MINUTES FROM THE COMBINED MEETING OF THE FINANCIAL and HEALTH POLICY & PLANNING SUBCOMMITTEES TO THE STATE EMPLOYEE BENEFITS COMMITTEE
May 19, 2022

The Financial Subcommittee and the Health Policy & Planning ("HP&P") Subcommittee to the State Employee Benefits Committee (the "Committee") met Thursday, May 19, 2022 in a combined meeting. In the interests of protecting the citizens of this State from the public health threat caused by COVID-19, participants had the option to attend virtually via Webex in addition to the option to attend in person.

Subcommittee Members Represented or in Attendance:

Director Faith Rentz, Statewide Benefits Office ("SBO"), Department of Human Resources ("DHR") (Appointee of Secretary Claire DeMatteis), Chair
Mr. Steven Costantino, Director Health Care Reform, Dept. of Health and Social Services ("DHSS") (Appointee of Secretary Molly Magarik) (Ms. Elisabeth Massa, Executive Director, Health Care Commission, designee for Director Costantino)
Ms. Jeanette Hammon, Sr. Fiscal and Policy Analyst, Office of Management & Budget ("OMB") (Appointee OMB Director Cerron 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 Trinidad Navarro)
Ms. Ashley Tucker, Deputy State Court Administrator, Administrative Office of the Courts, (Appointee of The Hon. Collins Seitz, Chief Justice, Delaware Supreme Court)
Ms. Judi Schock, Deputy Principal Assistant, Office of Management & Budget ("OMB") (Appointee of OMB Director Cerron Cade)

Subcommittee Members Not Represented or in Attendance:

Mr. Keith Warren, Chief of Staff, Office of the Lt. Governor (Appointee of Lt. Governor Bethany Hall-Long)
Mr. Daniel Madrid, Chief Operating Officer, Office of the State Treasurer (Appointee of The Honorable Colleen Davis, State Treasurer)
Mr. Robert Scoglietti, Deputy Controller General, Office of the Controller General ("OCG") (Appointee of Controller General Ruth Ann Jones)
Ms. Judy Anderson, Delaware State Education Association (Appointee of Mr. Taschner, Executive Director, DSEA)

Others in Attendance:

Ms. Leighann Hinkle, Deputy Director, SBO, DHR
Ms. Nina Figueroa, Health Policy Advisor, SBO, DHR
Ms. Samantha Mountz, SBO, DHR
Ms. Gabby Costagliola, Willis Towers Watson ("WTW")
Mr. Chris Giovannello, WTW
Ms. Jaclyn Iglesias, WTW
Mr. Brian Stitzel, WTW
Ms. Wendy Beck, Highmark Delaware
Ms. Christina Bryan, Delaware Healthcare Association
Ms. Julie Caynor, Aetna
Ms. Cherie Dodge Biron, Deputy Principal Asst., DHR
Ms. Sandy Hart, IBM
Ms. Charlene Hrivnak, CVS Health
Ms. Katherine Impellizzeri, Aetna
Ms. Heather Johnson, Controller, DHR
Ms. Lisa Mantegna, Highmark Delaware
Mr. Walter Mateja, IBM
Ms. Alexa Meinhardt, DPH
Mr. Michael North, Aetna
Ms. Paula Roy, Roy Associates
Ms. Janani Ramachandran, Hinge Health
Ms. Carole Mick, SBO, DHR - Recorder, State Employee Benefits Committee and Subcommittees

CALLED TO ORDER – DIRECTOR FAITH RENTZ, CHAIR
Director Rentz called the meeting to order at 10:06 a.m.

APPROVAL OF MINUTES – DIRECTOR RENTZ, CHAIR
A MOTION was made by Director Rentz and seconded by Mr. Oberle to approve the minutes from the Combined Subcommittee meeting on April 21, 2022.

MOTION APPROVED.
Ms. Elisabeth Massa abstaining from approval of the minutes.

Ms. Schock joined the meeting.

DIRECTOR'S REPORT – DIRECTOR RENTZ, CHAIR
SEBC Meeting Overview for May 23rd, 2022
The SEBC meeting will be Monday, May 23rd, 2022 and today's financial reports will be reviewed and presented. A contract award recommendation will be brought to the Committee on consulting and actuarial services for approval. A brief review of legislation, mandates, and other state initiatives that are impacting the State Group Health Plan (GHIP) will be presented to the Committee including updates with the third-party administrators (TPAs) regarding Senate Substitute 1 for Senate Bill 120.

