBER 4, 2021

The Health Policy & Planning ("HP&P") Subcommittee and the Financial Subcommittee to the State Employee Benefits Committee (the "Committee") met Thursday, November 4, 2021 in a combined meeting. 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
The Honorable Colleen Davis, State Treasurer, Office of the State Treasurer
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. Jeanette Hammon, Senior Fiscal & Policy Analyst, Office of Management & Budget ("OMB") (Appointee of Director Cade)
Mr. William Oberle, Delaware State Trooper's Association (Appointee of Mr. Taschner, Executive Director, DSEA)
Mr. Stuart Snyder, Chief of Staff, Department of Insurance (Appointee of Commissioner Navarro)
Ms. Judi Schock, Deputy Principal Assistant, OMB (Appointee OMB Director Cade)
Mr. Robert Scoglietti, Deputy Controller General, Office of the Controller General ("OCG") (Appointee of CG Jones)
Ms. Ashley Tucker, Deputy State Court Administrator, Administrative Office of the Courts ("AOC") (Appointee of 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 of Lt. Governor Hall-Long)

Others in Attendance:

Ms. Leighann Hinkle, Deputy Director, SBO, DHR
Mr. Chris Giovannello, Willis Towers Watson ("WTW")
Mr. Mark Gustein, WTW
Ms. Jaclyn Iglesias, WTW
Ms. Rebecca Warnken, WTW
Ms. Wendy Beck, Highmark Delaware
Ms. Nina Figueroa, Health Policy Advisor, SBO, DHR
Ms. Sandy Hart, IBM Watson Health
Ms. Charlene Hrivnak, CVS Health
Ms. Katherine Impellizzeri, Aetna
Ms. Heather Johnson, Controller, DHR
Mr. Walter Mateja, IBM Watson Health
Ms. Evelyn Nestlerode, Deputy State Court Administrator, CFO, AOC
Ms. Louisa Phillips, Delaware Healthcare Association
Ms. Paula Roy, Roy & Associates
Ms. Courtney Stewart, Deputy Director, OMB
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 10:00 a.m.

APPROVAL OF MINUTES –DIRECTOR FAITH RENTZ, CHAIR

A MOTION was made by Ms. Schock and seconded by Ms. Hammon to approve the minutes from the Combined Subcommittee meeting on October 7, 2021.
MOTION ADOPTED UNANIMOUSLY.

DIRECTOR'S REPORT – DIRECTOR RENTZ, CHAIR

State Employee Benefits Committee

At the October Committee meeting, Secretary Rick Geisenberger reviewed the work of the Retirement Benefits Study Committee ("RBSC") that is tasked with making recommendations on addressing the state's unfunded Other Post-Employment Benefits liability specifically as it pertains to retiree healthcare funding and plan design.

The RBSC released their first report on November 1, 2021, that recommended that the Committee explore Medicare retiree plan options and communications to educate stakeholders and retirees on the impact of the unfunded liability. The Committee will continue to discuss, and it is expected that the evaluation of options will be delegated to the Subcommittees.

The Committee will meet again on November 7, 2021, to review potential FY23 plan design options, a Health TPA RFP contract award recommendation, and revised FY23 projections.

Primary Care Dashboard Reporting

The Primary Care Dashboard has been revised to include GHIP member visits through June 30, 2021. Terminated providers reported in Q4 are not the same across both vendors.

FINANCIALS – MR. CHRIS GIOVANNELLO, WTW

September Fund Report

Revenues are running $19.5M under budget for the year, attributable to the $20.0M in supplemental funding that was approved and budgeted, but has not yet been received.

Director Rentz added that SBO continues to have discussions with OMB regarding the timing and availability of additional federal reimbursements that may be available for GHIP COVID-19 expenses since March 31, 2021; however, there is no update at this time.

As a result of a favorable quarter, medical and prescription claims are running $22.6M under budget attributable to one less invoice. Additionally, claims are projected to run higher in Q2 – Q4 to align with the budget.

Mr. Scoglietti queried whether the amount budgeted for claims in the first quarter is less and whether the amount increases by quarter. Mr. Giovannello confirmed that claims are budgeted to increase each quarter as members meet their deductibles and the plan picks up more of the claim share.

Mr. Oberle queried whether the favorable quarter was attributable to deferred care and referred to hospitals in Michigan and Colorado that have reported utilization surges resulting from the return of deferred care; he queried whether WTW could forecast the potential downstream impact to the GHIP. Mr. Giovannello responded that WTW is evaluating claim data and will provide an update at the next Subcommittee meeting on December 9, 2021.

