IN THE SUPERIOR COURT OF THE STATE OF DELAWARE

RISEDELAWARE INC., *et al.*,	)	
	)	
Plaintiffs,	)	
	)	
v.	)	
	)	C.A. No. N22C-09-526 CLS
Secretary Claire DeMatteis, in her official capacity as Secretary of the Delaware Department of Human Resources and Co-Chair of the State Employee Benefits Committee, *et al*.,	)	
	)	
Defendants.	)	
	)	

DEFENDANTS' BRIEF IN OPPOSITION TO PLAINTIFFS' PETITION FOR ATTORNEYS' FEES

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Dated: November 22, 2022

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INTRODUCTION

Plaintiffs' newly minted fee petition—laced with sensationalized and inaccurate assertions—should be denied for several reasons. Significantly, Plaintiffs waived their right to request attorneys' fees by failing to plead a request for fees in their Complaint ("Compl.").

Even if they had not waived their right to request fees, Plaintiffs have not advanced any applicable exception to the American Rule—i.e., that litigants bear their own attorneys' fees—for at least three reasons. *First,* Plaintiffs cannot show that statutory fee-shifting applies. Plaintiffs' attempted reliance on FOIA fails: Plaintiffs neither pleaded a FOIA claim, nor did they allege facts showing a FOIA violation. Statutory fee-shifting is unavailable.

Second, Plaintiffs have not shown, and cannot show, bad faith conduct by Defendants—either in the litigation or directly related thereto—that would give rise to a fee award. Indeed, nearly all the alleged conduct occurred before the Complaint was served. As such, the bad faith exception is inapplicable.

Third, Plaintiffs did not create a significant and ascertainable **monetary** benefit for State retirees. At most, Plaintiffs forced a delay in changes to State retiree benefits. But Plaintiffs have not pointed to an ascertainable, monetary benefit achieved. They cannot. As such, the common fund doctrine is inapplicable.

COUNTERSTATEMENT OF FACTS

Defendants vehemently dispute many factual assertions made by Plaintiffs in their petition. Due to word limitations, only the most glaring factual disputes are addressed below.[1]

The Public RFP Process

Contrary to Plaintiffs' statement of the facts, which alleges (wrongly) that Medicare Advantage was adopted "out of public eyesight," the State Employee Benefits Committee's ("SEBC") actions of which Plaintiffs complain were conducted in a public process with required public notice.

The SEBC issued a Request for Proposal ("RFP") for Medical Third Party Administration services on April 26, 2021. The proposal was amended on May 18, 2021, with Responses Due by June 25, 2021. *See* Rentz (Third) Aff. ¶4 ("Rentz Aff.").

The RFP specifically requested one bid for medical plans for active employees and a second bid for Medicare pensioners. Rentz Aff. ¶5. With regard to Medicare, the RFP stated that vendors may bid on "[t]he Medicare Supplement plan offered by the State today" and/or "[a] fully-insured group Medicare Advantage plan (which is

[1] Merely because an allegation is not addressed in this counterstatement of facts does not mean that Defendants concur with the Plaintiffs' contentions. Rather, Defendants do not address certain issues because such contentions are, *inter alia*, wholly irrelevant, clearly wrong, or otherwise have no bearing on the fee petition at bar.

not offered by the State today) both with and without Medicare Part D prescription drug coverage." *Id.* Vendors were not permitted to bid only on a Medicare Advantage plan. *Id.*

Discussion of the RFP by the SEBC occurred on May 10, 2021, which was noticed on the relevant agenda as "Medical Third-Party Administration (TPA) Services Request for Proposal Overview," and again on November 8, 2021 and December 13, 2021, each of which were properly placed on the publicly noticed agenda as "Health Third Party Administration RFP Contract Award Recommendation." *See* Rentz Aff. ¶6.

During its December 13, 2021 meeting, the SEBC voted to award the Medical Third Party Administrator contract (the "Commercial Contract"), for active state employees, to Highmark and Aetna, effective July 1, 2022. Rentz Aff. ¶7.

At least seven days prior to the February 28, 2022 meeting, the SEBC posted its agenda including notice that, "2021 Health Third Party Administrative Services RFP Award Recommendations… (c.) Medicare Plan Effective January 1, 2021," would be discussed.[2] *See* Rentz Aff. ¶8.

Along with the posted agenda, the State posted a document titled "FY23 Outstanding Decisions." Rentz Aff. ¶9. The content page lists the first section as,

[2] The plan would be effective January 1, 2023, and references to "January 1, 2021" in the agenda were the result of a typographical error. Rentz Aff. ¶9.

"2021 Third Party Administrative Service RFP Award Recommendations." *Id.* This is nearly identical to the language found on the posted agenda. *Id*.

The document includes charts that compare Medicare Supplement to Medicare Advantage, compare Medicfill to Medicare Advantage under both Aetna and Highmark, and a discussion of considerations when deciding between the options. *See* Rentz Aff. ¶10.[3]

During the meeting, the SEBC discussed the options, opened the floor for public comment, and voted to award the pensioners contract to Highmark for its Group Medicare Advantage plan (for medical only), effective January 1, 2023. *See* Rentz Aff. ¶11. On March 2, 2022, the SEBC sent Highmark a binding contract award letter notifying Highmark its Medicare Advantage plan had been approved. Rentz Aff. Ex. F.[4] The process all occurred in public.

Open Enrollment

Plaintiffs also make unfounded timing allegations alleging "intentional delay[] in notifications." Opening Brief ("OB") at 1. A standard process was

[3] While Plaintiffs rely on meeting minutes for certain contentions, the minutes are just that – minutes – and there is no requirement for a verbatim transcript. Del. Op. Atty. Gen. 11-IIB11, 2011 WL 4062222, at *3 (Aug. 17, 2011) (holding there is "no clearly implied statutory requirement to summarize the subjects discussed with any degree of specificity in the minutes FOIA requires to be prepared and maintained.").

[4] Plaintiffs' characterizations of Director Cade's comments are incorrect. Cade Aff. ¶¶3-5.

followed. Following any decision to award a contract to a successful bidder under an RFP, the State begins negotiations of the actual terms of the contract, a process that typically takes six to eight months, particularly for large, complex contracts such as this. Rentz Aff. ¶12. Pursuant to these negotiations, the Highmark Commercial Contract awarded on December 13, 2021 was finalized on August 25, 2022, and the Medicare Advantage contract awarded on February 28, 2022 was finalized on September 28, 2022. *Id*.

As the contracts were undergoing negotiation, the State began to prepare for open enrollment for the active state employees and non-Medicare retirees/pensioners, expediting the need to complete the contracts that would take effect first, the Commercial Contract. Rentz Aff. ¶13.

The open enrollment period for the Commercial Contract ran from May 2 to May 18, 2022. Active employees, pre-Medicare retirees and pensioners who wished to enroll in dental and vision care were all required to enroll during this May Commercial Contract open enrollment. Open enrollment for the pensioners' healthcare coverage, other than vision and dental, would not occur until the October 2022 Medicare open enrollment period. Rentz Aff. ¶14.

Medicare Advantage was introduced on June 1, 2022. Rentz Aff. ¶15. Normally, the SBO would have sent its first communication regarding a plan change that would be effective on January 1 in September of the year prior to the change.

Rentz Aff. ¶16. Here, however, the SBO specifically sent notice earlier than it normally would have so that pensioners had time to understand relevant changes with Medicare Advantage.

Following the June 1, 2022, communication, the SBO sent five additional letters, including several brochures, answers to frequently asked questions, and newsletters, and held thirty informational sessions where pensioners could get more information and ask questions. Rentz Aff. ¶17.

Town Hall Meetings

In addition to eighteen Medicare Advantage educational sessions held across three counties in August, information about the change was also provided via town hall meetings. The SBO Office of Pensions and Highmark attended six town hall style meetings on 9/12, 9/15, 9/22, 9/27, 9/28 (all prior to open enrollment), and 10/10/22 (during open enrollment). *See* Rentz Aff. ¶18. Each session included a PowerPoint presentation and an opportunity to ask questions. Each of the PowerPoint presentations informed pensioners that the new plan would be the Medicare Advantage plan and indicated that some services would need prior authorization. *Id*. ¶18.

Threat of Litigation and Execution of the Contract

Defendants never attempted to subvert this action (or any litigation) by executing the Highmark contract for pensioners. As explained more fully in the

DeMatteis Declaration, several communications were provided regarding contract execution. DeMatteis Decl. at ¶¶4-7. After the contract was executed on September 28, 2022, it was publicly posted to SEBC's website the next business day. DeMatteis Decl. ¶8. The negotiation of a contract of this size (over 180 pages) and the timing of execution was conducted in the normal course of business and clearly communicated. DeMatteis Decl. at ¶10.

Any contention that Defendants distributed misinformation related to the contract and its finality is incorrect: the contract was final when executed. DeMatteis Decl. ¶11. However, this Court's October 19, 2022 order staying implementation of the contract created a critical need within the meaning of 29 *Del. C.* § 6907(b), thereby allowing the waiver of the State's competitive bidding requirements and extension of the current Medicfill contract through 2023. DeMatteis Decl. ¶12.

Plaintiffs' Purported "Benefit" Does Not Accrue to All State Retirees

Despite Plaintiffs' assertion that they have achieved "monumental benefits" for 30,000 State retirees, this is *not* a class action, and no class claims have been alleged (nor could they be). Indeed, some retirees have been harmed by the Plaintiffs' conduct as a switch to Medicare Advantage would have reduced the monthly co-pay for those retirees at the highest tier of monthly co-pays by over 50%. *See* Rentz Aff. ¶19 (demonstrating a co-pay of $459.38 under Medicare Supplement with prescription and a co-pay of $216.19 under Medicare Advantage with

prescription). This co-pay reduction would have come with the same benefits coverage including the same prescription coverage and same provider network. Rentz Aff. ¶20.

Plaintiffs' GoFundMe Page

Plaintiffs have a GoFundMe page specifically for the purpose of raising funds for the legal costs of this lawsuit.[5] It appears to have raised over $80,000 of its $150,000 goal.[6] A significant number of the donors are anonymous.[7] As such, if this Court were to award fees, funds could not be returned to anonymous donors, thereby awarding Plaintiffs a windfall.

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5 Rise Delaware Legal Fees and Costs, GoFundMe, https://www.gofundme.com/f/risedelaware (last visited Nov. 21, 2022).

6 *Id.*

7 *Id.*

ARGUMENT

While the decision to award fees is a matter of discretion for the Court, the bad faith exception presents a high bar and is applied only in extraordinary circumstances.[8] Plaintiffs' request does not reach that high bar, and the petition should be denied.

I. Plaintiffs Waived Their Right to Seek Attorneys' Fees

Plaintiffs waived their ability to seek fees by failing to request them in their Complaint. An award of attorneys' fees is appropriate only where a request for attorneys' fees is pled.[9] Plaintiffs' Complaint seeks relief as follows:

> **WHEREFORE**, Plaintiffs respectfully request that judgment be entered as follows:
>
> (1) for declaratory relief pursuant to 10 *Del. C.* § 6501 and 29 *Del. C.* § 10141 as set forth herein;

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[8] *See Balooshi v. Global Corp.*, 2022 WL 576819, at *15 (Del. Super. Feb. 25, 2022), *aff'd*, 2022 WL 5052721 (Del. Oct. 5, 2022); *see also Fortis Advisor LLC v. Sillajen, Inc.*, 2019 WL 3338090, at *1 (Del. Super. June 25, 2019) (internal citation omitted).

[9] *Kramer v. Am. Pac. Corp.*, 1998 WL 442766, at *1-2 (Del. Super. July 28, 1998); *Maidmore Realty Co., Inc. v. Maidmore Realty, Inc.*, 474 F.2d 840, 843 (3d Cir. 1973); *Roche Diagnostics Operations, Inc. v. Abbott Diabetes Care, Inc.*, 2017 WL 4391735, at *18 (D. Del. Oct. 3, 2017) (finding that, unlike cases wherein no request for fees was included in a pleading, plaintiff had preserved its right to seek fees by including such a request and thereby providing notice that it would seek fees); *United Indus., Inc., v. Simon-Hartley, Ltd.*, 91 F.3d 762, 765 (5th Cir. 1996); *see also Abbott v. Gordon*, 2008 WL 821522, at *26 (Del. Super. Mar. 27, 2008) (finding that, where no request for fee-shifting had been pled, "the Court will not impose any."); *but see Dreisbach v. Walton*, 2014 WL 5426868, at *9 (Del. Super. Oct. 27, 2014) (stating—in dicta—a contrary view).

(2) for a stay of executing a contract with Highmark, or any further implementation of a Medicare Advantage Plan pending review pursuant to 29 *Del. C.* § 10144; and

(3) for such other relief as this Court deems just and appropriate.

Compl. at p. 38.

Because Plaintiffs have not pled a claim for attorneys' fees, the Court can dismiss the petition on this basis alone. Plaintiffs' catch-all request for "other relief as this Court deems just and appropriate" is insufficient.[10]

Here, Plaintiffs' Complaint provided zero notice that they would be seeking an award of attorneys' fees. Unlike litigants who have been found to preserve their request for fees, Plaintiffs plainly failed to seek fees, costs, expenses, or damages of any kind—they sought declaratory relief and a stay. Accordingly, Plaintiffs waived any right to request for attorneys' fees.

II. Even if Plaintiffs Did Not Waive Their Right to Seek Fees, the American Rule Applies

Delaware follows the "American Rule," under which parties are generally required to pay for their own attorneys' fees regardless of the outcome of litigation.[11] Delaware courts will depart from the American Rule where (a) contractual or statutory fee-shifting applies; (b) the moving party can show that its opponent

[10] *Benson v. Am. Ultramar Ltd.*, 1997 WL 317343 at *10-11, n.29 (S.D.N.Y. Apr. 19, 1997) (finding that a request for "costs and disbursements" is insufficient).

[11] *Balooshi*, 2022 WL 576819, at *15.

engaged in bad faith conduct in or closely related to the litigation; or (c) the movant created a common benefit.[12] None of these exceptions to the American Rule apply.

A. Plaintiffs Are Not Entitled to Statutory Fee-Shifting

Plaintiffs' claim that fees should be awarded pursuant to 29 *Del. C.* § 10005(d) because the Decision purportedly "determined that Defendants violated FOIA's open meeting laws" must be rejected. OB at 11. As a threshold matter, there is no count in the Complaint that seeks fees under FOIA. Thus, Plaintiffs' newly minted theory that it may recover fees under a FOIA fee shifting statute must be rejected on this basis alone.

Second, Plaintiffs mischaracterize the Decision by claiming that it holds that a FOIA violation occurred. OB at 11. The Decision merely addresses timeliness based upon the Defendants' suggestion that "the only remedy available … was a Freedom of Information Act violation of … [the] SEBC's action and Plaintiffs are time barred."[13] The Court did not hold that any FOIA violation occurred—nor could it—Plaintiffs' complaint lacks any count seeking a declaration that a FOIA violation occurred. Moreover, a FOIA claim could only have been brought in the Court of Chancery.[14]

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12 *See Slawik v. State*, 480 A.2d 636, 639 n.5 (Del.1984) (noting inherent power of the Courts to shift fees for bad faith or willful disobedience of a court order in addition to statutory fee-shifting).

13 *Decision* n. 10.

14 29 *Del. C.* §§ 10005(a), 10005(e).

Third, the Plaintiffs did not bring a FOIA claim for good reason: such a claim would have failed. All the FOIA statute requires is that adequate notice of the matters to be considered be given to the public, so that interested members will have an opportunity to appear and monitor or participate in the proceedings.[15] FOIA "is not a tool for use by those who disagree with the actions of their government to have those actions set aside[.]"[16]

The agenda for the February 28 meeting made clear that the SEBC would be addressing "2021 Health Third Party Administrative Services RFP Award Recommendations."[17] The RFP referenced explicitly and undeniably related to Medicare Advantage. Rentz Aff. ¶8-10. This is all the agenda notice required under FOIA.

An "agenda need not disclose each specific component of [a] proposal, so long as the agenda clearly and directly discloses the broader subject of which the components are a part."[18] "[T]he availability of other, perhaps better, methods of describing an agenda item does not equate to a violation of FOIA."[19] "The purpose of FOIA is not to provide a series of hyper-technical requirements that serve as

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15 *Lechliter v. Delaware Dep't of Natural Res. & Env't Control*, 2017 WL 2687690, at *2 (Del. Ch. Jun. 22, 2017) (citations omitted).

16 *Id.*

17 *Decision* *3.

18 *Chem. Indus. Council of Delaware, Inc. v. State Coastal Zone Indus. Control Bd.*, 1994 WL 274295, at *8 (Del. Ch. May 19, 1994).

19 Del. Op. Atty. Gen. 17-IB62, 2017 WL 6569378, at *2 (Dec. 15, 2017).

snares for public officials, and frustrate their ability to do the public's business, without adding meaningfully to citizens' rights to monitor that public business."[20] The RFP on the agenda expressly includes consideration of the Medicare Advantage plan. Any members of the public with "intense interest in" the Medicare Advantage change were on notice.[21] Thus, all FOIA agenda requirements were satisfied.

Finally, a successful FOIA plaintiff is not guaranteed an award of attorneys' fees. Indeed, such award is at the sound discretion of the Court.[22] But Plaintiffs must prevail on a FOIA claim before they can be deemed a "successful plaintiff" for a fee award.[23] Because Plaintiffs did not *bring* a FOIA claim, they cannot *prevail* on a FOIA claim.

B. Plaintiffs Have Not Demonstrated Bad Faith

The bad faith exception to the American Rule is applied only in the most extraordinary of cases: it is aimed at deterring "abusive litigation in the future, thereby avoiding harassment and protecting the integrity of the judicial process."[24] Pursuant to the bad faith exception, Delaware courts may award attorneys' fees

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20 *Lechliter v. Becker*, 2017 WL 117596, at *2 (Del. Ch. Jan. 12, 2017).

