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

The Health Policy & Planning ("HP&P") Subcommittee and the Financial Subcommittee to the State Employee Benefits Committee (the "Committee") met Thursday, December 9, 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)
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")
Ms. Jaclyn Iglesias, WTW
Ms. Rebecca Warnken, WTW
Mr. Brian Holloran, WTW
Ms. Wendy Beck, Highmark Delaware
Ms. Christina Bryan, Delaware Healthcare Association
Ms. Julie Caynor, Aetna
Ms. Sara Dunlevy, CVS Health
Ms. Nina Figueroa, Health Policy Advisor, SBO, DHR
Ms. Sandy Hart, IBM Watson Health
Ms. Charlene Hrivnak, CVS Health
Ms. Heather Johnson, Controller, DHR
Mr. Jay McCarthy, CVS Health
Mr. Walter Mateja, IBM Watson Health
Ms. Louisa Phillips, Delaware Healthcare Association
Ms. Paula Roy, Roy & Associates
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

Mr. Oberle requested to edit his remarks as written.

Treasurer Davis requested to edit her attendance as recorded.

A MOTION was made by Ms. Schock and seconded by Mr. Costantino to approve the minutes from the Combined Subcommittee meeting on November 4, 2021 as amended.
MOTION ADOPTED UNANIMOUSLY.

DIRECTOR'S REPORT – DIRECTOR RENTZ, CHAIR

Request for Proposal Updates

The Committee will meet on December 13, 2021, to review the CVS implementation and is expected to act on the recommendation of the Proposal Review Committee ("PRC") for the Medical Third-Party Administrator ("TPA") Request for Proposal ("RFP").

Additionally, the PRC was scheduled to make a formal recommendation to the Committee for the award of the Dental Plan TPA RFP; however, the PRC has not concluded its work. The PRC is expected to present its recommendation on January 24, 2021.

FINANCIALS – MR. CHRIS GIOVANNELLO, WTW

October Fund Report

October premium fund contributions were lower than budgeted attributable to the timing of receipts for non-payroll groups. The GHIP supplemental bill funding will post in December.

October claims came in $4.3M favorable to the budgeted amount, and $26.9M for the year for medical and pharmacy claims combined. The net impact of October to the GHIP is a $1.9M improvement in the projected deficit and a YTD variance of $4.5M.

There was a discussion clarifying the budget YTD variances and the use of 5% medical and 8% pharmacy trends.

Mr. Costantino requested a column to be added to the monthly fund report or elsewhere that would reference prior year data. Mr. Giovannello responded that the quarterly financial report will include a comparison to the previous year.

FY22 Q1 Plan Cost Analysis Report

The FY 22 Q1 report is on an incurred basis (i.e., not cash) and compares FY22 YTD medical and pharmacy claims to FY21 YTD as reported by Aetna, Highmark, CVS, and ESI. On a gross claim performance FY22 is slightly more favorable than FY21, with FY22 coming in at 2.0% less PEPY, and 1.3% less than FY21 PMPY attributable to improved commercial pharmacy rebates.

The report bifurcates the premium contributions based on the total medical and pharmacy expenses multiplied by the GHIP headcount.

The report compared the FY22 actual budget to the budget approved in August 2021. It was noted that there is one less invoice received than what was budgeted in both medical and pharmacy claims resulting in the appearance of claims being largely under budget.

Due to the timing of suppressed care, utilization of services is generally higher than the prior period. There was an increase in well care and preventive visits: 1.8% and 14.1% respectively. There was an increase in screening rates for colon, breast cancer, cervical cancer, and cholesterol.

There was a 0.3% decrease in inpatient admits with a 9.9% increase in length of stay and a 14.0% increase in cost per admit.

Ms. Anderson queried how the long-term financial impact of COVID-19 on the GHIP could be calculated for monitoring "long-haulers." Mr. Giovannello indicated that while it is too early to have meaningful insights on how the pandemic impacts health long-term, an ICD code tied to a COVID-19 diagnosis is being tracked by IBM Watson.

Mr. Costantino requested a report that would disaggregate the spending over 2-3 years. Mr. Giovannello responded that it is available through IBM Watson reporting and can be circulated to the Subcommittees. Director Rentz confirmed that it will be updated to include three years.