House Bill 303
This bill is currently pending, however, it would mandate that the GHIP would include coverage for all members to receive an annual preventative well check visit with a licensed behavioral health provider. Estimated fiscal impact is $2.4M annually. Amendments have been filed and the effective date, if passed, is January 1st, 2024 (No FY23 fiscal impact).

Other Legislative Updates
There is a bill that has not been filed and is related to chiropractic supportive care services. House Bill 400 would require the GHIP to provide additional protections to sensitive healthcare services on explanation of benefits. These bills do not have a fiscal impact to the GHIP and current insurers do not have concerns around these bills.

Mr. Oberle asked about Senate Bill 267; this bill is about cost sharing for prescription drugs, and Mr. Oberle inquired whether it would have an impact to the GHIP? Ms. Rentz confirmed that this bill does not apply to the GHIP and will not impact the GHIP.

FINANCIALS – MR. CHRIS GIOVANNELLO AND MR. BRIAN STITZEL, WTW

April Fund Equity Report
A coverage gap discount payment was received in the month of April along with a payment from the ESI Safeguard Rx program ($52,000) and the Aetna CareVio Year Three reconciliation payment of $20,000, making up the bulk of the $93,000 under Other Revenues.

Claims were about $62M relative to the $92M budgeted. The $29M COVID reimbursement payment hit the fund in April instead of FY23. Claims would have been $600,000 over budget for April, but with the $29M reimbursement payment, there's a $28.4M surplus for the month of April.

There is $14M in net income compared to $13.6M of an expected loss, driven by that reimbursement payment, the fund equity balance is reflecting $162M through April. Year to date variance is $56M.

FY22 Qtr 3 Financial Reporting
This report reviews year-to-date experience through 3rd quarter FY22, compared to the same period for FY21. Gross claims (medical and pharmacy) have increased 3%.

The total program cost decreased around 0.1% due to an increase in other pharmacy revenues offsetting gross claim costs. FY22 will see an extra rebate payment with the transition from ESI to CVS (rebate payments are now paid one quarter sooner than they previously were).

Premium contributions were flat when compared to FY21 and on a per employee per year (PEPY)/per member per year (PMPY) basis, we saw a slight decrease compared to FY21 which reflects higher claims but some additional other revenue items.

Comparing FY22 actual program costs to the FY22 original budget was favorable by 5.1%, however, $15M from the March Fund Equity report is excluded due to a timing issue with the vendors. By factoring in the $15M, the Fund is 3% favorable to budget.

The Summary Plan Information shows a break down between Aetna vs. Highmark and by participant status. Medicare retirees have an 81% loss ratio for FY22. There's a $23M delta between the total cost for Medicare Retirees and the budgeted cost due to switching from Medicfill to Medicare Advantage (MA). This $23M deficit needs to be made up for by the remaining participants in the risk pool which would be the Actives and non-Medicare retirees. Actives have a loss ratio of 105% and non-Medicare retirees have a loss ratio of 134%.

Non-Medicare retirees cost more than Actives based on each group's demographic profile, but both populations are paying the same premium rates for the same plan. This is something to consider as we think about the future state of the plan and premium contribution development. We are in an environment where we do have some rate increases for future consideration and we have lost that Medicare subsidy.

FY23 Projections and Utilization Update

Previous projections were forecasted for a $62.7M deficit by end of FY23 and $219M by the end of FY24. The Committee previously voted on the following measures: move Medicfill population to Group MA plan (medical only and administered by Highmark) and continue drug coverage through CVS EGWP, 8.67% premium rate increase (effective 7/1/22 for actives and non-Medicare retirees, and on 1/1/23 for Medicare retirees with EGWP), and adopt the CVS Drug Savings Review Program (effective 7/1/22 for non-Medicare Aetna and Highmark members).

The Committee voted on the additional measures that are reflected in our updated long-term projections: eliminate option for Medicare participants to enroll in medical coverage without prescription drug coverage (effective 1/1/23), and adopt the CVS Transform Diabetes Care for Aetna members and continue the Livongo diabetes care management program for Highmark members (both effective 7/1/22).

Ms. Hammon joined the meeting.

Mr. Giovannello reviewed projected surpluses and deficits for FY22, FY23 and FY24. Current FY22 projection is $61.9M because the $29M COVID reimbursement payment hit the Fund in April instead of FY23.