21 *Id.* at *2.

22 *Rudenberg v. Chief Deputy Attorney General of Dept. of Justice*, 2017 WL 7000854, at *1 (Del. Super. Dec. 8, 2017).

23 *Gannett Co. Inc. v. Bd. of Managers of the De. Criminal Justice Info. System,* 840 A.2d 1232, 1240 (Del. 2003).

24 *Dover Hist. Soc., Inc. v. City of Dover Plan. Comm'n*, 902 A.2d 1084, 1093 (Del. 2006).

where a "'losing party has acted in bad faith, vexatiously, wantonly, or for oppressive reasons.'"[25] The party seeking to invoke the exception must demonstrate "'by clear evidence that the party from whom fees are sought acted in subjective bad faith.'"[26] The bad faith exception may apply where a party commences an action in bad faith, unnecessarily prolongs or delays litigation, falsifies records, knowingly asserts frivolous claims, misleads the court, alters testimony, or changes position on an issue.[27] An award of fees for bad faith conduct must derive from either the commencement of an action in bad faith or bad faith conduct taken during litigation, and not from conduct that gave rise to the underlying cause of action.[28]

Plaintiffs have failed to demonstrate bad faith. First, the conduct alleged by Plaintiffs to be bad faith purportedly occurred prior to the institution of the litigation. OB at 14-15. Indeed, most of the conduct was pled in Plaintiffs' Complaint. Compl. ¶¶28-51. As such, it cannot give rise to fee-shifting for bad faith.[29]

Second, the only conduct Plaintiffs point to that occurred after institution of this action was the execution of the contract with Highmark. OB at 14-15. That

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25 *Id.*

26 *Lawson v. State*, 91 A.3d 544, 552 (Del. 2014) (citations omitted).

27 *Id.* (citing *Versata Enterprises, Inc. v. Selectica, Inc.,* 5 A.3d 586, 607 (Del.2010)); *see also Johnston v. Arbitrium (Cayman Islands) Handels AG,* 720 A.2d 542, 546 (Del.1998); *RBC Cap. Markets, LLC v. Jervis*, 129 A.3d 816, 877 (Del. 2015) (citing *Lawson*, 91 A.3d at 552; *Dover,* at 1093).

28 *Jervis*, 129 A.3d at 877 (citing *Versata,* 5 A.3d at 607).

29 *Id*.

contract was executed on September 28, 2022. Rentz Aff. ¶12. But service of process was not completed in this matter until September 29, 2022. Trans. ID 68208417. Further, as noted above, the timing of the contract's execution was communicated in advance of the filing of the Complaint and does not suggest bad faith. DeMatteis Decl. ¶¶4-7.

Plaintiffs' reliance on *Dover* is misplaced: there, the Court found that a defendant's destruction of a historical building was a direct response to plaintiffs' filing of a petition in the Superior Court for review of the issuance of an architectural review certificate.[30] But there, defendant irreversibly destroyed the building that was subject of the suit immediately upon being served with the complaint.[31] Not so here. *Dover* is inapplicable, and Plaintiffs fail to demonstrate bad faith.

C. The Common Fund Exception Does Not Apply

Under the common fund exception to the American Rule, "a litigant may . . . receive an award of attorneys' fees if: (a) the action was meritorious at the time it was filed, (b) an ascertainable group received a substantial benefit, and (c) a causal connection existed between the litigation and the benefit."[32] The common fund exception cannot be invoked merely because plaintiffs achieve a social benefit via

30 *Dover,* at 1089.
31 *Id.*
32 *Id.*

their litigation by requiring "a government agency . . . to do its job."[33] Rather, the *sine qua non* for an award of attorneys' fees pursuant to the common fund exception is the creation of "a substantial and quantifiable **monetary** benefit."[34]

In *Dover*, the Delaware Supreme Court rejected a plaintiffs' application for fees based on the common fund doctrine. There, the Court found that the benefit created by the plaintiff was that government agency at issue was ordered to reevaluate an application for architectural review.[35] The Court found, however, that such a social benefit was insufficient to support a fee award, finding that "[i]n the public interest litigation context, absent legislative authorization, fee-shifting applications are disfavored."[36]

On the other hand, in *Korn,* the Court highlighted that a plaintiff must achieve a *monetary* benefit to receive their attorneys' fees.[37] The Court distinguished *Dover*'s rejection of a common fund fee award and found that plaintiff had created a substantial monetary benefit for taxpayers when the defendant county "returned" approximately $540,000 to taxpayers by crediting a fund's surplus to the next year's taxes.[38]

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33 *Id.* at 1091; *see also Korn v. New Castle Cty.*, 922 A.2d 409, 413 (Del. 2007).
34 *Korn*, at 413 (emphasis supplied).
35 *Dover,* at 1091.
36 *Id.* (collecting cases).
37 *Korn*, at 413.
38 *Id.*

Assuming *arguendo* that the instant action was meritorious when filed, and that an ascertainable group (State retirees) received a benefit from the action in the form of a stay,[39] Plaintiffs have not created a substantial and quantifiable *monetary* benefit like the *Korn* plaintiffs. Indeed, to the extent they achieved any monetary benefit, Plaintiffs have not even attempted to quantify it.[40]

Plaintiffs have—at most—procured a one-year delay in the implementation of a new healthcare plan for State retirees. Any benefit created by Plaintiffs is merely speculative, especially so because not ***all*** State retirees benefit, and it would be difficult to determine who would benefit and by how much. Rentz Aff. ¶20 (stating that some of retirees have been harmed by this litigation, as a switch to Medicare Advantage would have reduced the monthly co-pay for those retirees at the highest tier of month co-pays by over 50%.).[41] Thus, no award is proper under the common fund doctrine.

III. Plaintiffs' "Litigation Liaison" is Not Entitled to Fees

Plaintiffs have cited not one case on point supporting an award to their Litigation Liaison. The *Scion Breckenridge* case Plaintiffs rely upon involved a law firm working for free to avoid a malpractice claim related to an underlying

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[39] Defendants reserve their right to appeal from a final judgment regarding, *inter alia*, the applicability of the APA in this instance.

[40] OB at 14 n.11.

[41] *See Korn,* at 413 (rejecting common benefit fees where the benefit achieved was unclear).

transaction—**not** a *pro bono* attorney, as Plaintiffs state. Indeed, Plaintiffs' own authorities make clear that awards for public interest-type litigation are disfavored absent explicit statutory authority.[42] "[T]he only *sure* way for *any* judge to know if, and to what extent, counsel have conferred a benefit in shareholder litigation is if they have actively appeared in front of him throughout the litigation."[43] Fees, ***if any***, should therefore be limited to litigation counsel.

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42 *Dover,* at 1091.

43 *In Re Infinity Broadcasting Corp. Shareholders Litg.,* 802 A.2d 285, 292 (Del. 2002).

CONCLUSION

Defendants respectfully request that Plaintiffs' Petition be denied.

DELAWARE DEPARTMENT OF JUSTICE

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November 22, 2022

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Plaintiffs,	)	
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	)	
Defendants.	)	

CERTIFICATE OF COMPLIANCE WITH TYPEFACE REQUIREMENT AND TYPE-VOLUME LIMITATION

1. This document complies with the typeface requirement of Superior Court Rule 107(b) because it has been prepared in Times New Roman 14-point typeface using Microsoft Word 2016.

2. This document complies with the type-volume limitation of Superior Court Rule 107(h)(1) because, pursuant to that rule, it contains 3,953 words, which were counted by Microsoft Word 2016.

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Attorneys for Defendants

November 22, 2022

CERTIFICATE OF SERVICE

I, Max B. Walton, hereby certify that, on this 22nd day of November 2022, I caused a copy of the foregoing to be filed and served upon the following via File&Serve*Xpress*:

David A. Felice
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Wilmington, DE 19808
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/s/ Max B. Walton
Max B. Walton (#3876)

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	)	
Defendants.	)	

STATE OF DELAWARE)
NEW CASTLE COUNTY)

AFFIDAVIT OF CERRON CADE IN OPPOSITION TO PLAINTIFFS' PETITION FOR ATTORNEYS' FEES

I, Cerron Cade, hereby depose and state as follows:

1. I am the Director of the State of Delaware Office of Management and Budget ("OMB").

2. I am over the age of 18 years and am competent to testify.

3. In paragraph 51 of Plaintiffs' Complaint, Plaintiffs quote a September 12, 2022 statement from me where I stated that the Medicare Advantage plan "was not adopted in early February but voted on in early June."

4. While I was aware that the State Employee Benefits Committee ("SEBC") approved the switch to Medicare Advantage on February 28, 2022, that

plan could not be implemented until the General Assembly approved the funds during the budget process and through passage of the bond bill. Approval of the applicable funding request occurred in June of 2022.

5. To the extent I misspoke on September 12, 2022, my intention was to say that the Medicare Advantage plan could not be implemented until the General Assembly approved the funding – which happened in June.

I declare under the penalty of perjury under the laws of Delaware that the foregoing is true and correct.

EXECUTED this the 22nd day of November 2022.

Cerron Cade

SWORN AND ASCRIBED before me this 22 day of November 2022.

Notary Public

My Commission Expires:

Patricia Keeley Bistany
NOTARY PUBLIC
STATE OF DELAWARE
My Commission Expires July 20, 2023

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	)	
Defendants.	)	

STATE OF DELAWARE)
KENT COUNTY)

AFFIDAVIT OF FAITH L. RENTZ IN OPPOSITION TO PLAINTIFFS' PETITION FOR ATTORNEYS' FEES

I, Faith L. Rentz, hereby depose and state as follows:

1. I am the Director of the State of Delaware Statewide Benefits Office ("SBO"), a division of the Department of Human Resources.

2. I am over the age of 18 years and am competent to testify.

3. In this capacity, I coordinate the procurement and implementation of benefits and benefit programs for state employees, retirees, and their families on behalf of the State Employee Benefits Committee ("SEBC").

4. The State Employee Benefits Committee ("SEBC") issued a Request for Proposal (RFP) for Medical Third Party Administration (TPA) services on

April 26, 2021. The proposal was amended on May 18, 2021, with responses due by June 25, 2021 by 1:00 p.m. *See* Exhibit A.

5. The RFP specifically requested one proposal for medical plans for active employees/non-Medicare pensioners only, and a second proposal for Medicare pensioners. *Id* at p. 4. With regard to Medicare pensioners, the RFP stated that vendors may bid on one or both of the following options: "[t]he Medicare Supplement plan offered by the State today" and "[a] fully-insured group Medicare Advantage plan (which is not offered by the State today) both with and without Medicare Part D prescription drug coverage." *Id.* Vendors were not permitted to bid only on a Medicare Advantage plan. *Id.*

6. Discussion of the RFP by the SEBC occurred during May 10, 2021, which was properly noticed on the agenda as "Medical Third-Party Administration (TPA) Services Request for Proposal Overview," and again on November 8 and December 13, 2021, each of which properly placed on the agenda as "Health Third Party Administration RFP Contract Award Recommendation." *See* Exhibit B.

7. During the December 13, 2021 meeting, the SEBC voted to award the Medical Third party Administrator first contract (the "Commercial contract"), for active state employees and non-Medicare retirees/pensioners, to Highmark and Aetna, effective July 1, 2022. *See* Exhibit C.

8. At least seven (7) days prior to the February 28, 2022 meeting, the SEBC posted its agenda including notice that, "2021 Health Third Party Administrative Services RFP Award Recommendations… (c.) Medicare Plan Effective January 1, 2023," would be discussed. *See* Exhibit D.

9. Along with the other materials for the February 28, 2022 meeting, the State posted a document titled "FY23 Outstanding Decisions." *See* Exhibit E. The content page lists the first section as, "2021 Third Party Administrative Service RFP Award Recommendations." *Id.* This is nearly identical to the language on the posted agenda which read, "2021 ***Health*** Third Party Administrative Services RFP Award Recommendations." (emphasis added). (*See* ¶ 8 *supra*). The plan would be effective January 1, 2023, and references to "January 1, 2021" in the agenda were the result of a typographical error.

10. The document includes charts which compare Medicare Supplement to Medicare Advantage, compare Medicfill to Medicare Advantage under both Aetna and Highmark, and a discussion of things to consider when deciding between the options. *See* Exhibit E.

11. During the meeting, the SEBC discussed the options, opened the floor for public comment and later, and voted to award the Medicare contract to Highmark and to move to a Group Medicare Advantage plan (for medical only), effective January 1, 2023. *See* Exhibit F.

12. Following any decision to award a contract to a successful bidder under an RFP, the State then begins negotiations of the actual terms of the contract, a process that typically takes six to eight months. Pursuant to these negotiations, the Commercial contract awarded on December 13, 2021 was finalized with Aetna on August 25, 2022 and with Highmark on September 12, 2022. The Medicare contract awarded on February 28, 2022 was finalized on September 28, 2022.

13. As the contracts were undergoing negotiation, the State began to prepare for open enrollment for the active state employees and non-Medicare retirees/pensioners expediting the need to complete the contracts that would take effect first, the Commercial Contracts.

14. The open enrollment period for the Commercial contracts ran from May 2 to May 18, 2022. Active employees, non-Medicare and Medicare retirees who wished to enroll in dental and vision care were all required to enroll during the Commercial contract open enrollment. Open enrollment for the Medicare contract, including Medicare Part D coverage, would not occur until October of 2022.

15. Medicare Advantage was introduced on June 1, 2022. This allowed the SBO to focus its attention on informing – and enrolling – active state employees and non-Medicare retirees/pensioner of their benefits effective July 1, 2022 prior to turning its attention to Medicare pensioners whose plan was not changing for an

additional six (6) months after active employee and non-Medicare retiree/pensioner enrollment was completed.

16. Normally, the SBO would have sent its first communication regarding the Medicare open enrollment period and any plan changes that would be effective on January 1, in September of the year prior to the change however, the SBO specifically sent notice earlier than it normally would have because of the change in the Medicare plan and, for a small number of benefit eligible Medicare pensioners, action would be required if enrollment in the Medicare Advantage and Medicare Part D drug coverage was intended.

17. Following the June 1, 2022 communication, the SBO, the Office of Pensions and Highmark sent additional letters, including several brochures, answers to frequently asked questions, and newsletters, and held thirty (30) informational session where benefit eligible Medicare retirees/pensioners could get more information and ask questions.

18. In addition, various legislators scheduled six (6) town hall style meetings on 9/12, 9/15, 9/22, 9/27, 9/28 (all prior to open enrollment), and 10/10/22 (during open enrollment) that the SBO, Office of Pensions, and Highmark attended. Each session included a power point presentation and an opportunity to ask questions. Each of the power point presentations informed retirees/pensioners that

the new plan would be the Medicare Advantage plan, and each indicated that some services would need prior authorization. *See* Exhibit G.

19. Despite the Plaintiff's assertion that they have achieved "monumental benefits" for 30,000 State retirees, some of the retirees have been harmed by the Plaintiff's conduct as a switch to Medicare Advantage would have reduced the monthly premium for those retirees/pensioners required to pay a portion of the monthly premium which can range from 50% to 100% depending upon the retiree/pensioner's years of pension creditable service at the time of retirement. *See* Exhibit E, p. 25 demonstrating a monthly premium of $459.38 for enrollment in the Medicare Supplement with prescription and a monthly premium of $260.44 for the year 2022. The cost of Advantage would have been even further reduced in 2023 to $216.18. *See* Exhibit H.

20. This premium reduction would have come with the same benefits coverage and no out-of-pocket costs for the same Medicare covered services as provided under the Special Medicfill including the same prescription coverage and access to providers, both in and out of the Highmark Delaware Freedom Blue PPO (Freedom Blue Medicare Advantage) network. *Id* at p. 7. Benefits coverage refers to the services covered (i.e. x-ray, prescription, bloodwork) regardless of whether or not those services require prior authorization.

I declare under the penalty of perjury under the laws of Delaware that the foregoing is true and correct.

EXECUTED this the 22nd day of November 2022.

Faith L. Rentz

SWORN AND ASCRIBED before me this 22 day of November, 2022.

Notary Public

My Commission Expires:
upon receipt

LINDA G. WHITE
Notary Public, State of Delaware
My Commission Expires Upon Office

EXHIBIT A

State of Delaware
Department of Human Resources
Statewide Benefits Office

STATE EMPLOYEE BENEFITS COMMITTEE

Request for Proposal for Medical Third-Party Administration (TPA) Services

RFP Release Date – April 26, 2021

Intent to Bid Due – Friday, April 30, 2021 by 1:00 PM ET

Proposals Due – Friday, June 18, 2021 by 1:00 PM ET

DHR2201-Med_TPA

97 Commerce Way, Suite 201 • Dover, DE 19904
Phone: (800) 489-8933 Fax: (302) 739-8339 www.de.gov/statewidebenefits

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Attachments

1. Master Report List FY21
    a. Aetna
    b. Highmark
2. Account Management Survey
3. Delaware Data Usage Terms and Conditions Agreement
4. Delaware Cloud Services Terms and Conditions Agreement
5. Network Diagram Template
6. GHIP Census (January 2021) (NDA REQUIRED)
7. GHIP Groups
8. File Layouts

I. Introduction

On behalf of the State of Delaware (the State), the State Employee Benefits Committee (SEBC) is seeking proposals to provide Medical Third Party Administration (TPA) services for the Group Health Insurance Plan (GHIP). The GHIP provides medical and prescription drug benefits to approximately 129,000 active and retired employees of the State of Delaware and their dependents, including approximately 16,000 employees, retirees and their dependents from non-State groups that are allowed to participate in the GHIP according to Delaware Code[1] (e.g., municipalities, local fire departments). For complete information about the State's benefit programs, please go to www.de.gov/statewidebenefits.

Public notice has been provided in accordance with 29 Del. C. § 6981. This RFP is available in electronic form through the State of Delaware Procurement website at www.bids.delaware.gov. Paper copies of this RFP will not be available.