The Fund Equity Balance is $148.4M through September 30, 2021, with a YTD surplus of $63.1M.

FY23 GHIP Projections

Long-term projections have been updated to include an updated headcount, revenue items, claims experience through FY22 Q1 and the projected operating expenses for FY23. A year-end surplus for FY23 is projected at $17.6M attributable to favorable claim experience and removing the first CVS invoice from the budget due to invoice timing. The FY23 projected deficit has been revised to $119.1M.

Assuming no other program changes, and to fully solve for the $119.1M projected deficit, a 14.0% premium rate increase will be needed on July 1, 2022 ($86.0M increase in state share and a $10.0M increase in revenue paid by the active/pre-65 retiree populations); this is an increase of $3.90 to $38.20 per employee per month ($46.80

to $458.40 per year) depending on plan and coverage tier and a state subsidy increase of $93.45 to $252.13 per employee per month ($1,121.40 to $3,025.56 per year).

The Subcommittee reviewed the savings opportunities previously presented, the number of members impacted, the cost to members, and the effect of each in reducing the required premium rate increase.

Opportunities to offset the required premium rate increase needed to solve for the projected deficit include but are not limited to Medical Third-Party Administrator Request for Proposal initiatives, plan design changes for active/pre-65 and Medicfill programs, adoption of proposed CVS Health pharmacy programs, adoption of mandatory bariatric carve-out and incentive modifications with SurgeryPlus.

Implementing an annual deductible of $50 single/$100 family or a $500 single/$1000 family 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. This option does not apply to First State Basic and CDH Gold plans that already have a deductible. An annual deductible must be met before the coinsurance begins. Preventive care under the Affordable Care Act is not subject to a deductible.

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 would impact 102,100 and 28,000 members respectively, and yield estimated savings totaling $6.2M that would result in a 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.

The Drug Savings Review program reviews prescription utilization to ensure that the prescription and dosage follow evidence-based medical guidelines. This program would impact 102,100 members and savings are estimated at $1.0M to $2.8M (includes savings for members) that would result in a reduction of 0.1% to 0.3% to the required premium rate increase; the estimated savings is dependent on the responsiveness of the provider community.

CVS may outreach to physicians in writing based on the member's claim history regarding patient safety and savings opportunities, but the treating provider retains discretion over the member's prescriptions therapy. The program is not intended to apply to the first fill but rather subsequent prescriptions.

There is a monthly administrative fee, but the program has a 3:1 minimum Return on Investment ("ROI") guarantee. The Drug Savings Review program can be implemented at the beginning of a quarter. For an effective date of January 1, 2022, CVS would have needed to be notified by October 15, 2021. The next possible effective date is April 1, 2022.

Ms. Hammon queried how the Drug Savings Review Program is different from the CVS review done at the pharmacy counter. Ms. Iglesias responded that reviewing prescriptions with utilization management protocols in place (e.g., generic before brand) doesn't necessarily evaluate the broader appropriateness of using the medication and provides an opportunity for the provider to communicate directly with the pharmacy manager.
Ms. Tucker queried the savings realized by other state plan sponsors that have adopted the program. Ms. Iglesias responded that while the program has been available commercially, she did not have the detail available specific to state plans and WTW will follow up.

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. This program would impact members who are taking specialty medications and savings are estimated at $6.9M to $7.7M that would result in a reduction of 0.8% to 0.9% to the required premium rate increase.

PrudentRx would contact members on a specialty medication that is exclusively filled by the CVS specialty pharmacy to enroll. Enrollment would allow members to 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, 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. According to PrudentRx, 96% of specialty brand drug scripts have copay assistance.

Ms. Hammon asked whether the percent of spending attributable to specialty prescriptions was a percent of total GHIP prescription costs. Ms. Iglesias replied that 49.4% is the percent of specialty prescription spend for the Commercial plan.

Mr. Costantino Joined the meeting.

PrudentRx enrollment begins when a member has been prescribed a specialty medication on the CVS Caremark specialty drug list, including highly utilized classes such as autoimmune, hepatitis C, multiple sclerosis, and oncology. The most common conditions for GHIP members using specialty drugs that would be affected by PrudentRx include atopic dermatitis, autoimmune, multiple sclerosis, and oncology.

If a member is already on one of these medications, CVS would outreach in advance of the program implementation. The program is offered to the Commercial population only; the EGWP population is not eligible.

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.