FY23 GHIP Projections

The projected FY23 budget has been revised down $15.2M to $963.7M driven by claims experience and builds in the recommendations most likely to be adopted by the Committee on December 13, 2021: PRC award recommendation for Medical TPA RFP, reinstatement of member cost-sharing for telehealth visits with community providers, implementation of the CVS Drug Savings Review Program, and the CVS Transform Diabetes Care Program.

An update to Other Revenues reflects a reduction attributable to the increase in monthly federal reinsurance payments for the EGWP program: $48.52 per retiree in 2021 to $65.68 in 2022.

Final FY23 budget projections and FY23 rate impact will be presented in February 2022.

The $119.1M projected deficit for FY23 has been reduced to $103.2M; the FY22 projected surplus remains at $17.6M.

There was a discussion clarifying the revised cost projections. The budget reflects the net expenditure: operating expenses minus other revenues. The revised cost projections are illustrative to include October claims experience, but the recommendation for rate action to be made in February will include an additional 6-7 months of data. Historically Q1 claims are lower (absent COVID-19), and claims run higher through Q4 as members meet deductibles; this is factored into the budget.

There was a discussion regarding the impact to the GHIP of a reduced workforce within the medical community and the potential for a moratorium on elective procedures.

The latest FY23 projected deficit of $103.2M must be solved through a combination of premium rate increases and other levers that can generate substantial plan savings. Assuming no other program changes, a 12.2% increase will be needed on July 1, 2022: a $75M increase in state-share revenue (90%) and a $9M increase to the active and pre-65 populations.

If the rate increase was smoothed over two years and targeted a $0 deficit for FY25, a 7.5% increase would be needed for FY23, FY24, and FY25 consecutively. In this scenario, the GHIP would end FY23 and FY24 in a deficit position after reserves.

A 12.2% rate increase effective July 1, 2022, equals a $3.40 - $33.29 per employee per month increase ($40.80 - $399.48 per year) and a State subsidy increase of $81.43 - $219.72 per employee per month ($977.16 - $2,636.64 per employee per year) depending on plan and coverage tier.

The current projection includes a $23.3M COVID-19 expense reimbursement payment received in June 2021 for claims paid through March.

A revised reporting of COVID-19 indicates the potential for an additional $15.8M in COVID-19 expense reimbursements that could hit the fund in FY22 or FY23; this could reduce the FY23 deficit to $86.3M.

If received, and assuming no other program changes, a 10.2% premium increase will be needed on July 1, 2022, to solve the projected FY23 deficit. Targeting a $0 deficit by the end of FY25 would require an annual premium rate increase of 7.2% in FY23, FY24, and FY25 consecutively. In this scenario, the GHIP would end FY23 and FY24 in a deficit position after reserves. A 7.2% increase yields approximately a $44M increase in state-share revenue (90%) and a $5M increase to the active and pre-65 populations.

There was a brief discussion regarding the unknown impact of new variants and increased COVID-19 expenses.

A 10.2% rate increase effective July 1, 2022, equals a $2.84 - $27.83 per employee per month increase ($34.08 - $333.96 per year) and a State subsidy increase of $68.09 - $183.70 per employee per month ($817.08 - $2,204.40 per employee per year) depending on plan and coverage tier.

There was a discussion regarding the long-term impact of deferred care on the downstream cost of care resulting from delayed diagnosis and treatment and whether these costs could be eligible for federal reimbursement. ICD codes are being developed to identify patients who have had a COVID-19 diagnosis; it is expected that over time, further data analysis will isolate what, if any, additional expenses may be attributable to COVID-19. Mr. Giovannello agreed to provide an update on the work being done.

It is unknown whether COVID-19 related expenses will continue to be reimbursed. It was noted that the $47.0M in deferred care in FY21 Q4 far exceed the $39.1M of COVID-19 expenses through October.

The American Rescue Plan Act provides funding allocated through the end of 2023, but other federal bills may extend some provisions.