Vendors may bid on:

1) **The medical plans for active employees/non-Medicare pensioners only – PPO[2] and HMO plan designs.**
2) **Item #1 above plus one or both of the following options for Medicare pensioners:**
    a. **The Medicare Supplement plan offered by the State today.**
    b. **A fully-insured group Medicare Advantage plan (which is not offered by the State today) both with and without Medicare Part D prescription drug coverage. Vendors cannot bid only on a Medicare Advantage plan.**

Award(s) will be made to one vendor for all medical plans or multiple vendors for any combination of medical plans. The SEBC will award contracts with an effective date of July 1, 2022 for all medical plans except for the Medicare pensioner plan options. The SEBC will award the contract for either the Medicare Supplement plan or the Medicare Advantage plan with an effective date of January 1, 2023.

NOTE: This RFP requests that bidders respond to "other services" (e.g., HSA administration, direct primary care, care navigation) that may be in addition to or attached to the above plans and may or may not be awarded for an effective date of July 1, 2022 (for most medical plans) or January 1,

[1] See https://delcode.delaware.gov.

[2] "PPO plan designs" includes the Comprehensive PPO, First State Basic and CDH Gold plans, which all provide in- and out-of-network coverage with point-of-care cost sharing between the State and plan participants.

2023 (for the Medicare pensioner plan options). These "other services" cannot be stand-alone bids or proposals.

Important Dates (A full timeline is included in Section I.B.)

Contract Effective Date – all plans except Medicare Supplement and Medicare Advantage	**July 1, 2022**
Contract Effective Date – Medicare Supplement or Medicare Advantage	**January 1, 2023**
RFP Release Date	**Monday, April 26, 2021**
Intent to Bid Due[3]	**Friday, April 30, 2021 by 1:00 p.m. ET (Local Time)**
Mandatory Pre-Bid Meeting (Conference Call)[4]	**Wednesday, May 5, 2021, 11:00 a.m. ET (Local Time)**
Questions Due from Vendors	**Friday, May 14, 2021 by 1:00 p.m. ET (Local Time)**
Proposal Submissions Due	**Friday, June 18, 2021 by 1:00 p.m. ET (Local Time)**

A. Background and Overview

Overview of the SEBC and the GHIP

The SEBC was established by the State Employee Benefits Consolidation Act, Title 29, Chapter 96 of the Delaware Code. . The SEBC has control and management of all employee benefits. The SEBC selects all carriers or third-party administrators necessary to provide coverage to State employees, enters into contracts for the purpose of general administration of employee benefits, determines if contracts are fully insured or self-insured, and adopts rules and regulations for the general administration of the employee benefit coverage.

The SEBC is co-chaired by the Director of the Office of Management and Budget (OMB) and the Secretary of the Department of Human Resources (DHR). The Committee is comprised of the Director of the Office of Management and Budget, the Secretary of the Department of Human Resources, the Insurance Commissioner, the Chief Justice of the Supreme Court, the State Treasurer, the Controller General, the Secretary of the Department of Health and Social Services,

[3] IMPORTANT: Your bid will not be accepted if the State of Delaware does not receive confirmation of an Intent to Bid. See Section II.B.1 for details.

[4] IMPORTANT: Your bid will not be accepted if your organization does not participate in the Mandatory Pre-Bid Meeting (Conference Call). See Section II.B.5 for details.

the Lieutenant Governor, and the Executive Director of the Delaware State Education Association or their designees. The Statewide Benefits Office (SBO) is a division within the DHR that functions as the administrative arm of the SEBC responsible for the administration of all statewide benefit programs with the exception of pension and deferred compensation benefits. These programs include, but are not limited to, health with wellness and disease management programs, prescription drug, dental, vision, disability, life, flexible spending accounts, pre-tax commuter benefits, employee assistance program, third-party network of surgeons of excellence and supplemental critical illness and accident benefits. Not all members of the GHIP are eligible for participation in all of the benefit programs.

The SBO administers the GHIP, which is self-insured by the State. Eligible participants include active and retired State employees from State agencies, school districts, charter schools, Delaware State University and Delaware Technical Community College, as well as employees of non-State groups (i.e., towns, fire companies, the University of Delaware), and COBRA participants and their enrolled dependents. By statute, employee unions cannot negotiate for benefits, therefore there are no union-specific, alternative plan designs for the PPO, HMO, CDH Gold or First State Basic medical plans or the prescription drug benefit plan. Plan participants are primarily located within the State of Delaware, although a small number of participants reside in other states and countries. There are multiple employer units and non-payroll groups located in three counties throughout the State, with each exercising a high degree of independence. The plan year for the GHIP begins on July 1 and coincides with the State's fiscal year, except for Medicare pensioners enrolled in the State's Special Medicfill Medicare Supplement plan, which begins on January 1. Medicare-eligible plan participants receive secondary medical coverage through the GHIP as well as prescription drug benefits through an Employer Group Waiver Medicare Part D plan implemented in calendar year 2013.

Current State of the GHIP

Currently, the State has contracted with Highmark Delaware and Aetna to administer the medical portion of the GHIP and is in the process of transitioning pharmacy benefit management (PBM) services from Express Scripts (ESI) to CVS Caremark (CVS) (effective July 1, 2021 for active employees and non-Medicare retirees and January 1, 2022 for Medicare retirees). Because the State utilizes multiple electronic human resources programs, such as PeopleSoft, and vendor databases at separate locations in various formats to collect and store participant data, the medical TPAs serve as the medical plan enrollment systems of record and share enrollment and claims data for all medical plans with the PBM, the SurgeryPlus third-party network of surgeons of excellence, and the GHIP data warehouse vendor, IBM Watson Health. The State contracts with ASI COBRA for administration of COBRA and with ComPsych for administration of employee assistance services.

The SEBC is responsible for the design of the medical plans available to the GHIP's participants and setting premium rates that can support the projected expenses of the GHIP. The percentage of employee/retiree and State share of the premium rates is established in Delaware Code as are

the actual plan offerings available to employees and retirees[5], as outlined in the chart below. Additional information about plan designs and premiums can be found on the SBO website:

- Highmark plan enrollees – active employees and non-Medicare pensioners: https://dhr.delaware.gov/benefits/agencies/highmark.shtml
- Highmark plan enrollees – Medicare pensioners: https://dhr.delaware.gov/benefits/medicare/highmark.shtml
- Aetna plan enrollees: https://dhr.delaware.gov/benefits/agencies/aetna.shtml

	Actives	Non-Medicare	Medicare Primary
Premium Cost Share Percentage Split	**State / Employee**	**State / Retiree**	**State / Retiree**
Highmark Comprehensive PPO	86.75% / 13.25%	86.75% / 13.25%	
Aetna HMO	93.5% / 6.5%	93.5% / 6.5%	
Aetna CDH Gold (with HRA)	95.0% / 5.0%	95.0% / 5.0%	
Highmark First State Basic	96.0% / 4.0%	96.0% / 4.0%	
Highmark Special Medicfill Supplement			100% / 0% * 95.0% / 5.0% **

*Retirees with full state share who retired before July 1, 2012.
**Retirees with full state share who retired after July 1, 2012.

Cost and utilization of the GHIP are regularly reported to the SEBC and its Financial Subcommittee; these publicly available reports include:

- **Quarterly financial and utilization reports,** such as these linked examples for FY20 Q4, FY21 Q1 and FY21 Q2
- **Quarterly incurred claims and site-of-care steerage reports**
- **Delaware Department of Human Resources Facts and Figures**
- **Other ad hoc analyses** such as:
  - Selected utilization trends, July 2019-June 2020
  - COVID-19 impact as of December 2020

Health management programs are provided through Highmark Delaware, Aetna and Aetna's subcontractor, CareVio[6]. These programs address both broad-based population health focused on closing gaps in care among high risk plan participants and condition-specific health concerns such as diabetes, maternity care, and behavioral health. Additional details about these programs are available to the public on the SBO's website (https://dhr.delaware.gov/benefits/), which interested

[5] Delaware Code, Title 29, Chapter 52 Web Address: http://delcode.delaware.gov/title29/c052/index.shtml
[6] CareVio is a health management program administered by a Delaware-based hospital system, Christiana Care, for Aetna HMO plan participants.

bidders are encouraged to review. The SBO also partners with other State agencies to deliver health-related programs and communications to GHIP participants, such as the State Department of Public Health educational campaigns about preventive cancer screenings, high blood pressure and diabetes prevention and management. A collection of the GHIP's health and wellness resources can be found online at https://dhr.delaware.gov/benefits/behavioral-health/index.shtml.

GHIP participants enrolled in a State of Delaware Aetna or Highmark Delaware non-Medicare health plan also have access to the SurgeryPlus surgeons of excellence program for elective surgical procedures. The SEBC adopted the SurgeryPlus program as a step toward promoting greater competition among facility providers in Delaware and as a way to provide plan participants with easier access to high quality providers in value-based contracts (i.e., contract based on quality of care and outcomes delivered, not fee-for-service). Plan participants can choose to use a SurgeryPlus provider as a no-cost alternative to their medical plan network providers. SurgeryPlus shares data on member utilization of this program with the medical TPAs. Additional details about the SurgeryPlus program, including the financial incentives available to members who use a SurgeryPlus provider for elective surgeries, can be found online at https://dhr.delaware.gov/benefits/surgery-plus/index.shtml.

The SEBC expects that the TPA(s) selected from this RFP will be an active participant in the Delaware Health Information Network (DHIN) to create a single interface for providers and patients to access health information that supports care coordination, performance reviews and patient engagement, and eliminates duplicative reporting burdens.

DHIN is a statutory (16 Del. C. Ch. 103) not-for-profit instrumentality of the State of Delaware, created to promote the design, implementation, operation and maintenance of facilities for public and private use of healthcare information in the state.

A public-private partnership, DHIN serves as the state-designated health information exchange, facilitating the sharing of clinical and financial healthcare information (as appropriate) among providers and stakeholders, including hospitals, physicians, state agencies, payers, employers and labs, with the goal of improved efficiencies in the health care delivery system.

At a glance, DHIN:

- **Covers all of Delaware**: Every acute care hospital and Federally Qualified Health Center, as well as nearly all providers who make orders, voluntarily participate with DHIN.

- **Supports regional health information exchange**: DHIN's Community Health Record stores patient data by health systems from all or parts of six states and the District of Columbia.

- **Delivers data daily:** DHIN delivers 14 million results annually, adding up to more than 150 million clinical results and reports delivered since its inception in 2007. To date, more than three million patients from all fifty states can be found in DHIN's master patient index.

In addition to its robust clinical data repository, DHIN has also been tasked with housing and managing Delaware's All Payer Claims Database (APCD). The APCD currently contains claims

records for 720,000 individuals, representing more than 60% of Delaware residents. This includes Delaware Medicare, Medicaid, the GHIP as well as some other commercial health plans. Claims data span 2013 through 2020. Additional details about the ACPD can be found at https://dhin.org/healthcare-claims-database/.

The SEBC expects that the TPA(s) selected from this RFP will, prior to the time in which services to the SEBC are provided under an awarded contract:

- Enter into appropriate agreements and stand ready to submit data to the Health Care Claims Database pursuant to the enabling legislation, associated DHIN regulations, and the Data Submission Guide. Information on the Delaware Health Care Claims Database is available at https://dhin.org/healthcare-claims-database. All required data must be submitted in a timely fashion and pursuant to DHIN requirements, unless explicitly exempted by Delaware or federal law.

- Contract with DHIN at DHIN's prevailing per member, per month rate for all members to the suite of services provided to payers by DHIN. Such services shall include access to the Community Health Record, Event Notification Services, and Clinical Gateway. A three-party agreement with DHIN, the SEBC and the medical TPA will be required. Payment to DHIN for DHIN services shall be timed to begin concurrently with the services provided to SEBC under any awarded contract.

The SEBC expects that the tools and associated data provided by DHIN will be used by the successful TPA(s) in support of administrative efficiencies in data gathering to support HEDIS reporting, audits of providers for clinical quality purposes, and care coordination.

In addition to the foregoing requirements, and in further support of these efforts, the SEBC expects any successful TPA(s) to:

- Help to alleviate and retire, to the fullest extent possible, reporting burdens currently placed on providers and other entities or individuals contracted to deliver care, if and to the extent such reports contain information already available in DHIN.

- Leverage their contracting power with providers and other entities or individuals contracted to deliver care, to encourage and promote the use of DHIN services, including the Community Health Record, Event Notification Services, and the submission of clinical encounter data (including point of care lab test results) to DHIN for inclusion in its clinical data repositories.

    - To the extent that the successful TPA(s) owns or enters into contracts with telehealth providers, walk-in or urgent care clinics, home health services, rehabilitative services, skilled nursing and long term care facilities or other care organizations, it will require such providers to, if technologically feasible, contract with DHIN to provide clinical encounter data to the DHIN database and use DHIN services in order to improve care coordination and provide administrative simplicity with respect to audits and compliance.

- In order to further the State of Delaware's progress towards achieving the Triple Aim Plus One, and in support of the development of value-based payment models and cost, quality, efficiency and population health studies that also further these goals, the successful TPA(s) will require that any data submitted to DHIN by its contracted care providers be permitted to be used for all purposes authorized under the DHIN governing statute, regulations, and relevant federal law.

- Promote the use of Health Check Connect, DHIN's personal health record, as a mode of accessing all of the patient's clinical health data from a single source.

Future State of the GHIP

The SEBC has established the GHIP Strategic Framework to articulate a mission statement and a series of goals, strategies and tactics that support the mission of the GHIP. While the mission statement has remained unchanged since the GHIP Strategic Framework was first established in December 2016, the rest of the framework was updated in February 2020 to reflect the latest strategic direction from the SEBC on what the GHIP will aim to accomplish over the next 3-5 years.

The mission statement and goals articulated in the current GHIP Strategic Framework[7] are:

Mission Statement: Offer State of Delaware employees, retirees and their dependents adequate access to high quality healthcare that produces good outcomes at an affordable cost, promotes healthy lifestyles, and helps them be engaged consumers.

Goals:

1. Using the Alternative Payment Model (APM) Framework and FY2021 medical spend as a baseline[8], increase GHIP spend through advanced APMs[9] to be at least the following by the end of FY2023 (as a percent of total spend):
    - Category 3: 40%
    - Category 4: 10%
2. Reduction of GHIP diabetic cost per-member-per-month (PMPM) by 8% by the end of FY2023[10] using FY2021 spend as a baseline.

[7] Additional information about the GHIP Strategic Framework, including the current strategies and tactics, can be found online at https://dhr.delaware.gov/benefits/sebc/documents/2020/0217-ghip-strategic-framework.pdf.

[8] Estimated FY21 baseline medical spend in advanced APMs: Category 3 – 17%, Category 4 – 0%. Based on GHIP-specific data provided by Highmark and Aetna.

[9] Defined by the Health Care Learning and Action Network's Alternative Payment Model (APM) Framework as Category 3 and Category 4 models. More information about the APM Framework can be found at https://hcp-lan.org/apm-refresh-white-paper/.

[10] Estimated reduction in diabetic member cost for FY21 is approximately 1.5% ($0.7m).

3. Limit total cost of care inflation for GHIP participants at a level commensurate with the Health Care Spending Benchmark[11] by the end of FY2023 by focusing on specific components, which are inclusive of, but not limited to:

    - Outpatient facility costs
    - Inpatient facility costs
    - Pharmaceutical costs

4. In light of the GHIP's changing demographic profile, strive for an incremental increase in unique users utilizing a specific point-of-enrollment and/or point-of-care engagement platform/consumerism tool[12] by at least 5% annually.

The GHIP medical TPAs are key partners in supporting the goals of the Strategic Framework, and the evaluation process of this RFP will focus heavily on how each bidder is positioned to support these goals. Bidders will be required to describe their proposed programs, solutions and partnerships, including readiness to implement and track record of success, that can help the SEBC and SBO achieve the goals of the GHIP Strategic Framework. Higher scoring consideration will be given to bidders that can most effectively support the SEBC and SBO in achieving those goals.

Recognizing the transformational level of change required to achieve the GHIP Strategic Framework goals, the SEBC acknowledges this change may be phased in over time and will reflect this in the bidder evaluation process. Bidders are encouraged to propose or illustrate creative delivery strategies that support the Strategic Framework goals and could be available within the terms of this agreement, even if not yet market-ready by July 1, 2022.

Additionally, bidders will be required to describe how they will demonstrate and guarantee the value of their proposed solutions, including but not limited to, the measurement, reporting, and service level agreements associated with those solutions. Where possible, this description should include bidders' history of delivering on guarantees for similar solutions provided to other plan sponsors.

Finally, the SEBC and SBO are committed to supporting other state-level health care initiatives where possible through the GHIP and expect that the GHIP medical TPA(s) will do the same. This includes supporting the work of the Delaware Department of Insurance's Office of Value Based Health Care Delivery to establish the following health care Affordability Standards[13]:

- Increase primary care investment
- Decrease unit price growth for certain services

[11] Currently pegged at 3.25% for CY2021.

[12] Through FY2021, this tool will continue to be administered under the purview of the SBO. Post-FY2021, selection of a specific engagement platform / consumerism tool will be at the discretion of the SEBC.

[13] Additional information about the Affordability Standards can be found at https://insurance.delaware.gov/wp-content/uploads/sites/15/2020/12/Delaware-Health-Care-Affordability-Standards-Report-12182020.pdf.

- Expand Alternative Payment Model adoption

Bidders will be asked to describe how their proposed solutions will align with these Affordability Standards and other statewide health initiatives.