Under Other Revenues, the EGWP rebate payments have been running higher than forecast in FY22, so we're starting to see those additional EGWP rebate payments in FY22, which is $2.9M.

Previous projections showed a $62.7M deficit for FY23, so a 8.67% rate action was approved (adds $62.9M in revenue to the Fund); this rate action has now been incorporated into our long-term projections and offsets the projected deficit in FY23.

There's an additional $5M in surplus because the amount of the COVID reimbursement payment was $29M and we were previously forecasting $24M. Claims experience was relatively stable, and the updated other revenues is due to new participants in drug coverage, which will lead to some additional rebate payments for the EGWP. An $8.8M surplus is expected by the end of FY23.

For FY24, prior forecast was $219.3M deficit. The impact of the 8.67% rate action compounds each year, so we now have $129.4M in additional revenue, over FY23 and into FY24 and reducing the FY24 deficit. Current projections show a $79.1M deficit for FY24, which we'll discuss what that means in terms of a potential rate action.

Mr. Oberle asked, the COVID reimbursement was $5M over what was anticipated, is there any anticipation for additional reimbursement? Ms. Rentz responded, there is not a firm commitment that additional funding will occur. This reimbursement came from the CARES Act and any other expenses that the Fund is reimbursed for, from January 2022 forward would have to come from other funding sources (none have been confirmed at this time).

Mr. Oberle added that Congress enacted legislation providing more relief funds for testing purposes, and went on to ask who is the final arbiter on what funds (including COVID relief money) flow into the GHIP's fund? Ms. Rentz responded that she cannot speak to who makes the final decision on the funds coming into Delaware and it is her understanding based on the funds that have been received that the DOJ, Governor's Office, and OMB is reviewing how they are allocated. The only remaining funds that may be received would be the ARPA funds and there isn't any commitment that the GHIP will receive that funding.

Updated long-term projections were reviewed through FY26 which included the $8.8M surplus projected by the end of FY23 and the projected deficit of $79.1M for FY24.

FY24 is showing some favorable trends with 2.5% increase in Operating Expenses on a per member per year basis. Under Other Revenues is projecting significant growth going from $188M in FY23 to $223M in FY24 because of the full implementation of the new CVS Health contract. The 8.67% rate action has been added to future projections.

Premium contributions are projectecd to go from $804M in FY23 to $767M due to moving the Medicare population to the MA and losing the subsidy from Medicfill. The experience is favorable, but there are some other factors at play which are contributing to the FY24 deficit. This reflects all items voted on by the SEBC as of the April 25 meeting.

These projections do not reflect any potential impact for FY23 from pending legislation or legislation with an unknown outcome on the GHIP. As we get more information on the cost impact of outstanding legislation, we'll incorporate it into our long-term projections, but this is something to consider, recognizing that the $79.1M deficit does not include the impact of that legislation.

The bills that are being monitored are SB 25 (effective 1/1/23, chiropractic reimbursement not less than Medicare), SS 1 for SB 120 (effective 1/1/23, sustaining primary care through increased reimbursements), an HB 219 (effective immediately, provides enhanced oversights and transparency as it relates to PBMs).

Mr. Giovannello reviewed potential premium rate increase scenarios in light of the projected FY24 deficit. The $79.1M projected FY24 deficit is driven by three things: healthcare trend (5.5% medical and 8% pharmacy), lost Medicfill subsidy triggered by move to Group MA Plan with $0 medical only premium, and the GHIP surplus being fully depleted by the end of FY23.

Favorable projected experience for FY23 includes: operating expenses only increasing by 2.5% over FY23, other revenues are projected to increase $34.7M in FY23, and a $36.7M reduction in premium revenue due to reduced Medicfill subsidy. This does require additional active and pre-65 retiree contributions to make up for the projected deficit, to be offset by any additional program changes that would lower the deficit as well.

Current projections would require a 10% rate increase effective 7/1/2023 to solve for the $79.1M projected FY24 deficit. Smoothing the rate increase over three years to solve for FY26 deficit requires an 8% annual rate increases per year in FY24, FY25, and FY26.

The potential impact of future Delaware legislative activity may further increase the projected deficit, and any additional increases in health care trend beyond the 5.5% medical and 8% pharmacy trend assumptions may have a similar result.

FY23/FY24 Cost Avoidance Opportunities

Mr. Stitzel provided an overview of potential cost avoidance opportunities that are aligned with the GHIP mission statement and goals which are intended to provide cost reduction/savings opportunities that are least disruptive to GHIP.