Director Rentz asked to clarify that if members do not enroll in the PrudentRx program prior to filling their first specialty prescription that they would have a 30% coinsurance regardless of whether the medication was listed on the CVS Caremark specialty drug list. Ms. Iglesias responded that there is a period after the prescription has been filled where the member must enroll in PrudentRx to have the 30% coinsurance waived.

Director Rentz queried whether PrudentRx would require members to use mail order for first fill at retail pharmacies to be excluded for specialty medications not included on the CVS Caremark specialty drug list. Ms. Iglesias responded that there is a subset of other conditions (e.g., hepatitis B, HIV, and transplants) that could be included/excluded from the program; WTW will confirm with CVS to see if the state has the discretion to include other conditions and whether the 30% coinsurance and first fill would apply to specialty medications for those conditions.

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%).

Mr. Scoglietti asked for clarification regarding where the net savings come from. Ms. Iglesias responded that increasing the coinsurance amount increases the potential copay assistance that could be obtained through the

manufacturer assistance programs and by having the plan design set a zero dollar out of pocket, the plan gains the benefit of having the 30% coinsurance routed through the manufacturer assistance programs.

Mr. Scoglietti queried whether members who declined to enroll and therefore were subject to a 30% coinsurance could enroll later. Ms. Iglesias confirmed that members can enroll at any time.

Ms. Anderson queried the current copay for specialty medications. Ms. Iglesias responded that specialty medications filled through mail-order range from $16-100 on average.

Ms. Anderson clarified that a 30% coinsurance is estimated to be $1,700 per specialty prescription. Ms. Iglesias confirmed that amount would vary depending on the medication, but the average cost to the GHIP for a specialty prescription is $5,600 and 30% of that average is approximately $1,700.

Director Rentz, on behalf of Mr. Snyder who was unable to connect by audio, expressed concern regarding the additional time that it would take to fill a prescription by mail order. She requested the average fill time for a prescription by CVS Specialty versus PrudentRx.

Mr. Costantino expressed concern regarding CVS contracting to PrudentRx within the framework of their PBM business. He requested references from plan sponsors who have implemented PrudentRx prior to making a recommendation to the Committee. Ms. Iglesias will request references from CVS.

Mr. Scoglietti asked for clarification on the current process for the first fill of specialty medications. Ms. Iglesias confirmed that currently the first fill of specialty medications can be obtained at retail pharmacies; however, some specialty medications can only be obtained through mail order. Prudent Rx would require all medications to be filled by mail order including first fills.

Mr. Snyder expressed concern with requiring a mail order for the first fill of a specialty medication in cases where there is a sense of urgency. Ms. Iglesias responded that prescriptions can be shipped overnight but WTW will request clarification regarding cases where prescriptions are time sensitive.

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 program would impact all diabetic members and savings are estimated at $1.9M that would result in a reduction of 0.2% to the required premium rate increase. This is a potential replacement for Livongo for active and non-Medicare health plan members when the State's current third-party administrator contracts with Aetna and Highmark Delaware end on June 30, 2022. The ngTDC program was approved for the EGWP Medicare retiree population at the SEBC meeting on October 11, 2021.

Program changes for consideration include mandating the use of the SurgeryPlus benefit for bariatric surgery. This program would impact 102,100 members and savings are estimated at $1.2M that would result in a reduction of 0.1% to the required premium rate increase.

Finally, program changes to the incentive structure for SurgeryPlus (e.g., removing the financial incentive for bariatric surgery) would impact 102,100 members and savings are estimated at 0.1M that would result in a negligible reduction to the required premium rate increase.

Highmark and Aetna bariatric networks in Delaware have increased from 51 Centers of Excellence ("COE") in CY19 to 65 in CY20.

Currently, GHIP members have the choice to use their medical plan provider network or obtain the surgery through SurgeryPlus. SurgeryPlus provides concierge support to locate a provider, schedule an appointment, coordinate follow-up care, provide travel benefits associated with using a COE provider, and more.

Assuming financial incentives for bariatric procedures were discontinued, the gross cost avoidance to the state from SurgeryPlus is approximately $13,751 per bariatric procedure. Potential cost avoidance associated with carving out bariatric surgery is highly dependent upon the number of procedures conducted during FY23.

In FY21 the state paid members approximately $407K in incentives for all procedures. There is an estimated FY23 cost avoidance of $108,250 by decreasing Tiers A-C by $500 per procedure and Tier D by $250 per procedure (A: Joint Replacement/Spine, B: Cardiac/GYN, C: Hernia/Gallbladder/Orthopedics/ENT, D: Gastroenterology/Pain Management/Other).