B. Timetable/Deadlines

The following timetable is expected to apply during this RFP process:

Event	Target (Eastern Time)
RFP Released	Monday, April 26, 2021
Intent to Bid	Due by Friday, April 30, 2021, 1:00 p.m.
Mandatory Bidder Conference Call	Wednesday, May 5, 2021, 11:00 a.m.
Questions due to SBO from Confirmed Bidders	Due by Friday, May 14, 2021, 1:00 p.m.
Responses to Questions to Confirmed Vendors	By Friday, May 28, 2021, 5:00 p.m.
Deadline for Bids	Due by Friday, June 18, 2021, 1:00 p.m.
Notification of Finalists - Invitation to Interview	End of July, 2021
Finalist Interviews [14]	Monday, August 23, 2021 or Tuesday, August 24, 2021
Contract Award	Monday, November 8, 2021
Implementation	December, 2021 – April, 2022
Must have a signed contract by April 1, 2022 in order to accept file feeds to prepare for Open Enrollment	April 1, 2022
Open Enrollment	May, 2022
Contract Effective Date – all plans except Medicare Supplement and Medicare Advantage	July 1, 2022

[14] The SEBC will require each of the finalists to make a presentation. Though the interviews are normally required to be in-person in Dover, Delaware (at the expense of the proposing firm), the SBO may decide to conduct them by webinar. The presentation will require a demonstration of your online member-facing and plan management self-service portal for plan sponsors.

Event	Target (Eastern Time)
Contract Effective Date – Medicare Supplement and Medicare Advantage	January 1, 2023

C. Proposal Objectives and Scope of Services

Bidding organizations must have prior experience directly related to the services requested in this RFP. The selected medical TPA(s) will be required to provide the following Scope of Services, at a minimum[15]:

1. Support the goals of the GHIP Strategic Framework:

a) Offer solutions that increase GHIP spend through advanced alternative payment models[16].

b) Offer solutions that reduce GHIP diabetic cost per-member-per-month (PMPM).

c) Offer solutions that limit total cost of care inflation for GHIP participants at a level commensurate with the Health Care Spending Benchmark[17] by the end of FY2023 by focusing on specific components, which are inclusive of, but not limited to:

- Outpatient facility costs,
- Inpatient facility costs, and
- Pharmaceutical costs.

d) Offer point-of-enrollment and/or point-of-care engagement platform and/or consumerism tools along with solutions to increase GHIP member engagement in those tools.

2. Provide competitive financial terms for the requested scope of services:

a) Offer competitive fee proposal compared to competitors.

b) Guarantee performance of the requested scope of services (both financial and non-financial performance guarantees), including guarantees that hold the TPA accountable for helping meet the goals of the GHIP Strategic Framework.

c) Offer credits to offset the costs associated with implementation (if applicable).

d) Offer solutions that uphold and support the Affordability Targets of the Office of Value Based Health Care Delivery.

[15] This list is meant to be comprehensive, but the detailed requirements are set forth in the Minimum Requirements and Questionnaire sections of this RFP that are available online via ProposalTech.

[16] Defined by the Health Care Learning and Action Network's Alternative Payment Model (APM) Framework as Category 3 and Category 4 models. More information about the APM Framework can be found at https://hcp-lan.org/apm-refresh-white-paper/.

[17] Currently pegged at 3.25% for CY2021.

3. Deliver on the core administrative functions of a medical TPA:

a) Deliver all enrollment processing and claim administration functions of a typical third-party administrator.

b) Possess qualified and experienced personnel to provide excellent customer service to GHIP participants.

c) Provide experienced account management personnel who are responsive to the needs and requests of the Statewide Benefits Office.

d) Support the communication of GHIP benefits (including any changes) to participants during Open Enrollment.

e) Provide reporting on GHIP member experience using providers contracted through alternative payment models (i.e., utilization, clinical and financial outcomes).

f) Possess the ability to execute a comprehensive implementation project plan (communications, file transitions, testing, etc.) to ensure a smooth transition to new TPA or (for incumbent) to support implementation of new communications or benefits if awarded a new contract.

4. Support the GHIP's programs and plan offerings:

a) Administer the current GHIP plan designs.

   a. For the HMO plan, the State prefers to retain the current requirement that PCP referrals are necessary in order for plan participants to obtain specialty or ancillary care. However, bidders will be required to address whether the PCP referral requirement is an optional component of their HMO products that can be activated or deactivated according to the plan sponsor's preference.

b) Support plan provisions that optimize the effectiveness of the GHIP benefit offering.

c) Deliver comprehensive care management programs, including condition-specific programs (e.g., diabetes musculoskeletal, behavioral health, maternity, fertility and family building support) that align with the Strategic Framework as well as top cost drivers for the GHIP; programs should be effective at engaging members through various modalities and steering them to the most effective care at the right time with the right providers.

d) Offer solutions that aid plan participants in navigating the health care system to efficiently meet their clinical needs.

e) Integrate with other benefit programs and vendors supporting GHIP participants.

f) Partner with other community health resources (e.g., in partnership with the Delaware Department of Health and Social Services, the Department of Public Health) to coordinate care for GHIP participants.

g) Provide supplemental coverage to Medicare-eligible retirees and their Medicare-eligible dependents, either in the form of a Medicare Supplement or group Medicare Advantage plan.

   - This RFP is requesting proposals for the administration of a Medicare Supplement plan for retirees.

- If bidders have a group Medicare Advantage program that would service State retirees and be beneficial for the GHIP, please provide information on that plan (both with and without Medicare Part D prescription drug coverage) along with rates for an effective date of January 1, 2023 for evaluation purposes.
- If the State were to offer a Medicare Advantage plan, it would be as a full replacement group Medicare Advantage plan that mirrors the current Medicare Supplement plan design (i.e., passive PPO on a non-benefit differential basis that pays 100% of all Medicare services), provided that the Medicare Advantage plan provides adequate access to medical providers in all areas where retirees reside.

5. Maintain a provider network that meets the current and future state goals of the GHIP[18]:

a) Support investments in access to primary care.

b) Promote primary care integration with behavioral health care (including treatment of substance abuse), including:

   a. Willingness to test new models of integrating Behavioral Health and Primary Care in Delaware,

   b. Participation in the roll-out of these new models statewide, and

   c. Demonstrated focus on provider diversity.

c) Facilitate consumer choice of providers who deliver higher-quality care at a lower total cost of care. This may include, but not be limited to:

   a. TPAs demonstrating commitment to transparency and quality reporting by requiring in-network facilities report key safety and quality data to publicly accessible databases like the Leapfrog Hospital Survey and the Leapfrog Ambulatory Surgery Center Survey.

   b. TPAs enforcing accountability for doctors/hospitals to improve safety and quality practices, by taking actions such as:

      i. Requiring that the TPA's quality director and/or medical director meet annually with network hospital executives and their patient/quality leaders to discuss opportunities for improvement.

      ii. Requiring that network facilities and physician organizations tie low quality/safety scores and frequency of low value care delivered to individual provider performance incentives/disincentives.

      iii. Requiring that network hospitals abide to a "Never Events" policy for serious medical errors.

[18] **It should be noted that the State makes no guarantees of volume in terms of member steerage toward any new or existing plans or programs included in any bidder's proposal.** The State is willing to work with the selected organization(s) to develop and implement solutions that will drive steerage – e.g., communications, possibly plan design changes, etc. – even though the State will not make any guarantees of projected membership in each plan.

c. TPAs demonstrating commitment to identifying patterns of low value care within provider networks, ensuring the plans are incorporating into provider quality policy guidelines, and communicating "Choosing Wisely" to members.

d) Support financial rewards to providers who delivery higher-quality care and lower total cost of care.

e) Offer a network solution that minimizes disruption and provides adequate access to providers for traditional PPO, HMO, and consumer directed plans, with "adequate access" defined by the standards outlined in the GeoAccess Appendices N-P.

6. Possess extensive experience and qualifications to provide the requested Scope of Services:

a) Able to follow through with operational commitments, such as protection demonstrated through performance guarantees offered to the State and has outstanding references that demonstrate the ability to meet the State's needs.

b) Have at least five (5) years' experience as an organization administering the requested scope of services with clients of similar size and complexity.

c) Has existing customers of similar size (number of covered employee lives), industry and experience administering the requested scope of services and offered best practice solutions for meeting the State's needs.

d) Has experience contracting with providers to establish advanced payment models and can track and report on the clinical and financial outcomes from those models.

e) Have outstanding references from both current and terminated customers of comparable size and complexity to the State.

7. Provide excellent account management services to the State:

a) Designated account manager will be accessible and responsive to requests from the SEBC and SBO.

b) Account manager will be a senior level resource with at least five (5) years' experience providing account management services for medical TPA customers of similar size and complexity.

c) Account manager will complete projects within required timeframes, possess problem solving expertise and proactively suggest programs and solutions aligned with the Strategic Framework that would support the ongoing benefit strategies of the SEBC and SBO, including new products and services available to the State through the TPA's organization.

d) Provide meaningful and timely management reporting, with the expectation that the amount of focus on metrics related to value-based contracting models will increase over time. Such metrics may include, but are not limited to quality and safety data on hospital acquired conditions (e.g., infections, falls, medica errors) for GHIP participants.

e) Integrate with the GHIP data warehouse vendor and the DHIN according to the description provided in I.A. Background and Overview.

8. If not the incumbent, provide superior program implementation support. If the incumbent, provide superior support for implementation of any plan design changes or new medical programs:

a) Assuming a contract award no later than November 8, 2021, medical TPA is able to successfully implement medical TPA services for a July 1, 2022 effective date for the medical plan options offered to active employees and non-Medicare pensioners, and a January 1, 2023 effective date for the medical plan offered to Medicare pensioners.

b) Implementation manager will have successfully managed at least five (5) prior implementations which included services that are similar to the requested scope of services for the State.

c) Lead the implementation process taking direction from the State.

d) Conduct a pre-implementation testing process to ensure accuracy of the medical benefits administration, including claims and customer service, prior to Open Enrollment; results of this testing will be shared with the State.

9. Provide excellent customer service to participants

a. Provide dedicated, knowledgeable, and accessible member support services.

b. Provide a secure and multifunctional member website that allows convenient access to enrollment, plan information, and member tools (i.e., provider finder, medical procedure cost estimator).

c. Provide GHIP participants with the tools and resources that will promote transparency in provider quality, safety and cost, including site of care steerage, and encourage participants to make informed decisions about their health. These tools should include information from nationally-recognized groups (e.g., Leapfrog Hospital Survey Results, Leapfrog Hospital Safety Grades, CMS Hospital Compare, CMS Physician Compare and Healthgrades). These tools should be practically and realistically applied to GHIP membership and implemented efficiently across the member population.

d. Leverage the work that the State has already put into its benefits website for members to access information and education on their benefits, to support the goal of driving consumerism.

e. Distribute member ID cards and benefit information.

f. Support all program-related member communications including Open Enrollment, direct mailings, and other types of media.

10. Maintain data security:

a) Computer, network, and information security is of paramount concern for the State and the Department of Technology and Information (DTI). Standard controls for data security are required.

b) The ownership of the data remains with the State and indemnification for the State for data breaches is required.

c) A SOC-1 report and Business Associate Agreement are also required.

11. Agree to State requirements for contracting, including but not necessarily limited to:

a) Medical TPA must act as an independent contractor and indemnify the State.

b) All requirements in the terms in the Legal section of the Minimum Requirements.

D. Evaluation Process

1.0 Proposal Review Committee

The Proposal Review Committee (PRC) will review all proposals submitted that meet the requirements of the RFP. The PRC shall be comprised of representatives from each of the following offices:

- Department of Human Resources
- Office of Management and Budget
- Controller General's Office
- Department of Health and Social Services
- State Insurance Commissioner's Office
- State Treasurer's Office
- Chief Justice of the Supreme Court
- Lieutenant Governor's Office
- Executive Director of the Delaware State Education Association

The SBO shall determine the firms that meet requirements pursuant to selection criteria of the RFP and procedures established in 29 Del. C. § 6981 and 6982. The PRC reserves full discretion to determine the competence and responsibility, professionally and/or financially, of vendors. Vendors are to provide in a timely manner any and all information the PRC may deem necessary to make a decision. The PRC shall interview at least one (1) of the qualified firms.

The minimum requirements are mandatory. Failure to meet any of the minimum requirements in the RFP may result in disqualification of the proposal submitted by your organization.

The SEBC will not respond to a question in the question and answer process that asks whether or not a bid would be disqualified if the vendor does not meet a specific minimum requirement. The bid must be submitted and then analyzed in its entirety.

The PRC shall make a recommendation regarding the award of contract to the SEBC who shall have final authority, in accordance with the provisions of this RFP and 29 Del.C. §6982, to award a contract to the winning firm or firms as determined by the SEBC in its sole discretion to be in the best interests of the State of Delaware. The SEBC may negotiate with one or more firms during the same period and may, at its discretion, terminate negotiations with any or all firms. The SEBC reserves the right to reject any and all proposals. Pursuant to 29 Del. C. § 6986, the SEBC may award a contract to multiple vendors if the SEBC determines that it is in the best interest of the State. However, it is the intention of the SEBC to probably award more than one contract.

2.0 Evaluation Criteria

All proposals shall be evaluated using the same criteria and scoring process. The following criteria shall be used by the PRC to evaluate proposals.

Topic	Points Awarded		Description / Examples
	Non-Medicare Plans	Medicare Plans Only	
Financial Proposal	30 points	30 points	See Section I.C. Proposal Objectives and Scope of Services for examples of criteria that may be considered in the evaluation of bidders' proposals.
Plan Administration	15 points	20 points for Medicare Supplement 15 points for Medicare Advantage	See Section I.C. Proposal Objectives and Scope of Services for examples of criteria that may be considered in the evaluation of bidders' proposals.
Program Design and Offerings	15 points	20 points for Medicare Supplement 15 points for Medicare Advantage	See Section I.C. Proposal Objectives and Scope of Services for examples of criteria that may be considered in the evaluation of bidders' proposals.

Topic	Points Awarded		Description / Examples
	Non-Medicare Plans	Medicare Plans Only	
Adequate Network Access	15 points	n/a for Medicare Supplement 15 points for Medicare Advantage	See Section I.C. Proposal Objectives and Scope of Services for examples of criteria that may be considered in the evaluation of bidders' proposals.
Experience and References	10 points	15 points for Medicare Supplement 10 points for Medicare Advantage	See Section I.C. Proposal Objectives and Scope of Services for examples of criteria that may be considered in the evaluation of bidders' proposals.
Tools and Technology	10 points	10 points	See Section I.C. Proposal Objectives and Scope of Services for examples of criteria that may be considered in the evaluation of bidders' proposals.
Responsiveness	5 points	5 points	• Compliance with the submission requirements of the bid including format, clarity, conformity, realistic responses, and completeness. • Responsiveness to requests during the evaluation process.
Subtotal – Core Criteria	**100 points**	**100 points**	
Value-added Services	**25 points**	**25 points**	Offers other value-added services that can optimize the effectiveness of the benefit offerings.
Grand Total	**125 points**	**125 points**	Sum of Core Criteria and Value-added Services

It is the proposing firm's sole responsibility to submit information relative to the evaluation of its proposal and the SEBC is under no obligation to solicit such information if it is not included with the proposing firm's proposal. Failure of the proposing firm to submit such information in a manner so that it is easily located and understood may have an adverse impact on the evaluation of the proposing firm's proposal.

The SEBC will use the information contained in each bidder's proposal to determine whether that bidder will be selected as a finalist and for contract preparation. The proposal the SEBC selects will be a binding document. As such, the SEBC will expect the proposing firm to honor all representations made in its proposal.

The proposals shall contain the essential information for which the award will be made. The information that is required in response to this RFP has been determined by the SEBC and the PRC to be essential in the evaluation and award process. Therefore, all instructions contained in this RFP must be met in order to qualify as a responsive contractor and to participate in the PRC's consideration for award. Proposals that do not meet or comply with the instructions of this RFP may be considered non-conforming and deemed non-responsive and subject to disqualification at the sole discretion of the PRC.

3.0 RFP Award Notification

The contract(s) shall be awarded to the vendor(s) whose proposal is determined by the SEBC to be most advantageous, taking into consideration the evaluation criteria set forth in the RFP. The SEBC is not obligated to award the contract(s) to the vendor(s) who submits the lowest bid or the vendor(s) who receives the highest total point score. Rather the contract(s) will be awarded to the vendor(s) whose proposal is determined by the SEBC to be the most advantageous. The award is subject to the appropriate State of Delaware approvals. After a final selection is made, the winning vendor(s) will be invited to enter into a contract(s) with the State; remaining vendors will be notified in writing of their selection status.

4.0 Award of Contract

The final award of a contract(s) is subject to approval by the SEBC. The SEBC has the sole right to select the winning vendor(s) for award, to reject any proposal as unsatisfactory or non-responsive, to award a contract(s) to other than the lowest priced proposal, to award multiple contracts, or not to award a contract, as a result of this RFP. Notice in writing to a vendor(s) of the acceptance of its proposal by the SEBC and the subsequent full execution of a written contract will constitute a contract and no vendor will acquire any legal or equitable rights or privileges until the occurrence of both such events.

E. Confidentiality of Documents

The State of Delaware and its constituent agencies are required to comply with the State of Delaware Freedom of Information Act, 29 *Del. C.* § 10001, *et seq.* ("FOIA"). FOIA requires that the State of Delaware's records are public records (unless otherwise declared by FOIA or other law to be exempt from disclosure) and are subject to inspection and copying by any person upon a written request. The content of all proposals is subject to FOIA's public disclosure obligations. However, there shall be no disclosure of any vendor's information to a competing vendor or in fulfillment of a FOIA request during the bidding and contract development process.

Organizations are advised that when the contract has been fully executed the contents of the proposal and terms of the contract, including administrative fees, will become public record and nothing contained in the proposal or contract will be deemed to be confidential except the proprietary information. If your bid contains the phrase "confidential and proprietary" or simply the word "confidential" on each page, such status will not automatically be granted.

The State of Delaware wishes to create a business-friendly environment and procurement process. As such, the State respects the vendor community's desire to protect its intellectual property, trade secrets, and confidential business information (collectively referred to herein as "confidential business information"). Proposals must contain sufficient information to be evaluated. If a vendor feels that they cannot submit their proposal without including confidential business information, they must adhere to the following procedure or their proposal may be deemed unresponsive, may not be recommended for selection, and any applicable protection for the vendor's confidential business information may be lost.