One tactic is to move the non-Medicare retirees to the ACA pre-65 retiree marketplace and provide them with an HRA that can be used to offset participants' cost of purchasing insurance on the marketplace. Members will have more choice of plan options, potentially lower premium costs, options for low-income subsidies, and reduced OPEB liability (which is a goal of the Retirement Benefits Study Committee).

The option to expand the GHIP's COE strategy by mandating bariatric surgery through SurgeryPlus and other surgical procedures could reduce cost by steering members to high quality providers that produce better health outcomes, which can result in reduced long-term costs. Potential implications of this tactic could include: provider disruption and may move care out-of-state; estimated savings for FY24 could be as high as $10M or more, but requires further analysis to refine that estimate.

Another consideration is to implement a CDHP/HSA plan to drive additional health care consumerism and may also support employee attraction/retention efforts. With a CDHP/HSA plan, there is potential for member disruption due to the requirement for members to meet a higher deductible prior to the plan sharing in the cost of services (though potential savings for FY24 could range from $2M - $10M).

Other considerations include value-based contracting arrangements, implementation of PrudentRx, and implementation of a musculoskeletal (MSK) solution.

Mr. Oberle asked, regarding value-based contracting, has there been a review of the certificate of need and whether that process will have a negative impact in terms of cost? Mr. Stitzel responded that the certificate of need has not been considered and that could potentially have negative ramifications on driving those to the lower cost site. Discussion was had around the certificate of need process. Ms. Rentz added that the certificate of need process was presented before the Sunset Committee (in 2021) and a decision was made to continue with the process. The SBO will take this as a follow up and research where it stands today.

Mr. Giovannello reviewed the scenarios of the monthly rate increases for employees with depicted impacts of an 8% increase ($$2.42-$23.72 per employee per month/PEPM) and 10% increase ($3.02 - $29.66 PEPM) effective 7/1/2023. The 10% rate increase scenario is the one-time rate increase that would solve for the deficit by the end of FY24.

Mr. Costantino joined the meeting.

GHIP utilization Updates

Mr. Giovannello reviewed high level utilization updates over three years' worth of data. Inpatient utilization per 1,000 was stable from 2020 to 2021. The allowed per admission increased 4.6% and the average length of stay increased 5.8%. The inpatient facility payments increased by 7.8% and 7.3%. The inpatient surgical stays decreased 7.7% and PEPM has decreased 11.5%. Inpatient medical utilization increased by 10% and drove to a 19.7% increase PEPM. The PEPM payments for maternity increased 40.3% over 2020.

Outpatient facility claims increased of 15.2% PEPM and 2021 PEPM for outpatient facility was only 4.3% higher than 2019. In 2021, outpatient surgeries surpassed the 2019 utilization rates, while ER, specialty drugs, and diagnostic services still lag utilization levels from 2019.

Other utilization services that where discussed include: physician outpatient, radiology outpatient and physician inpatient saw PEPM's decreased compared to 2019, while other professional services had modest gains. Mental health and substance abuse services increased 13.1% in 2020 and 30.7% in 2021. Outpatient laboratory PEPM increased rapidly in 2021, up 27.4% over 2020, triggered by increases in utilization and unit cost.

CONDITION-SPECIFIC PROGRAMS FOR THE GHIP, MR. BRIAN STITZEL, WTW

Mr. Stitzel reviewed the condition-specific programs for the GHIP. Musculoskeletal conditions contributed to $87.9M in spending from plan participants and the GHIP. For plan participants (non-Medicare plans only) there is coverage for physical therapy, chiropractic visits, joint/spine surgery and other procedures that support musculoskeletal health.

Hinge Health and SWORD Health have previously been presented to the subcommittee as possible vendors to the address the rise in musculoskeletal cost for the GHIP. Mr. Stitzel reviewed the comparison between Hinge Health and SWORD Health.

The recommedation for discussion is the implementation of Hinge Health via SurgeryPlus contract with an off-cycle go-live date no earlier than 1/1/2023. This recommendation is based on musculoskeletal-related issues representing a significant claim component for the GHIP. The Hinge Health program helps address care and cost restrictions in SB120.

Mr. Oberle asked, for both Hinge Health and SWORD Health, would there be an option for those members in the plan? Additionally, would plan participants be required to participate in these programs and be precluded from hands on physical therapy? Mr. Stitzel responded that it is an option for members and only charged against the plan when/if the member uses the program.