COVID-19 Financial Impact

There was a review of the utilization analysis provided by IBM Watson Health. There will be ongoing analysis to evaluate the impact of COVID-19 on the GHIP long-term cost projections, trend assumptions, minimum reserve, and rate action planning.

There was a total of $39.1M paid for COVID-19 testing, treatment, and vaccinations from the onset of the pandemic through October 2021. The GHIP received $23.3M in COVID-19 expense reimbursements based on expenses paid through March 2021. The GHIP could receive an additional $15.8 in reimbursement in FY22 or FY23.

Utilization varied depending on visit type. Preventive visits were above pre-pandemic levels for adult preventive, well-child, and mammograms, but were lower in other areas such as well-baby and other cancer screenings.

Utilization reached the highest levels since the start of the pandemic during FY21 Q4, exceeding the baseline year in many instances, but a dip in utilization was observed in FY22 Q1.

Imaging for outpatient hospital settings decreased 15.8% from baseline, freestanding utilization decreased 4.7% from baseline.

ER utilization remains below the baseline period for most top conditions.

Outpatient mental health visits increased 11.4% above baseline that may be attributable to increased access.

Outpatient substance abuse visits have been below baseline; in the most recent quarter, it was down 31.0%.

Inpatient mental health admissions have been below baseline; in the most recent quarter, admissions were 17.4% below baseline.

Increased utilization of outpatient mental health services, including virtual behavioral health visits, likely contributing to a reduction in inpatient admissions.

Inpatient substance abuse admissions increased by 90% from FY20 Q4 to FY21 Q4.

Utilization remains below baseline for most top clinical conditions. The top outpatient surgical procedures reached the highest level in FY21 Q4. Utilization for the top elective surgical procedures remains consistently below the baseline. Top surgical admissions were below baseline, except for the insertion of a stent for a blocked artery in the heart during FY21 Q1 & Q4.

In FY21 the average paid per visit for traditional telemedicine provided by Amwell, Doctor on Demand, and Teladoc is less expensive ($56), but not meaningfully different than PCP providers ($79). Other telemedicine providers are more expensive ($84), but not meaningfully different; the difference may be attributable to individual provider contracts.

Total emergency room ("ER") visits decreased from July 2019 through June 2021 (data excludes Medicare population); however, there was no reduction in the percent of steerable visits. It is estimated that there is $13.2M in potential cost avoidance for non-emergent ER visits.

Treasurer Davis asked whether ER visits that occurred outside of primary care office hours and those that had been referred to the emergency room by pediatric or primary care had been removed from the eligible steerage data. Mr. Giovannello will follow up.

Emergency room visits that result in admission are excluded from outpatient hospital data.

There was a decrease in high-tech imaging from FY19 to FY20 (excludes PET Scans), but then an increase from FY20 to FY21. High-tech imaging visits in an outpatient hospital setting accounted for 58.3% during FY19; only 55.4% were performed in the same setting during FY21. While some high-tech imaging needs to be performed in an inpatient hospital setting, there was $11-12M in potential cost avoidance if all high-tech imaging services were performed at a freestanding facility.

The cost for basic imaging in a hospital setting is 97% more than at a freestanding facility. Basic imaging visits in an outpatient hospital setting accounted for 43.5% during FY19; only 39.7% were performed in the same setting during FY21. While some basic imaging needs to be performed in an outpatient hospital setting, there was $3-4M in potential cost avoidance if all basic imaging services were performed at a freestanding facility.

There were no copay changes for imaging services in FY21.

In FY21 the average paid per visit for preferred lab services was 60.1% less than those performed in hospital outpatient labs, even after the average paid per visit increased 18.9% from FY20 to FY21. While some lab services need to be performed in an outpatient hospital setting, there was $3-4M in potential cost avoidance if all lab services were performed at a preferred lab.

The next steps will include ongoing monitoring for emerging plan experience related to COVID-19 testing and treatment, care deferral by type of care, as well as the cost savings for the GHIP initiatives adopted to date. Additionally, there is an opportunity for potential plan design changes to promote the utilization of preferred sites of care, and there will be ongoing discussions regarding the timing and level of future rate action.