In order to allow the State to assess a vendor's confidential business information, vendors will be permitted to designate appropriate portions of their proposal as confidential business information. Fees or premiums are only considered confidential and proprietary during the bid evaluation process.

If you are providing any information you declare to be confidential or proprietary for the purpose of exclusion from the public record under 29 Del. C. ch. 100, Delaware Freedom of Information Act, you must follow the directions for submission outlined below and within Section II.C., Submission of Proposal.

The confidential business information must be submitted as one electronic pdf copy as follows:

1) A letter from the vendor's legal counsel describing the information in the attached document(s) and representing in good faith that the information in each document is not "public record" as defined by 29 Del. C. § 10002. The letter must briefly state the reason(s) that the information meets the said definitions. (See Section II.C., Submission of Proposal, for detailed instructions.) For example, "Appendix C – *Disaster Recovery Plan* – is confidential and proprietary and is not public record as defined by FOIA at 29 Del. C. § 10002(d)".

2) As an attachment to the letter, you must include a list of the question number and topic of the question. For example, #3.2.5, References.

A vendor's determination as to its confidential business information shall not be binding on the State. The State shall independently determine the validity of any vendor designation as set forth in this section. Any vendor submitting a proposal or using the procedures discussed herein expressly accepts the State's absolute right and duty to independently assess the legal and factual validity of any information designated as confidential business information. Accordingly, vendor(s) assume the risk that confidential business information included within a proposal may enter the public domain.

The State is not responsible for incorrect redactions or reviewing your submission to determine whether or not any information asserted as confidential and proprietary is redacted. Mistakes in redactions are the sole responsibility of the bidder.

II. Terms and Conditions

A. Proposal Response Requirements

1. **Conformity** – Your proposal must conform to the requirements set forth in this RFP. The SEBC reserves the right to deny any and all exceptions taken to the RFP requirements. By submitting a bid, each vendor shall be deemed to acknowledge that it has carefully read all sections of this RFP, including all forms, schedules, appendices, and exhibits hereto, and has fully informed itself as to all existing conditions and limitations. The failure or omission to examine any form, instrument or document shall in no way relieve vendors from any obligation in respect to this RFP.

2. **Concise and Direct** – Please provide complete answers and explain all issues in a concise, direct manner. Unnecessarily elaborate brochures or other promotional materials beyond those sufficient to present a complete and effective proposal are not desired. Please do not refer to another answer if the question appears duplicative, but respond in full to each question. If you cannot provide a direct response for some reason (e.g., your company does not collect or furnish certain information), please indicate the reason rather than providing general information that fails to answer the question. **"Will discuss" and "will consider" are not appropriate answers, nor is a reference to the current contractual terms by an incumbent.** All information requested is considered important. If you have additional information you would like to provide, include it as an exhibit to your proposal. If your organization is an incumbent, please reply with a full explanation to every question since the review committee may not be familiar with the current contract or your services.

3. **Realistic** – It is the expectation of the SEBC that vendors can fully satisfy the obligations of the proposal in the manner and timeframe defined within their proposal. Proposals must be realistic and must represent the best estimate of time, materials, and other costs including the impact of inflation and any economic or other factors that are reasonably predictable. The State of Delaware shall bear no responsibility or increased obligation for a vendor's failure to accurately estimate the costs or resources required to meet the obligations defined in the proposal.

4. **Completeness of Proposal** – The proposal must be complete and comply with all aspects of the specifications. Any missing information could disqualify your proposal. Proposals must contain sufficient information to be evaluated and, therefore, must be complete and responsive. Unless noted to the contrary, we will assume that your proposal conforms to our specifications in every way. The SEBC reserves full discretion to determine the competence and responsibility, professionally, and/or financially, of vendors. Failure to respond to any request for information may result in rejection of the proposal at the sole discretion of the SEBC.

5. **Discrepancies, Revisions and Omissions in the RFP** – The vendor is fully responsible for the completeness and accuracy of their proposal and for examining this RFP and all

addenda. Failure to do so is at the sole risk of the vendor. **Should the vendor find discrepancies, omissions, unclear or ambiguous intent or meaning, or terms not appropriate to the services requested in the Scope of Services or Minimum Requirements** the vendor shall submit a notification via ProposalTech at least ten (10) business days before the proposal due date, therefore, no later than 1:00 p.m. ET, Friday, June 4, 2021, by submitting the *RFP Terms and Conditions Exception Tracking Chart*, Appendix C. This will allow for the issuance of any necessary addenda. It will also help prevent the opening of a defective proposal and exposure of the vendor's proposal upon which an award could not be made. All unresolved issues should be addressed in the proposal. (An example would be if a minimum requirement asked for a service that is outside of generally accepted industry standards for medical TPA services.)

If it becomes necessary to revise any part of the RFP, an addendum will be posted on the State of Delaware's website at www.bids.delaware.gov and in ProposalTech. The State of Delaware or SEBC is not bound by any statement related to this RFP made by any State of Delaware employee, contractor or its agents.

6. **Questions** – The SEBC anticipates this will be an interactive process and will make every reasonable effort to provide sufficient information for vendor responses. Vendors are invited to ask questions during the proposal process and to seek additional information, if needed. However, do not contact any member of the SEBC about this RFP. Communications made to other State of Delaware personnel or attempting to ask questions by phone or in person will not be allowed or recognized as valid and may disqualify the vendor. Vendors should only rely on written statements issued via ProposalTech. **All proposing vendors must submit their questions electronically via ProposalTech no later than Friday, May 14, 2021, by 1:00 p.m. ET.** The SBO will put all questions received and the responses into one document and post it on ProposalTech.

7. **Fee Proposal**

   At its sole discretion, and as it serves the best interest of the State, the State reserves the right to negotiate for an award for any pricing basis. The State is expecting your bid response to reflect your best offer for medical TPA services as there is no guarantee that a best and final offer will be requested later in this process.

B. General Terms and Conditions

1. **Intent to Bid** – **!!!IMPORTANT!!!**

   a. You must indicate your Intent to Bid via the Messaging function within ProposalTech by Friday, April 30, 2021, at 1:00 p.m. ET (local time).

   b. Your bid will not be accepted if the State of Delaware does not receive your written confirmation of an Intent to Bid. Include the following information: company name, mailing and physical address, and the name, title, and email address of the primary contact along with the same information for a secondary contact.

2. **Non-Disclosure Agreement** - A signed Non-Disclosure Agreement (NDA) is required in order to receive some of the attachments and appendices noted in the Table of Contents. The NDA will be provided to you via ProposalTech after your organization is approved as a medical TPA and submits your Intent to Bid. After indicating the data destruction term and signing the NDA, scan all the pages of the NDA and send a PDF of the executed NDA to the RFP Administrator via the Messaging function within ProposalTech.

3. **No Bid** – To assist us in obtaining competitive bids and analyzing our procurement processes, if you sign into the Questionnaire within ProposalTech and choose not to bid, we ask that you let us know the reason. We would appreciate your candor. For example: objections to (specific) terms, do not feel you can be competitive, or cannot provide all the services in the Scope of Services. Please submit your decision not to bid along with the rationale via ProposalTech.

4. **Definitions** –

    a. The following terms are used interchangeably throughout this RFP:

        i. bidder, vendor, contractor, organization, service provider

        ii. member (of the GHIP), participant (specifically enrolled or participating)

        iii. retiree, pensioner

        iv. SEBC, State of Delaware

        v. proposal, bid, vendor's submission

        vi. non-payroll group, participating group

        vii. shall, will, and/or must

        viii. Scope of Services, Scope of Work

        ix. fees, rates

        x. rates, premiums

    b. Customer Service – Services to the members/participants, not the State, SEBC or SBO personnel.

    c. Account Management – Services provided to your client - the State, SEBC and SBO personnel.

    d. Appendix – Form provided in the RFP that needs to be completed by the bidder.

    e. Attachment – Informational document provided in the RFP.

f. Exhibit – Attachment requested to the vendor's bid response. Examples would be a copy of the bidder's business license, a resume, or sample mailings.

5. **Mandatory Pre-Bid Meeting – A conference call will take place on Wednesday, May 5, 2021, at 11:00 a.m. ET (local time).**

   Your bid will not be accepted if your organization does not participate in the conference call. Topics will include general information and administrative requirements for bid preparation. The primary contact for the RFP should attend along with anyone who is primarily responsible for entering responses in ProposalTech. Only one person acting as the representative from your company is required to attend, but anyone on your team is welcome to participate. A roll call will be taken to confirm attendance.

   Meeting minutes may be taken. If new or additional information is provided, an addendum may be released to address information provided during the mandatory pre-bid conference call. Questions regarding other topics will not be entertained and must be submitted in the Questions and Answers process.

6. **Consistency of Bid Response with Finalist Interview** – A summary of each vendor finalist's bid response will be provided to the PRC in advance of the finalist interviews. In the event that you are selected as a finalist, it is imperative that you notify the State via ProposalTech of any material differences between your bid response and your finalist presentation no later than five (5) business days before the finalist meeting to ensure adequate time to notify the PRC of those changes.

7. **Best and Final Offer ("BAFO")** – The State **may or may not** request improved rates or pricing as a Best and Final Offer. Therefore, you are encouraged to submit your best pricing initially in your bid response. A BAFO may be requested of finalists.

Contract Term

The term of the contract will be for three (3) years beginning July 1, 2022 and ending June 30, 2025 (FY23, FY24 and FY25), with the exception of the Medicare Supplement and Medicare Advantage plans, which will have a three (3) year contract term beginning January 1, 2023 (FY23-FY24, FY24-FY25, FY25-FY26). The vendor must guarantee financial terms through June 30, 2025 for all plans outside of the Medicare Supplement and Medicare Advantage, which must be guaranteed through December 31, 2025. The State will have the option to renew the contract for two (2) additional one-year periods: FY26 and FY27.

Contract Termination

The term of the contract between the winning organization and the State will be for three (3) years and may be renewed for two (2) additional one (1) year extensions at the discretion of the SEBC. The contract may be terminated for convenience, without penalty, by the State with 150 days written notice. The contract may be terminated for cause by the vendor with 150 days written notice to the State. In the event the winning firm materially breaches any

obligation under this Agreement, the State may terminate this Agreement upon thirty (30) days written notice.

Performance Guarantees

The State expects exceptional client account management and participant customer service from their vendors and is interested in evaluating financial and non-financial performance guarantees. The State reserves the right to negotiate both financial and non-financial performance guarantees. ***If your offer does not receive a clarifying question or any other response from the State, it does not infer acceptance.***

Future Contract Development

It is imperative that the contract drafting and finalization process be timely and accurately reflect the minimum requirements and other applicable contractual terms in the RFP. A fee will be at risk as set forth in the Performance Guarantees if this requirement is not met.

Use of Subcontractors

Subcontractors are subject to all the terms and conditions of the RFP and the companies and their services must be clearly explained in your proposal. A subcontractor is any company that is under direct contract to perform services for the State's account. An example of a business that might provide services on the State's account, but is not a subcontractor, is the United States Postal Service. Companies that provide services through the Medical TPA, including without limitation HSA administration, direct primary care, or care navigation, are considered subcontractors. If elected by the SEBC, these services will not be contracted separately. The SEBC reserves the right to approve any and all subcontractors.

Required Reporting of Fees and 2nd Tier Spend

Monthly Vendor Usage Report - One of the State's primary goals in administering all its contracts is to keep accurate records regarding actual value/usage. This information is essential in order to update the contents of a contract and to establish proper bonding levels if they are required. The integrity of future contracts revolves around the State's ability to convey accurate and realistic information to all interested parties. For benefit programs, only administrative fees that can be identified as separate from any bundled pricing and are not employee-pay-all are reported.

A complete and accurate Usage Report shall be furnished in an Excel format and submitted electronically to the State's central procurement office at the end of each fiscal year stating the monthly administrative fees on this contract. It will be posted on the contract award page of the www.bids.delaware.gov website and therefore administrative fees are not considered confidential and proprietary. *The SBO will submit this report on your behalf.*

2nd Tier Spending Report - In accordance with Executive Order 44, the State of Delaware is committed to supporting its diverse business industry and population. The successful Vendor will be required to accurately report on the participation by subcontractors who are Diversity Suppliers which includes: minority (MBE), woman (WBE), veteran owned business (VOBE), or service

disabled veteran owned business (SDVOBE) under this awarded contract. The reported data elements shall include but not be limited to: name of state contract/project, the name of the Diversity Supplier, Diversity Supplier contact information (phone, email), type of product or service provided by the Diversity Supplier and any minority, women, veteran, or service disabled veteran certifications for the subcontractor (State OSD certification, Minority Supplier Development Council, Women's Business Enterprise Council, VetBiz.gov).

Accurate 2nd Tier Reports shall be submitted to the Office of Supplier Diversity on the 15th (or next business day) of the month following each quarterly period. For consistency, quarters shall be considered to end the last day of March, June, September and December of each calendar year. Contract spend during the covered periods shall result in a report even if the contract has expired by the report due date. *You will be asked for this information and the SBO will submit this report on your behalf.* For benefit programs, only 2nd Tier Spend fees that can be identified as separate from any bundled pricing and are not employee-pay-all are reported.

Offshore Vendor Activity

An activity central to the Scope of Services cannot take place at a physical location outside of the United States. Only support activities, including those by a subcontractor, may be performed at satellite facilities such as a foreign office or division. Failure to adhere to this requirement is cause for elimination from future consideration.

Rights of the PRC

- The PRC reserves the right to:
  - Select for contract or negotiations a proposal other than that with lowest costs.
  - Reject any and all proposals received in response to this RFP.
  - Make no award or issue a new RFP.
  - Waive or modify any information, irregularity, or inconsistency in a proposal received.
  - Request modification to proposals from any or all vendors during the review and negotiation.
  - Negotiate any aspect of the proposals with any organization.
  - Negotiate with more than one organization at the same time.
  - Pursuant to 29 Del. C. § 6986, select more than one contractor/vendor to perform the applicable services.

- Right of Negotiation – Discussions and negotiations regarding price, performance guarantees, and other matters may be conducted with organizations(s) who submit proposals determined to be reasonably acceptable of being selected for award, but proposals may be accepted without such discussions. The PRC reserves the right to further clarify and/or negotiate with the proposing organizations following completion of the evaluation of proposals but prior to contract execution, if deemed necessary by the PRC and/or the SEBC. ***If any portion of a bid response does not receive a clarifying question or any other response from the State, the non-response does not infer acceptance of that***

portion of the bid response by the State. The SEBC also reserves the right to move to other proposing firms if negotiations do not lead to a final contract with the initially selected proposing firm. The PRC and/or the SEBC reserves the right to further clarify and/or negotiate with the proposing firm(s) on any matter submitted.

- Right to Consider Historical Information – The PRC and/or the SEBC reserves the right to consider historical information regarding the proposing firm, whether gained from the proposing firm's proposal, question and answer conferences, references, or any other source during the evaluation process.

- Right to Reject, Cancel and/or Re-Bid – The PRC and/or the SEBC specifically reserve the right to reject any or all proposals received in response to the RFP, cancel the RFP in its entirety, or re-bid the services requested. The State makes no commitments, expressed or implied, that this process will result in a business transaction with any vendor.

C. Submission of Proposal

1. **General Directions for Electronic Submission** –

   The RFP process is being conducted electronically using the Proposal Technologies Network, Inc. (ProposalTech) application. The official proposal submission process is via ProposalTech.

   For any organization that may be unfamiliar with this Web-based tool, ProposalTech representatives will schedule training sessions at your convenience. In advance of the accessing the electronic Questionnaire on the ProposalTech website, you may view an online training demo of the system and its functionality. This demo takes approximately five minutes and will improve your understanding of the system's functionality. Click on the link below to view the flash demo:
   http://www.proposaltech.com/help/docs/response_training_798x599.htm

   If you have any questions regarding the registration process or have technical questions specific to ProposalTech, contact ProposalTech Support at (877) 211-8316 x84.

2. **Accessing the electronic Questionnaire** – vendors must first take the following actions:

   In order to register for the Questionnaire go to
   http://www.proposaltech.com/home/app.php/register.

   Enter your email address into the field provided. No registration code is necessary. Click "Begin Registration." If you already have an account with ProposalTech, it will be listed on the registration page. If you do not, you will be asked to provide company information. Once your account has been confirmed, check the appropriate box for the State of Delaware Medical TPA RFP and click the "Register" button. If approved by the State as a valid medical TPA, an invitation will be emailed to you within fifteen

minutes. If you have any questions regarding the registration process, contact ProposalTech Support at 877-211-8316 x84.

The primary contact should access the website to initiate review and acceptance of the Questionnaire as noted above. Primary contacts will be responsible for establishing permission to access the Questionnaire for other individuals within their organizations. Multiple users from your organization may access the Questionnaire simultaneously.

Detailed instructions for the completion and submission of your Questionnaire responses will be found in the eRFP. ProposalTech will be available to assist you with technical aspects of utilizing the system.

If you would like to schedule a ProposalTech training session please contact ProposalTech at (877) 211-8316, choose option 4, or send an email to support@proposaltech.com.

3. **Attachments and Appendices –**

   As listed in the Table of Contents, some of the attachments and appendices require a Non-Disclosure Agreement (NDA). The NDA will be provided to you after your organization is approved as a Medical TPA and submits your Intent to Bid (see Section I.B.1 for instructions on submitting your Intent to Bid).

4. **Confidential Information, Generally –**

   Confidential and proprietary information identified in the attorney's letter and redacted from the vendor's proposal will be treated as confidential during the evaluation process.

5. **Directions for Confidential and Proprietary Submission, <u>if any</u> –**

   See the **Confidentiality of Documents** section.