Ms. Iglesias reviewed bariatric surgery as an option which has been shown to be safe and effective in patients where diet, exercise, and medications have not helped morbidly obese patients sustain normal or near-normal weight.

Bariatric surgery has been demonstrated to reduce diabetes, hypertension, hyperlipidemia, and has been shown to increase life expectancy. Considerations for changes to GHIP's bariatric surgery coverage to mandate the use of SurgeryPlus for bariatric surgery. Bariatric benefits are not an ACA Essential Health Benefit and are not required to be covered at all.

SurgeryPlus provided an updated analysis of estimated cost/savings of about $14,000 per procedure and $800,00-$3.2M per year. Potential annual savings associated with bariatric surgery is dependent upon the number of procedures conducted, and several factors can impact the number of procedures.

Implementation of this program would require a longer period of pre-surgical prep (6+ months). The communications should be targeted to describe any noteworthy differences in clinical policy guidelines for bariatric surgery between SurgeryPlus and the medical carriers. Also, communicate to members that this program emphasizes provider quality and affordability for members and the GHIP.

For the medical carriers, administrative changes to coverage, plan documentation describing benefit provisions, claims and appeals processing, online provider directory and member websites would be necessary. Additionally, the customer service and care management teams would need training for this change. Bariatric surgery providers should be notified of this change in coverage.

The recommendation for discussion is to implement bariatric surgery to SurgeryPlus for an effective date no earlier than 1/1/2023. This recommendation provides more consistency in achieving high quality outcomes for members, enhancements to member experience, aligns with GHIP goals to reduce total cost of care and

maintain focus on quality of care delivered. SurgeryPlus would allow the GHIP to pilot such a carve-out approach for bariatric surgery.

Ms. Schock asked when the deadline for a recommendation would need to be made. Ms. Iglesias responded that the June Subcommitte meetings are canceled and WTW would asked for a recommendation at the July Subcommittee meeting. Mr. Oberle commented that he supports bariatric surgery through SurguryPlus and asked if WTW has looked into other carve-out opportunities. Ms. Iglesias stated that they have started to look into other opportunities to reduce cost to the GHIP.

SPOUSAL COORDINATION OF BENEFIT (SCOB) POLICY PROPOSED CHANGES – DIRECTOR RENTZ, CHAIR

This policy was effective January 1, 1993 and last changed in May 2018. This policy applies to spouses eligible for health care coverage through their own employer. Effective July 1, 2011, the policy was amended to include retiree health care coverage to spouses who where collecting a pension from their employer. This policy ensures fiscal responsibility for the GHIP where other employers are offering health care benefits to their employees and retirees.

The policy change is due to the transition to the MA plan effective January 1, 2023 and to clarify existing provisions in response. SBO would like to present final recommended changes to the SCOB Policy to the SEBC at their meeting on August 22, 2022.

Potential changes include modifications or discontinuation of the policy to a pensioner whose spouse is Medicare eligible. The Centers for Medicare & Medicaid Services (CMS) only allows enrollment in one qualified MA plan, so if a spouse has other Medicare coverage, the spouse cannot be enrolled in both.

The SCOB Policy allows for other coverage if it is a less favorable plan than the GHIP in terms of the out-of-pocket costs to the spouse for services. The SCOB Policy and the contribution requirement is tied to the amount of premium the spouse pays and does not consider member out-of-pocket costs. Annual certification is required for Active and non-Medicare pensioners. Medicare pensioners are only required to submit SCOB form for spouse coverage changes. Audits have not been conducted for Medicare eligible spouses being covered by pensioners.

Additional considerations include: clarification on HMO plan service area for spouses who have an HMO (active and non-Medicare pensioners only) and information on spouses who are considered a partner, owner, or principal in a law firm, accounting firm or any other type of business.

Research will be conducted on Medicare retiree benefits currently being offered by State employers to compare GHIP Medicare coverage. Administrative implications will also be considered.

OTHER BUSINESS
No other business.

PUBLIC COMMENT
No public comment was provided.

ADJOURNMENT
A MOTION was made by Mr. Oberle and seconded by Ms. Tucker to adjourn the public session at 11:51 a.m. MOTION ADOPTED UNANIMOUSLY.

Respectfully submitted,

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Carole Mick, Statewide Benefits Office, Department of Human Resources
Recorder, State Employee Benefits Committee, and Subcommittees