FY23 PLANNING OPPORTUNITIES – MS. JACYLN IGLESIAS

The Subcommittees reviewed several savings opportunities to address the FY23 projected deficit and discussed the likelihood of each for adoption by the Committee.

The savings opportunities that the Subcommittees were least likely to recommend to the Committee for consideration included:

- 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 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 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 yield estimated savings totaling $6.2M that would result in a reduction of 0.7% to the required premium rate increase.

- Program changes to the incentive structure for SurgeryPlus (e.g., removing the financial incentive for bariatric surgery) would yield estimated savings of $0.1M that would result in a negligible reduction to the required premium rate increase.

The savings opportunities that the Subcommittees were most likely to be recommended for the Committee's consideration included:

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

- The CVS Drug Savings Review program reviews prescription utilization to ensure that the prescription and dosage follow evidence-based medical guidelines. This program savings is 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.

- 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 Medicfill Plan at the SEBC meeting on October 11, 2021.

The savings opportunities that the Subcommittees would like to consider further before making a recommendation included:

- The CVS PrudentRx specialty copay card program 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.

- Program changes for consideration include mandating the use of the SurgeryPlus benefit for bariatric surgery. Based on current utilization program savings are estimated at $1.2M that would result in a reduction of 0.1% to the required premium rate increase.

There were additional questions, feedback, and discussion from the Subcommittees regarding the current savings considerations and future savings opportunities.

Treasurer Davis expressed support for further discussion of offering a high-deductible HRA option that would provide potential savings to the GHIP without shifting the cost to members. Ms. Iglesias acknowledged that HRA plan options are planned for future discussion and consideration.

Mr. Costantino supports any required premium rate increase be spread out over three years.

Mr. Scoglietti requested clarification regarding the differences between the current prescription refill process and that offered by PrudentRx. Ms. Iglesias responded that copay would change to a 30% coinsurance which would be reduced to $0 out-of-pocket for members who enroll in PrudentRx.

Ms. Anderson requested a side-by-side comparing the PrudentRx program against the current prescription refill process and costs from the member's perspective. Ms. Iglesias will provide a follow-up.

Ms. Schock highlighted the savings potential of the Prudent Rx program and supports a further discussion of the program.

Mr. Constantino requested modeling of the impact on the projected savings if copays for behavioral health were carved out of the reinstatement. Mr. Giovannello will provide a follow-up.

Mr. Scoglietti does not support the changes to the SurgeryPlus incentive design.

Ms. Anderson also does not support changes to the SurgeryPlus incentive design and would like to see growth in the network of SurgeryPlus bariatric providers in Sussex County before adopting a bariatric carveout.

SBO will reach out to other states regarding the PrudentRx program to bring back more information regarding the concerns brought forth by Subcommittees in early 2022.

Recommendations for FY23 savings opportunities will be presented to the Committee as discussed for potential vote and adoption on December 13, 2021. Savings opportunities where the Subcommittees have requested further study will continue to be evaluated and any additional recommendations will be presented to the Committee as appropriate.

OTHER BUSINESS

As presented in the Medical TPA RFP, the Committee is expected to delegate the exploration of retiree Medicare options to the Subcommittees to formulate recommendations by March around potential changes for an effective date of January 1, 2023.

Mr. Oberle requested further consideration to additional steerage opportunities designed to steer employees to freestanding facilities; he added that he does not support increases to ER copays. Director Rentz will bring back for discussion in early 2022 to include working with medical TPAs to provide additional member education.

Mr. Snyder would like to see a list of preferred imaging locations sent to members as a part of the EviCore approval and review process already being conducted by the medical TPAs. Director Rentz will follow up regarding what is in place today and areas for potential opportunities.

Mr. Snyder requested confirmation that the data regarding imaging related to ER visits was redacted from the steerable savings opportunities. Mr. Mateja will provide a follow-up.

Ms. Anderson queried whether an update was available from Johns Hopkins comparing healthcare costs in Delaware to regional states. Mr. Costantino added that it would be helpful to have data on what is driving the overall trend. Director Rentz will provide a follow-up.

PUBLIC COMMENT
No public comment was provided.

ADJOURNMENT
A MOTION was made by Treasurer Davis and seconded by Mr. Snyder 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