6. **Directions for the Redacted Electronic Copy, <u>if applicable</u> –**

   a. Any information you deem confidential and proprietary as identified in the attorney's letter must be redacted. The State is not responsible for incorrect redactions or reviewing your submission to determine whether or not the information asserted as confidential and proprietary is redacted. Mistakes in redactions are the sole responsibility of the bidder.

   b. <u>PDF</u> - A *complete* electronic copy of your entire redacted RFP response is needed in a PDF format; please do not submit only the pages that require redaction. ProposalTech has functionality that allows you to download a PDF copy of your entire proposal so you can redact any confidential and proprietary information. If you have any questions regarding how to download a copy of your entire proposal,

please contact ProposalTech Support at 877-211-8316 x84. You must include all the documents as directed above in the *General Directions for Electronic Copies* above. For large sections or appendices, please include a sheet that identifies the material, not pages of black redactions. For example, "Appendix C – *Disaster Recovery Plan* – is confidential and proprietary and is not public record as defined by FOIA at 29 Del. C. § 10002(d)".

7. **Follow-Up Responses and Finalist Presentations**

   a. The same format requirements apply to follow-up responses and presentation materials. **If information in any of the follow-ups and presentation matches the type that was requested for a confidential and proprietary determination, you must upload a redacted electronic version of the document(s).**

   b. Finalist Presentation – You will be asked for a non-redacted electronic copy that includes PDFs of any supplemental materials or handouts to be uploaded via ProposalTech.

   c. If there is a new type of information that was not included in your original bid and you deem it confidential and proprietary, you must submit an additional required attorney's letter and upload via ProposalTech.

8. **Proposal Submission Date –** Your complete proposal must be submitted via ProposalTech no later than **1:00 p.m. ET on Friday, June 18, 2021**. Any proposal received after this date and time shall not be considered.

9. **Proposal Opening –** To document compliance with the deadline, the proposals will be date and time stamped upon submission via ProposalTech. Proposals will be opened only in the presence of State of Delaware personnel or their designee. There will be no public opening of proposals, but a public log will be kept of the names of all vendor organizations that submitted proposals and the list will be posted on www.bids.delaware.gov. Proposals become the property of the State of Delaware at the proposal submission deadline. The contents of any proposal shall not be disclosed or made available to competing entities during the negotiation process.

10. **Officer Certification** – All vendors participating in this RFP will be required to have a company officer attest to compliance with RFP specifications and the accuracy of all responses provided. You will be required to fill out an *Officer Certification Form* and include it in your bid package.

11. **Vendor Errors/Omissions** – The SEBC will not be responsible for errors or omissions made in your proposal. You will be permitted to submit only one proposal. You may not revise submitted proposals or information after the applicable deadline.

12. **Modifications to Submitted Proposal** – Changes, amendments or modifications to proposals shall not be accepted or considered after the time and date specified as the deadline for submission of proposals.

13. **General Modifications to RFP** – The SEBC reserves the right to issue amendments or change the timelines to this RFP. All firms who registered to respond to the Questionnaire will be notified via ProposalTech of any modifications made by the SEBC to this RFP, where applicable. If it becomes necessary to revise any part of the RFP, a notification of addendum will be emailed to all vendors via ProposalTech who registered to respond and it will also be posted on the State of Delaware's website at www.bids.delaware.gov.

14. **Proposal Clarification** – The SEBC may contact any vendor in order to clarify uncertainties or eliminate confusion concerning the contents of a proposal. Clarifications (known as "follow-ups") will be requested in writing via ProposalTech and the vendor's responses will become part of the proposal.

15. **References** – The SEBC may contact any customer of the vendor, whether or not included in the vendor's reference list, and use such information in the evaluation process. Additionally, if applicable to the scope of work or services in this RFP, the State of Delaware may choose to visit existing installations of comparable systems, which may or may not include vendor personnel. If the vendor is involved in such site visits, the State of Delaware will pay travel costs only for the State of Delaware personnel for these visits. Please note that the consulting firm Willis Towers Watson will be contacting references provided by bidders in response to this RFP on the SEBC's behalf.

16. **Time for Acceptance of Proposal –** The bidder agrees to be bound by its proposal for a period of at least 180 days, during which time the State may request clarification or corrections of the proposal for the purpose of the evaluation. The State reserves the right to ask for an extension of time if needed.

17. **Incurred Costs** – This RFP does not commit the SEBC to pay any costs incurred in the preparation of a proposal in response to this request and vendor/bidder agrees that all costs incurred in developing its proposal are the vendor/bidder's responsibility. The State shall bear no responsibility or increased obligation for a vendor's failure to accurately estimate the costs or resources required to meet the obligations defined in the proposal.

18. **Basis of Cost Proposal** – Your proposal must be based on your estimated cost of all expenses for the services and funding arrangements requested.

19. **Certification of Independent Price Determination** – By submission of a proposal, the proposing firm certifies that the pricing guarantees or fees submitted in response to the RFP have been arrived at independently and without – for the purpose of restricting competition – any consultation, communication, or agreement with any other proposing firm or competitor relating to those premium rates or fees, the intention to submit a proposal, or the methods or factors used to calculate the fees or premium rates proposed. You will be required to submit a *Non-Collusion Statement* and include it in your bid package via ProposalTech.

20. **Improper Consideration** – Bidder shall not offer (either directly or through an intermediary) any improper consideration such as, but not limited to, cash, discounts, service, the provision of travel or entertainment, or any items of value to any officer, employee, group of employees, retirees or agent of the SEBC in an attempt to secure favorable treatment or consideration regarding the award of this proposal.

21. **Representation Regarding Contingent Fees** – If it is your business practice to engage services from any person or agency to secure or execute any of the services outlined in this RFP, any commissions and percentage, contingent, brokerage, service, or finder's fees must be included in your proposed rates. The SEBC will not pay any separate brokerage fees for securing or executing any of the services outlined in this RFP. **Therefore, all proposed fees must be net of commissions and percentage, contingent, brokerage, service or finders' fees.**

22. **Confidentiality** – All information you receive pursuant to this RFP is confidential and you may not use it for any other purpose other than preparation of your proposal.

23. **Solicitation of State Employees** – Until contract award, vendors shall not, directly or indirectly, solicit any employee of the State of Delaware to leave the State's employ in order to accept employment with the vendor, its affiliates, actual or prospective contractors, or any person acting in concert with the vendor, without prior written approval of the State's contracting officer. Solicitation of State of Delaware employees by a vendor may result in rejection of the vendor's proposal.

    This paragraph does not prevent the employment by a vendor of a State of Delaware employee who has initiated contact with the vendor. However, State of Delaware employees may be legally prohibited from accepting employment with the contractor or subcontractor under certain circumstances. Vendors may not knowingly employ a person who cannot legally accept employment under state or federal law. If a vendor discovers that they have done so, they must terminate that employment immediately.

24. **Consultants and Legal Counsel** – The SEBC may retain consultants or legal counsel to assist in the review and evaluation of this RFP and the vendors' responses. Bidders shall not contact the consultant or legal counsel on any matter related to this RFP unless written permission and direction is provided.

25. **Contact with State Employees** – Unless expressly requested to contact another State employee or the SBO's consulting firm, direct contact with State of Delaware employees regarding this RFP other than the designated contact, Ms. Laurene Eheman, is expressly prohibited without prior consent. Ms. Eheman's contact information is 302-760-7060 and via email at laurene.eheman@delaware.gov. You are authorized to contact the SEBC's consulting firm, Willis Towers Watson, through Proposal Tech. Vendors directly contacting State of Delaware employees risk elimination of their proposal from further consideration. Exceptions exist only for organizations currently doing business with the State who require contact in the normal course of doing that business.

26. **Organizations Ineligible to Bid** – Any individual, business, organization, corporation, consortium, partnership, joint venture, or any other entity including subcontractors currently debarred or suspended is ineligible to bid. Any entity ineligible to conduct business in the State of Delaware for any reason is ineligible to respond to the RFP.

27. **Exclusions** – The PRC reserves the right to refuse to consider any proposal from a vendor who:

    a. Has been convicted for commission of a criminal offense as an incident to obtaining or attempting to obtain a public or private contract or subcontract, or in the performance of the contract or subcontract;

    b. Has been convicted under State or Federal statutes of embezzlement, theft, forgery, bribery, falsification or destruction of records, receiving stolen property, or other offense indicating a lack of business integrity or business honesty that currently and seriously affects responsibility as a State contractor;

    c. Has been convicted or has had a civil judgment entered for a violation under State or Federal antitrust statutes;

    d. Has violated contract provisions such as:

        i. Knowing failure without good cause to perform in accordance with the specifications or within the time limit provided in the contract; or

        ii. Failure to perform or unsatisfactory performance in accordance with terms of one or more contracts;

        iii. Has violated ethical standards set out in law or regulation; and

        iv. Any other cause listed in regulations of the State of Delaware determined to be serious and compelling as to affect responsibility as a State contractor, including suspension or debarment by another governmental entity for a cause listed in the regulations.

State of Delaware
Department of Human Resources
Statewide Benefits Office

STATE EMPLOYEE BENEFITS COMMITTEE

Request for Proposal for Medical Third-Party Administration (TPA) Services

RFP Release Date – April 26, 2021

AMENDMENT #1 – 05/18/21

Proposals Due –
~~Friday, June 18, 2021 by 1:00 PM ET~~
Friday, June 25, 2021 by 1:00 PM ET

DHR2201-Med_TPA

97 Commerce Way, Suite 201 • Dover, DE 19904
Phone: (800) 489-8933 Fax: (302) 739-8339 www.de.gov/statewidebenefits

REVISED:

	Original Due Date	**REVISED Due Date**
Questions due to SBO from Confirmed Bidders	By Friday, May 14, 2021, 1:00 p.m.	By Friday, **May 21**, 2021, 1:00 p.m.
Responses to Questions to Confirmed Vendors	By Friday, May 28, 2021, 5:00 p.m.	By Friday, **June 4**, 2021, 5:00 p.m.
Deadline for Bids	By Friday, June 18, 2021, 1:00 p.m.	By Friday, **June 25**, 2021, 1:00 p.m.

SUPPLEMENTING the List in the Table of Contents, Introduction Document, Page 2:
Appendix R: Medical ASO – Fee Quotes, and, Network Provider Discounts
Appendix S: Fully-Insured Medicare Advantage Plan Quotes

ADDED Appendix T – MAPD Rx Disruption Worksheets:
Completion of this appendix is required for any bidder that is submitting a proposal for a Medicare Advantage plan with Part D Drug Coverage (MAPD). Appendix requires the bidder to provide data on the prescription drug formulary and retail pharmacy network that are included in the bidder's MAPD proposal.

ADDED Attachment 9 – State of Delaware Health Care Legislation:
Provides list of all bills related to health care that have either been signed into law by the Governor of the State of Delaware over the last six years or have been introduced during the 151st General Assembly during the current legislative session (7/1/2020 – 6/30/2022). Bidders must comply with any signed bills. It is the responsibility of the bidders to follow any legislation that is introduced and passed during the current legislative session (151st General Assembly) and which impacts and/or applies to the State Group Health Insurance Plan and ensure full compliance as required in the final bill.

ADDED Attachment 10 – GHIP Claims and Enrollment Summary:
Provides a summary of publicly available data on GHIP paid claims and average enrollment (employees/retirees and members) by quarter, for the eight (8) quarters from FY19 Q3 (01/01/2019) to FY21 Q2 (12/31/2020).

ADDED Attachment 11 – Medicfill Rx Claims 01.01.2020 – 12.31.2020 (NDA REQUIRED):
Contains prescription drug claims for the Highmark Special Medicfill Medicare Supplement plan. Data time period reflects claims incurred January 1, 2020 through December 31, 2020 and paid from January 1, 2020 through March 31, 2021. Requires signed NDA from bidder.

EXHIBIT B

AGENDA
STATE EMPLOYEE BENEFITS COMMITTEE MEETING
May 10, 2021 – 2:00pm

In accordance with the Proclamation Authorizing Public Bodies to Meet Electronically, "in the interests of protecting the citizens of this state from the public health threat caused by COVID-19," this meeting will be held via WebEx, without a physical location. Members of the public may participate using the information provided. Meeting materials will be posted in advance on the Public Meeting Calendar and the SEBC Meeting Materials page.

https://www.webex.com/
Meeting Number (access code): 135 243 7580 Meeting Password: SEBC
or Join by Phone Toll Free: 1-866-205-5379

1. Call to Order
2. Approval of April 19, 2021 SEBC meeting minutes*
3. Director's Report/Subcommittee/Legislative Updates
4. Financials
    a. FY21 Q3 Financial Reporting
    b. COVID-19 Cost Reporting
    c. GHIP Long Term Projection Recast
5. Medical Third-Party Administration (TPA) Services Request for Proposal Overview
6. Other Business
7. Public Comment
8. Adjournment

Visit the SEBC website at dhr.delaware.gov/benefits/sebc for further details. Meeting materials are posted after each meeting.

***Agenda items may require action and approval by the Committee.**
The Committee may move into Executive Session for the purpose of discussing confidential financial information and trade secrets or the content of documents excluded from the public record pursuant to 29 Del.C. §10004(b)(6), and to receive legal advice pursuant to 29 Del.C. §10004(b)(4) relating to pending or potential litigation. The Committee may move into Executive Session for one or more of these reasons.

REVISED AGENDA
STATE EMPLOYEE BENEFITS COMMITTEE MEETING
November 8, 2021 – 2:00 pm

Until further notice, in the interests of protecting the citizens of this State from the public health threat caused by COVID-19, all State Employee Benefits Committee meetings will continue to be conducted via Webex without a physical location. Members of the public may participate virtually or by phone using the information provided. Meeting materials will be posted in advance on the Public Meeting Calendar and the SEBC Meeting Materials page.

https://www.webex.com/
Meeting number (access code): 135 230 4808 Meeting Password: SEBC
or Join by Phone Toll Free: 1-866-205-5379

1. Call to Order
2. Approval of October 11, 2021 SEBC meeting minutes*
3. Director's Report/Subcommittee/Legislative Updates
4. Financials
    a. September 2021 Fund Report
    b. FY23 GHIP Projections
5. FY23 Planning – Plan Design Considerations
6. Health Third Party Administration RFP Contract Award Recommendation*
7. Other Business
8. Public Comment
9. Executive Session
    a. Health Appeal
    b. Healthcare Contracting pursuant to 29 Del. C. § 10004(b)(6) to discuss the content of documents excluded from the public record under 29 Del C. § 10004(l)(2) (Trade secrets and commercial or financial information obtained from a person of a privileged or confidential nature).
10. Adjournment

Visit the SEBC website at dhr.delaware.gov/benefits/sebc for further details. Meeting materials are posted after each meeting.

***Agenda items may require action and approval by the Committee.**
The Committee may move into Executive Session for the purpose of discussing confidential financial information and trade secrets or the content of documents excluded from the public record pursuant to 29 Del.C. §10004(b)(6), and to receive legal advice pursuant to 29 Del.C. §10004(b)(4) relating to pending or potential litigation. The Committee may move into Executive Session for one or more of these reasons.

REVISED AGENDA
STATE EMPLOYEE BENEFITS COMMITTEE MEETING
December 13, 2021 – 2:00 pm

Until further notice, in the interests of protecting the citizens of this State from the public health threat caused by COVID-19, all State Employee Benefits Committee meetings will continue to be conducted via Webex without a physical location. Members of the public may participate virtually or by phone using the information provided. Meeting materials will be posted in advance on the Public Meeting Calendar and the SEBC Meeting Materials page.

https://www.webex.com/
Meeting number (access code): 135 793 4564 Meeting Password: SEBC
or Join by Phone Toll Free: 1-866-205-5379

1. Call to Order
2. Approval of November 8, 2021 SEBC meeting minutes*
3. Director's Report/Subcommittee/Legislative Updates
4. Health Third Party Administration RFP Contract Award Recommendation*
5. Financials
    a. October 2021 Fund Report
    b. FY22 Qtr 1 Financial Reporting
    c. FY23 GHIP Projections
    d. FY21 Utilization Update
6. FY23 Planning – Plan Design Considerations*
7. CVS Implementation Updates
8. Retirement Benefits Study Committee Update
9. Other Business
10. Executive Session
    a. Health Appeal*
11. Public Comment
12. Adjournment

Visit the SEBC website at dhr.delaware.gov/benefits/sebc for further details. Meeting materials are posted after each meeting.

***Agenda items may require action and approval by the Committee.**
The Committee may move into Executive Session for the purpose of discussing confidential financial information and trade secrets or the content of documents excluded from the public record pursuant to 29 Del.C. §10004(b)(6), and to receive legal advice pursuant to 29 Del.C. §10004(b)(4) relating to pending or potential litigation. The Committee may move into Executive Session for one or more of these reasons.

EXHIBIT C

MINUTES FROM THE MEETING OF THE STATE EMPLOYEE BENEFITS COMMITTEE
December 13, 2021

The State Employee Benefits Committee (the "Committee") met at 2:00 p.m. on December 13, 2021. 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.