Member feedback provided by SurgeryPlus indicated that of those who completed a procedure, 90% responded "very positive" or "somewhat positive". Additionally, 50% responded that the most important factor in their choice to utilize the benefit was "cost".

In addition to the potential savings options prepared for the Subcommittee's consideration, Mr. Oberle queried whether there would be any consideration to offering an HRA option for the Medicare population. Director Rentz responded that changes to EGWP plans are on a different timeline and that a further evaluation by the Subcommittees is likely and changes could be adopted as early as January 2023.

Mr. Oberle also requested the Subcommittees' consideration of any additional site of care steerage to freestanding facilities for radiology and lab work. Director Rentz will follow up with updated modeling.

Ms. Hammon is in favor of adopting the copay changes for telemedicine provided by community medical providers. Ms. Anderson requested clarification regarding copays for telemedicine prior to the pandemic. Ms. Iglesias responded that if adopted the copays for third-party telemedicine providers (e.g., Teledoc) would remain at $0, but copays for telemedicine provided by a community provider (i.e., a member's PCP) would resume.

Mr. Scoglietti also supports copay changes for telemedicine and site of care steerage.

Ms. Hammon supports further consideration of copays for Medicfill and increased deductibles for pharmacy. Director Rentz acknowledged the support and noted that plan changes for the Medicare pensioner population would not be effective until January 1, 2023.

Ms. Hammon supports further consideration of the CVS Drug Savings Review program; however, she expressed a lack of information related to PrudentRx.

Mr. Scoglietti and Ms. Schock support further consideration of all three CVS savings options.

Mr. Costantino queried whether the information was available regarding the contract between CVS and PrudentRx. Ms. Iglesias was unfamiliar with the details.

Mr. Costantino supports further consideration of PrudentRx but queried whether there was an opportunity to negotiate the percent that PrudentRx would keep as it is paid by monies set aside by drug manufacturers for copay assistance. WTW will inquire further and follow-up.

Ms. Anderson is sensitive to the populations that require specialty medications, and she would like further clarification and details on the member experience related to enrollment and utilization of Prudent Rx. Additionally, Ms. Anderson supports further consideration of reinstituting copays for telemedicine.

Mr. Costantino queried whether the CVS Drug Savings Review made best practice recommendations based on claims and utilization and or if it was a member-level prescription review. Ms. Iglesias confirmed the recommendations are tailored to the individual member and based on evidence-based best practices.

No Subcommittee members expressed opposition for further consideration of Transform Diabetes Care.

Ms. Hammon did not oppose to program changes related to SurgeryPlus but queried whether the savings would outweigh the administrative burden. Director Rentz will evaluate further and follow up.

Ms. Hammon supports further consideration of deductibles for the PPO/HMO plans.

Mr. Scoglietti supports further consideration of mandating bariatric procedures through SurgeryPlus; however, he does not currently support reducing the existing incentives.

Ms. Hammon requested available data related to the potential cost avoidance of bariatric surgery as it pertains to mitigating the cost of other related medical conditions. Ms. Iglesias will share the results of broader studies that have studied the downstream impact of bariatric surgery.

The maximum annual savings opportunity if all program changes were adopted for FY23 is $24.0M - $45.0M and would reduce the projected $119.1M deficit to $74.0M - $95.0M and would still require a 9-11% premium rate increase to solve for the remaining deficit.

There was a discussion regarding the disruption to members that would result from implementing all program changes in addition to premium rate increases, and that premium rate increases are paid equally by all members while increases to copays impact those that utilize the services.

Mr. Oberle is not opposed to some of the proposed changes but prefers a premium rate increase over the adoption of all proposed program changes that he perceives as a cost shift to employees.

Director Rentz will incorporate all comments to be shared with the Committee on November 8, 2021. To be included in the FY23 budget is expected that the Subcommittees will be asked to finalize any recommendations at the meeting on December 9, 2021, to be elevated for the Committee's consideration on December 13, 2021.

OTHER BUSINESS
No new business was presented.

PUBLIC COMMENT
No public comment was provided.

EXECUTIVE SESSION
A MOTION was made by Mr. Scoglietti and seconded by Ms. Anderson to move into Executive Session at 12:09 p.m. MOTION ADOPTED UNANIMOUSLY.

ADJOURNMENT
A MOTION was made by Mr. Costantino and seconded by Mr. Snyder to adjourn the meeting at 12:29 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