Committee Members Represented or in Attendance:

Director Cerron Cade, Office of Management & Budget ("OMB"), SEBC Co-Chair and Ms. Judi Schock, Deputy Principal Assistant, (OBO Director Cade)
Acting Secretary Jessilene Corbett, Department of Human Resources ("DHR"), Acting Co-Chair
The Honorable Colleen Davis, State Treasurer, Office of the State Treasurer ("OST")
The Honorable Chief Justice Collins Seitz, Delaware Supreme Court
Controller General Ruth Ann Jones, Office of the Controller General ("OCG")
Secretary Molly Magarik, Department of Health & Social Services ("DHSS")
Mr. Stuart Snyder, Chief of Staff, Department of Insurance ("DOI") (OBO The Honorable Trinidad Navarro, Insurance Commissioner)
Mr. Jeff Taschner, Executive Director, Delaware State Education Association ("DSEA") (Appointee of The Honorable John Carney, Governor)
Mr. Keith Warren, Chief of Staff, Office of the Lieutenant Governor (OBO The Honorable Bethany Hall-Long, Lieutenant Governor)

Others in Attendance

Director Faith Rentz, Statewide Benefits Office ("SBO"), DHR
Deputy Director Leighann Hinkle, SBO, DHR
Deputy Attorney General Adria Martinelli, Dept. of Justice, SEBC Legal Counsel
Mr. Chris Giovannello, Willis Towers Watson ("WTW")
Mr. Marc Gutstein, WTW
Ms. Jaclyn Iglesias, WTW
Ms. Rebecca Warnken, WTW
Ms. Joanna Adams, Pension Administrator, Office of Pensions ("OPen")
Ms. Judy Anderson, DSEA
Ms. Wendy Beck, Highmark Delaware
Ms. Jennifer Bredemeier, University of Delaware
Ms. Rebecca Byrd, ByrdGomes
Ms. Julie Caynor, Aetna
Ms. Marian Coker, Information Resource Specialist, Department of State
Mr. Steven Costantino, Dir. Healthcare Reform, DHSS
Ms. Cherie Dodge Biron, Deputy Principal Asst., DHR
Ms. Sara Dunlevy, CVS Health
Mr. John Ficaro, Aetna
Ms. Nina Figueroa, Health Policy Advisor, DHR, SBO
Ms. Jacqueline Faulcon, READAA
Ms. Julie Greenwood, University of Delaware
Ms. Jeanette Hammon, Sr. Fiscal Policy Analyst, OMB
Ms. Sandy Hart, IBM Watson Health
Ms. Charlene Hrivnak, CVS Health
Ms. Katherine Impellizzeri, Aetna
Ms. Heather Johnson, Controller, DHR
Mr. Jamie Johnstone, Deputy Principal Assistant, Dept. of Finance ("DOF")
Mr. Adam Knox, Highmark Delaware
Ms. Lizzie Lewis, Hamilton Goodman Partners
Mr. Dan Madrid, Chief Operating Officer, OST
Ms. Lisa Mantegna, Highmark Delaware
Mr. Walt Mateja, IBM Watson Health
Mr. Sean McNeeley, Director of Bond Finance, DOF
Ms. Carole Mick, Administrative Specialist, DHR, SBO
Ms. Alexis Miller, Highmark
Mr. Paul Miller, BeneCare
Mr. Nick Moriello, Highmark
Ms. Kathy Nedelka, PHRST

Mr. Michael North, Aetna
Ms. Louisa Phillips, Delaware Healthcare Association
Ms. Paula Roy, Roy Associates
Ms. Elizabeth Sampo, Aetna
Ms. Carrie Schiavo, Delta Dental
Mr. Robert Scoglietti, Deputy Controller General, OCG
Mr. Charles Simons, Highmark Delaware
Ms. Martha Sturtevant, Exec. Sec., SBO, DHR – Recorder
Ms. Ashley Tucker, Deputy State Court Administrator, Admin Office of the Courts
Ms. Elizabeth Vogelsong, BeneCare

CALLED TO ORDER
Director Rentz called the meeting to order at 2:00 p.m.

APPROVAL OF MINUTES – DIRECTOR FAITH RENTZ, DHR, SBO
A MOTION was made by Mr. Taschner and seconded by Controller General Jones to approve the minutes from the November 8, 2021, meeting of the State Employee Benefits Committee.
MOTION ADOPTED UNANIMOUSLY

DIRECTOR'S REPORT – DIRECTOR FAITH RENTZ, DHR, SBO
Proposal Review Committee Updates
The PRC was scheduled to make a formal recommendation to the Committee for the award of the Dental Plan Third Party Administrator ("TPA") Request for Proposal ("RFP"); however, the PRC has not concluded its work. The PRC is expected to present its recommendation on January 24, 2022.

HEALTH TPA RFP CONTRACT AWARD RECOMMENDATIONS – MS. JACLYN IGLESIAS, WTW
There was a recap of the Medical TPA RFP recommendation from the Proposal Review Committee ("PRC"):

The PRC recommends continued evaluation of these Medicare plan options following the recommendations from the Retirement Benefits Study Committee (released on November 1, 2021), with no immediate contract award of a Medicare product at this time. A decision on the administration of a Medicare plan for CY23 should be made no later than March 31, 2022, to provide sufficient time for implementation and communication of that plan option before the current Special Medicfill Medicare Supplement plan contract terminates on December 31, 2022. If the Committee elects to offer the Special Medicfill Medicare Supplement plan beyond December 31, 2022, the Committee could award the contract to Highmark Delaware based on the scoring results by the PRC.

Secretary Magarik joined the meeting.

The PRC recommends a contract award of the HMO and CDH Gold plans to Aetna for an initial three-year term effective July 1, 2022, through June 30, 2025, with two optional one-year period extensions. Such award shall be subject to the approval of the Department of Technology and Information and Department of Insurance and a finalized contract which shall include performance guarantees.

The PRC recommends a contract award of the Comprehensive PPO and First State Basic plans to Highmark Delaware for an initial three-year term effective July 1, 2022, through June 30, 2025, with two optional one-year period extensions. Such award shall be subject to the approval of the Department of Technology and Information and Department of Insurance and a finalized contract which shall include performance guarantees.

The PRC recommends continued evaluation and discussion by both the Financial and Health Policy & Planning Subcommittees, with recommendations brought to the SEBC in February 2022, for the disease and care management options for each vendor, the type of HMO plan for Aetna, and a recommendation on the Everside Health primary care model for the Aetna CDH Gold and HMO plans.

A MOTION was made by Treasurer Davis and seconded by Acting Secretary, Dr. Corbett to award the Medical Third-Party Administrator Request for Proposal to Highmark Delaware and Aetna as recommended by the Proposal Review Committee for an effective contract date of July 1, 2022.
1 Abstention – Mr. Stuart Snyder
MOTION ADOPTED

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.

FY22 Q1 UPDATE and FY23 GHIP PROJECTIONS – MR. GIOVANNELLO, WTW

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 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.

The projected FY23 budget has been revised down $15.2M to $963.7M driven by claims experience and builds in the PRC award recommendation for Medical TPA RFP and the Subcommittee recommendations most likely to be adopted by the Committee: 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.

The latest FY23 projected deficit 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.

Mr. Taschner queried what the amount of rate action would be needed in FY23 and FY24 if starting with 12.2% in FY23 and the target remained the same for FY25. Mr. Giovannello estimated a rate increase that coincides with the trend: 5-7%.

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.

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.

FY21 UTILIZATION UPDATE – MR. CHRIS GIOVANELLO, WTW

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. The impact of the pandemic on the GHIP in FY22 and beyond remains largely unknown and will depend on many factors including the level of care deferral, ongoing vaccination costs, change in service mix (e.g., sustained shift to virtual care), the downstream impacts from missed preventive visits, compounding mental health issues, and unknown health needs of COVID-19 survivors, and a potential new wave of infection.

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.

Emergency room utilization remains below the baseline period for most top conditions.

Outpatient mental health visits increased 11.4% above baseline which may be attributable to increased access. Substance abuse visits have been below baseline levels in all quarters except FY21 Q1 and in the most recent quarter, down 31.0% when compared to the baseline period.

Inpatient mental health admissions have been below baseline; in the most recent quarter, admissions were 17.4% below baseline. Inpatient substance abuse admissions increased by 90.4% from FY20 Q4 to FY21 Q4.

Admissions for substance abuse during FY22 Q1 were 24.3% above baseline. Increased utilization of outpatient mental health services, including virtual behavioral health visits, likely contributing to a reduction in inpatient admissions.

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, except for the insertion of a stent for a blocked artery in the heart during FY21 Q1 & Q4. Elective procedures remain below baseline.

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

When reviewing the top 5 non-emergent diagnoses in emergency rooms compared to their costs in urgent care, there was $2.6M in potential cost avoidance.

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.

Secretary Magarik noted the challenge of communicating to members so that they understand their choices, stay healthy, and save costs. She advocated for additional support as needed for the Statewide Benefits Office.

FY23 PLANNING CONSIDERATIONS – MS. JACLYN IGLESIAS, WTW

The Committee reviewed several FY23 savings opportunities recently reviewed by the Subcommittees that aim to reduce the anticipated FY23 premium rate increase needed to solve the projected deficit.

Savings opportunities can come from but are not limited to, Medical TPA RFP initiatives, plan design changes for active/pre-65 and Medicfill programs, adoption of proposed CVS Health pharmacy programs, and adoption of mandatory bariatric carve-out and incentive modifications with SurgeryPlus.

The following three opportunities have been recommended by the Subcommittees for further evaluation and consideration by the Committees:

- Reinstating copays for telehealth utilization in the commercial population would yield an estimated cost avoidance of $4.0M that would result in a 0.5% reduction to the required premium rate increase. Additional discussion is needed regarding the treatment of behavioral health telemedicine visit copays with community providers, which have $15 and $20 copays in the HMO and PPO plans respectively. Maintaining $0 copays for behavioral health virtual visits with community providers would reduce the cost avoidance to $2M for FY23.

- The CVS Drug Savings Review program reviews prescription utilization to ensure that the prescription and dosage follow evidence-based medical guidelines. The cost avoidance 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 the net cost avoidance is estimated at $1.9M 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.

These recommendations have been built into the revised projections.

Additional savings opportunities that the Subcommittees would like to consider further before making a recommendation include:

- 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 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 which would result in a reduction of 0.1% to the required premium rate increase.

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.

There was no motion made from the Committee on the recommendations as presented.

CVS IMPLEMENTATION UPDATE – DIRECTOR RENTZ, DHR, SBO

The commercial population transitioned to CVS Health for pharmacy benefits on July 1, 2021. The transition has been smooth overall with 411,849 total prescription claims filled for 101,055 members.

Director Cade joined the meeting.

All performance guarantees have been met or exceeded by CVS Caremark. Member satisfaction is at 2% over the member service target of 90%.

SBO is working through escalated member transition issues on a case-by-case basis to reach a resolution. Calls into CVS Customer Care continue to decrease; there have been 14,285 total calls since implementation, with an average of 2.5 seconds to answer each call.

The primary reasons for calls into CVS Customer Care pertain to denial of claims and prior authorizations. Appeal denials have not been higher than 0.05% of paid claims. Denials represented 0.69% of all claims in July and have steadily decreased to 0.3% of all claims in October.

A member who is receiving a denial pertaining to a prior authorization is primarily a result of timeframes built into the plan design to ensure that members are monitored and taking the most appropriate medications for their condition and/or diagnosis.

Another pain-point for members has been related to prescriptions written by providers to be dispensed as written ("DAW"). If the medication is not listed on the CVS formulary, or if there is a generic equivalent of the medication, and no prior written support has been submitted indicating why that member requires the brand medication, the Choice Program applies. Through the Choice Program, the member will receive a penalty at the point-of-sale by paying a non-preferred copay plus the difference between the cost of the generic and the brand medication. However, this represents 0.27% of claims and continues to decrease as members transition to generic medications as the plan intends.

SBO meets with CVS monthly to review key utilization metrics. Of the 101,055 eligible members per month, the average utilization of members is 36.7% for a total gross cost of $69.0M with the GHIP paying $64.9M, for a member cost-share of 5.9%.

The generic dispensing rate is 77.7% and the generic substitution rate is 97.5%. More outreach is needed to educate members and providers on available generic substitution.

Through November, specialty medications represent $27.0M and 39.4% of the GHIP's total gross costs, but only 1.2% of total prescriptions. For the members who are paying for specialty medications, their cost-share is 1.0%.

The formulary is not managed by the GHIP and therefore is not managed by the Committee. The formulary is evaluated regularly and varies across PBMs.

Effective utilization management strategy is key for cost containment and quality oversight. The Pharmacy Benefit Manager ("PBM") monitors marketplace trends to ensure member access to clinically appropriate and cost-effective medications.

The PBM contract includes utilization management where prior authorization may be required (e.g., step therapy, member education, Diabetic One copay program, and the Choice Program) when lower-cost generic/brand medications are available, when the medication is known to have side effects and/or be misused, or when additional steps (e.g., testing) are needed to ensure the medication will be effective.

There was a review of prior authorization trends by month for approved and denied claims by specialty and non-specialty formulary and clinical medications. July was the highest denial month with 0.69% and trended downward to 0.33% in November as members learn to use their benefits.

Members who wish to appeal a prescription claim denial have two levels of appeals with CVS Health, one with the SBO, and a final appeal option to the Committee. Level one and two appeals to CVS peaked in August with a sharp decline in September that continued through November.

In the first five months of the contract, there were 930 claims where members were charged a copay as part of the Choice program to fill DAW prescriptions where a generic equivalent was available. In most cases the pharmacy will contact the provider, at the member's request, with a generic option; however, there are some instances where members choose to pay the penalty.

Penalties for DAW prescriptions have decreased each month, but SBO is working with CVS to identify members for additional education and outreach regarding available options to eliminate that penalty.

SBO will continue to serve as the point of contact for escalated issues. Where appropriate, SBO and CVS are applying lessons learned to the EGWP Medicare implementation. SBO will continue to communicate and provide regular updates.

RETIREMENT BENEFIT STUDY UPDATE – DIRECTOR RENTZ, DHR, SBO

Committee members reviewed the Retirement Benefits Study Committee ("RBSC") report delivered at the RBSC meeting on November 29, 2021. The meeting focused on the 2021 OPEB actuarial valuation and the corresponding updates to funding, eligibility, and benefit options previously presented. The updates did not include savings projections associated with the Committee's adoption of any Medicare Advantage program pending the award of the Health TPA RFP.

The RBSC and the Committee's PRC recommend that the Committee continue to review plan options and Medicare exchange options for the Medicare population.

The recommendation is for a decision on the administration of a Medicare Plan for CY23 be made not later than March 2022 to allow sufficient time for implementation and communication of that plan option before the current Special Medicfill Medicare Supplement plan contract terminates on December 31, 2022.

If the Committee elects to offer the Special Medicfill Medicare Supplement plan beyond December 31, 2022, the Committee could award the contract to Highmark Delaware or Aetna based on the scoring results by the PRC.

Both finalists were qualified to administer both a Special Medicfill Medicare Supplement plan and a group Medicare Advantage product to the Medicare pensioner population, with Highmark Delaware's Medicare Advantage product being slightly more favorable than Aetna's product based on the results of the scoring.

Further consideration and evaluation will be delegated to the Subcommittees.

OTHER BUSINESS

No new business was presented.

PUBLIC COMMENT
The public did not present further comment.

EXECUTIVE SESSION
A MOTION was made by Secretary Magarik and seconded by Mr. Taschner to move into Executive Session at 3:56 p.m.
MOTION ADOPTED UNANIMOUSLY

ADJOURNMENT
A MOTION was made by Mr. Taschner and seconded by Dr. Corbett to adjourn the meeting at 4:27 p.m.
MOTION ADOPTED UNANIMOUSLY

Respectfully submitted,

_____
Martha Sturtevant, Executive Secretary, Statewide Benefits Office, Department of Human Resources
Recorder, State Employee Benefits Committee, and Subcommittees

State of Delaware
DEPARTMENT OF HUMAN RESOURCES

December 17, 2021

via e-mail

Ms. Wendy Beck, Executive Client Manager
Highmark Delaware
800 Delaware Avenue
Wilmington, DE 19801

Re: Request for Proposal for a Medical Third Party Administrator for the Group Health Insurance Program (GHIP)

Dear Ms. Beck:

On December 13, 2021, pursuant to the terms listed in the Request for Proposal (RFP) and based on the recommendation of the Proposal Review Committee, the State Employees Benefits Committee (SEBC) voted in favor of awarding the medical benefit administrative services for the GHIP contracts effective July 1, 2022 as follows:

1. Award contract to Highmark Delaware effective July 1, 2022 with an initial term of three years with two one-year optional renewals subject to finalized contract for administration of the following health plans on a self-insured basis:
    - First State Basic Plan, and
    - Comprehensive PPO Plan
2. Contract award to Aetna effective July 1, 2022 with an initial term of three years with two one-year optional renewals subject to finalized contract for administration of the following health plans on a self-insured basis:
    - Consumer Directed Health Plan with HRA, and
    - HMO Plan

The awards are subject to approval of the Department of Technology and Information and Department of Insurance and a finalized contract which shall include performance guarantees.

There will be continued evaluation and discussion by both the Financial and Health Policy & Planning Subcommittees, with recommendations brought to the SEBC in February, 2022 with respect to disease and care management options for each vendor, the type of HMO plan for Aetna, and a recommendation on the Everside Health primary care model for the Aetna CDH Gold and HMO plans.

Additionally, there will be continued evaluation of the Medicare plan options in accordance with the recommendations from the Retirement Benefits Study Committee (released on November 1, 2021), with no immediate contract award of a Medicare product at this time. A decision on the administration of a Medicare plan for calendar year 2023 should be made no later than March 31, 2022, in order to provide sufficient time for implementation of that plan option before the current Special Medicfill Medicare Supplement plan contract terminates on December 31, 2022.

We thank you again for your time during the RFP and interview process and extend our congratulations to the Highmark Delaware team! We are looking forward to continuing to work with you!

Respectfully,

Faith L. Rentz, Deputy Director
Statewide Benefits Office and Insurance Coverage Office

cc: File
Dr. Jessilene Corbett, Acting Secretary, DHR and Co-Chair, SEBC
Cerron Cade, Director, OMB and Co-Chair, SEBC

State of Delaware
DEPARTMENT OF HUMAN RESOURCES

December 17, 2021

via e-mail

Ms. Katherine Impellizzeri, Account Director
Aetna
151 Farmington Avenue
Hartford, CT 06156

Re: Request for Proposal for a Medical Third Party Administrator for the Group Health Insurance Program (GHIP)

Dear Ms. Impellizzeri:

On December 13, 2021, pursuant to the terms listed in the Request for Proposal (RFP) and based on the recommendation of the Proposal Review Committee, the State Employees Benefits Committee (SEBC) voted in favor of awarding the medical benefit administrative services for the GHIP contracts effective July 1, 2022 as follows:

1. Award contract to Highmark Delaware effective July 1, 2022 with an initial term of three years with two one-year optional renewals subject to finalized contract for administration of the following health plans on a self-insured basis:
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    - Consumer Directed Health Plan with HRA, and
    - HMO Plan

The awards are subject to approval of the Department of Technology and Information and Department of Insurance and a finalized contract which shall include performance guarantees.

There will be continued evaluation and discussion by both the Financial and Health Policy & Planning Subcommittees, with recommendations brought to the SEBC in February, 2022 with respect to disease and care management options for each vendor, the type of HMO plan for Aetna, and a recommendation on the Everside Health primary care model for the Aetna CDH Gold and HMO plans.

Additionally, there will be continued evaluation of the Medicare plan options in accordance with the recommendations from the Retirement Benefits Study Committee (released on November 1, 2021), with no immediate contract award of a Medicare product at this time. A decision on the administration of a Medicare plan for calendar year 2023 should be made no later than March 31, 2022, in order to provide sufficient time for implementation of that plan option before the current Special Medicfill Medicare Supplement plan contract terminates on December 31, 2022.

We thank you again for your time during the RFP and interview process and extend our congratulations to the Aetna team! We are looking forward to continuing to work with you!

Respectfully,

Faith L. Rentz

Faith L. Rentz, Deputy Director
Statewide Benefits Office and Insurance Coverage Office

cc: File
Dr. Jessilene Corbett, Acting Secretary, DHR and Co-Chair, SEBC
Cerron Cade, Director, OMB and Co-Chair, SEBC

EXHIBIT D

AGENDA
STATE EMPLOYEE BENEFITS COMMITTEE MEETING
February 28, 2022 – 2:00 pm

Until further notice, in the interests of protecting the citizens of this State from the public health threat caused by COVID-19, all State Employee Benefits Committee meetings will continue to be conducted virtually without a physical location. Members of the public may participate virtually or by phone using the information provided. Meeting materials will be posted in advance on the Public Meeting Calendar and the SEBC webpage.

https://www.webex.com/
Meeting number (access code): 2690 883 8132 Meeting Password: SEBC
or Join by Phone Toll Free: 1-866-205-5379

1. Call to Order

2. Approval of January 24, 2022 SEBC meeting minutes*

3. Director's Report/Subcommittee/Legislative Updates

4. 2021 Health Third Party Administrative Services RFP Award Recommendations*

    a. Active/non-Medicare Care Management Programs
    b. Aetna HMO Model
    c. Medicare Plan Effective January 1, 2023

5. CVS Drug Savings Review Recommendation*

6. Financials

    a. January 2022 Fund Report
    b. FY22 Qtr 2 Financial Reporting
    c. FY23 GHIP Projections

7. FY23 Health Plan Premium Recommendations*

8. Other Business

9. Public Comment

10. Adjournment

Visit the SEBC website at dhr.delaware.gov/benefits/sebc for further details. Meeting materials are posted after each meeting.

***Agenda items may require action and approval by the Committee.**
The Committee may move into Executive Session for the purpose of discussing confidential financial information and trade secrets or the content of documents excluded from the public record pursuant to 29 Del.C. §10004(b)(6), and to receive legal advice pursuant to 29 Del.C. §10004(b)(4) relating to pending or potential litigation. The Committee may move into Executive Session for one or more of these reasons.

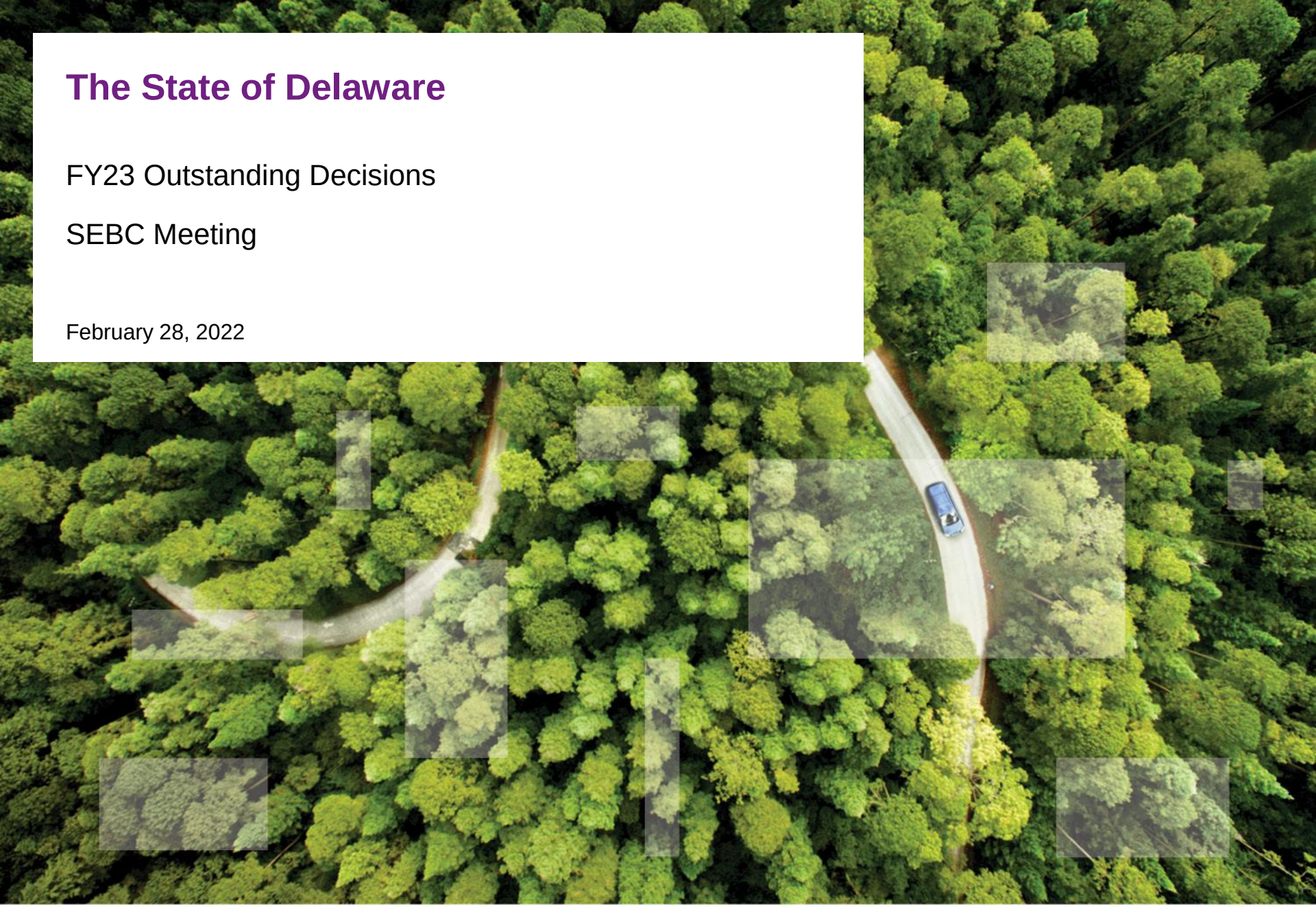
EXHIBIT E

The State of Delaware

FY23 Outstanding Decisions

SEBC Meeting

February 28, 2022



Willis Towers Watson

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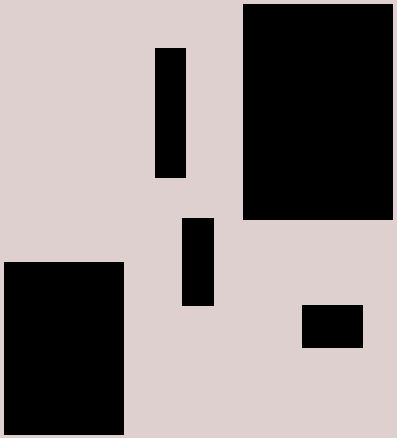
Medicare Plan Options

Overview



Medicare pensioner plan options

Overview of medical TPA RFP scoring decision for Medicare

- On November 2, 2021, the Proposal Review Committee (PRC) voted affirmatively on the following recommendations related to the Medicare plan options:
  - Both Highmark Delaware and Aetna are qualified to administer both a Special Medicfill Medicare Supplement plan as well as a Group Medicare Advantage (Group MA) product to the Medicare pensioner population, with Highmark Delaware's Medicare Advantage product being slightly more favorable than Aetna's product based on the results of the scoring
  - Of a total of 125 points, the scores by plan were as follows:
    - Special Medicfill Medicare Supplement: Highmark Delaware scored 80.4, Aetna scored 78.2
    - Medicare Advantage: Highmark Delaware scored 83.0, Aetna scored 80.2
  - The PRC recommended continued evaluation of these Medicare plan options in accordance with the recommendations from the Retirement Benefits Study Committee (released on November 1, 2021), with no immediate contract award of a Medicare product at that time
  - **The PRC also recommended that the State Employee Benefits Committee (SEBC) should reach a decision on the administration of a Medicare plan for calendar year 2023 no later than March 31, 2022, in order to provide sufficient time for implementation of that plan option before the current Special Medicfill Medicare Supplement plan contract terminates on December 31, 2022**
  - Should the SEBC wish to offer the Special Medicfill Medicare Supplement plan beyond December 31, 2022, then the SEBC could potentially do so through an award to Highmark Delaware based on the scoring results by the PRC
  - Subcommittee members discussed the Medicare plan options for FY23 and formulated recommendations that will be discussed at today's meeting

Medicare pensioner plan options

Industry perspective – Medicare Supplement vs Group Medicare Advantage

Plan type	Description	Current state	Future state
Medicare Supplement* and Coordination of Benefit (COB) plans	▪ Employer-sponsored plans that provide benefits secondary to Medicare ▪ No federal funding for medical claims ▪ Federal funding available for Rx claims (usually not sufficient to fully offset cost) ▪ Generally self insured for larger employers ▪ Employer sets plan design	▪ Shrinking enrollment in recent years due to advent of Medicare marketplace approach driving enrollment in individual coverage	▪ Continued shrinkage as employers continue shift to marketplace plans or convert to group MA plans ▪ Enrollment will decline as older members of closed groups pass away
Group Medicare Advantage (Group MA)	▪ Private group plans that replace Medicare Parts A and B ▪ Always fully insured ▪ Part D Rx coverage can be included or excluded from group MA plan ▪ Significant federal funding covers lion's share of cost ▪ Minimum design standards set by Centers for Medicare and Medicaid (CMS) ▪ Wide latitude for employer custom design	▪ Enrollment over 3m as group MA plans can often match current benefits at lower cost ▪ Many employers offer group MA plans as a full replacement passive Preferred Provider Organization (PPO) that minimizes network disruption ▪ Major group MA insurers: UHC, Humana, Aetna	▪ Good fit for employers with substantial post-65 groups where movement to a Medicare marketplace is not feasible ▪ Stability and growth predicated on continuing favorable federal funding

*GHIP Medicfill plan is a Medicare Supplement plan.

- Per Delaware statute, the State Employee Benefits Committee (SEBC) is tasked with deciding the types of Medicare options available to Delaware retirees

Medicare pensioner plan options

GHIP-specific considerations related to Group MA with Part D Rx coverage

Considerations for including Part D Rx coverage (MAPD)	Considerations for excluding Part D Rx coverage (MA only)
▪ Simplified administration under one carrier ▪ Short term financial predictability with known fixed premiums covering both medical and prescription drug spend ▪ 2020 Pharmacy Benefits Manager (PBM) RFP included flexibility for the State to discontinue Employer Group Waiver Plan (EGWP) for Rx coverage through CVS ▪ More advantageous than MA only to GHIP cash position in year of implementation due to payment timing lag for rebate and EGWP revenues under existing Rx plan	▪ The State is already benefiting from significant federal and PBM subsidies via the EGWP ▪ The State recently concluded negotiation of highly competitive financial terms for the EGWP contract under CVS ▪ Cost volatility is low for the portion of Rx drug spend not covered by Part D ▪ Additional PBM disruption for members including potential change in pharmacy network, formulary, etc. for 1/1/2023, following the change in PBMs from Express Scripts to CVS effective 1/1/2022

Medicare pensioner plan options

Overview of proposed options – Medicfill vs Group MA

Plan feature	Medicfill (current)	Proposed Group MA (Aetna)	Proposed Group MA (Highmark)
Plan type	▪ Self-funded medical/EGWP	▪ Fully-insured MA (medical only) or MAPD	▪ Fully-insured MA (medical only) or MAPD
Federal funding	▪ Retained by GHIP (EGWP only)	▪ Retained by Aetna	▪ Retained by Highmark
Medical plan design[1]	▪ Member responsible for Part B premium only ($170.10/month for 2022)	▪ Same as Medicfill	▪ Same as Medicfill
Rx plan design[2]	▪ Generic copay: $8 / $16 retail/mail ▪ Brand formulary: $28 / $56 ▪ Brand non-formulary: $50 / $100 ▪ Out-of-pocket max: None[3]	▪ Same as Medicfill	▪ Same as Medicfill
Provider network	▪ Passive PPO (members may seek care from any medical provider that accepts Medicare assignment) ▪ See appendix for more details	▪ Same as Medicfill ▪ Mirrors access to providers available today	▪ Same as Medicfill ▪ Mirrors access to providers available today
CY 2023 premium rate (per retiree per month)[4]	▪ $459.38 total ▪ $260.44 medical ▪ $198.94 Rx	▪ Redacted	▪ $162 total (MAPD) ▪ $0 medical (MA medical only) ▪ $162 Rx
Group MA transition credit	▪ N/A	▪ $	▪ $$$

1. Plan fully covers medical out-of-pocket costs not covered by Medicare Part B, other than the Part B premium
2. Prescription drug copays and 5% premium cost share applies for pensioners retiring on or after 7/1/2012; State share is 100% for pensioners retiring before 7/1/2012; State pays 100% of State Share for pensioners with 20+ years of service
3. Catastrophic Coverage: After yearly out-of-pocket drug costs reach $7,050, retirees pay the greater of 5% coinsurance or from $3.95 to $9.85 copayment per script based on drug tier
4. Assumes no change in rates effective 7/1/2022; Medicfill rates represent funding revenue only; actual cost of Medicfill program differs from the current funding rates

Considerations for Medicare plan options

- Balance short term financial impact to the GHIP of Medicare Supplement vs. Medicare Advantage plan options with the longer-term impact of change in terms of OPEB liability
- Another option discussed by the Retirement Benefits Study Committee (RBSC) – the Medicare marketplace – is outside the scope of this RFP and was not considered in this analysis
- Changes in Medicfill program design that reduce the State's unfunded OPEB liability can be recognized once the changes have been announced, regardless of effective date
- Important for SEBC to thoroughly evaluate all options and make the best decision for the GHIP, for pensioners and for the State’s retiree liability obligations
- Any change from the current Medicfill plan will require extensive outreach and communication in advance of the plan effective date
- If moving from Medicfill to Group MA, Medicare rates will reset to the fully-insured rate (with or without Rx), and will reduce overall subsidy for active and pre-65 rates

SEBC Decision Points:

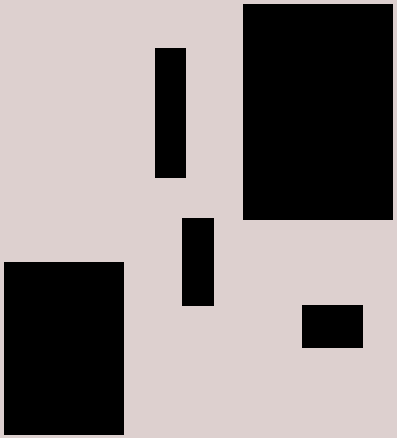
- **Maintain Medicfill plan or move to Group MA product, effective 1/1/23 (or later)**
- **Aetna or Highmark**
- **Including/Excluding Part D drug coverage as part of Group MA product**

Medicare pensioner plan options

Decisions requiring vote by SEBC

- The joint Subcommittees provide recommendations for the following with regards to a Medicare plan:
  - Effective January 1, 2023, move to Group Medicare Advantage Plan
  - Award administration of the Group MA plan to Highmark
  - Maintain existing self-funded EGWP coverage

Active/Non-Medicare Plan Considerations



Active Non-Medicare Plan Considerations

Overview of outstanding decisions for 2/28 SEBC vote

- Subcommittee members discussed the following programs for FY23 and formulated recommendations that will be discussed at today's meeting:
  - Care management program option for each medical vendor
  - Aetna HMO plan's PCP election/referral requirement
  - Other FY23 opportunities for consideration
- At the conclusion of today's discussion, the SEBC will be asked to take a vote on Subcommittee recommendations

Outstanding decisions from the Medical RFP

Care management programs – Aetna

Outstanding decision	Effective date of decision	Estimated FY23 Admin Cost / (Savings)
Aetna HMO and CDH Gold plans: Choose which care management program to implement: ▪ Option 1 (“One Advisor”): Targets more people, engages with them earlier, uses more advanced technology, is more integrated with other Aetna services ▪ Option 2 (“One Flex”): Targets fewer people, uses less advanced technology/integration, is lower cost than Option 1 Both programs are new to the State Group Health plan and both offer performance guarantees.	7/1/2022 (SEBC must vote by 2/28)	**($0.6M)** – Option 1 **($1.7M)** – Option 2 Savings are based on administrative costs only and do not factor in any potential savings from the performance guarantee.

- Aetna appeared before the Combined Subcommittees in January to present on key differences between these programs, using several member scenarios to illustrate how the member’s experience would be different under each option, and answered questions from Subcommittee members, who were briefed on both options prior to this meeting
  - This briefing focused on information Aetna submitted in its response to the 2021 Medical RFP including descriptions of each program, fees, performance guarantees, outcomes achieved and case studies

- At the February Subcommittee meeting, follow-ups from Aetna’s presentation were discussed; this included clarification of the engagement rates produced by each option, further description of how both care management programs address components of the member experience such as members’ social determinants of health, early identification of members with pre-diabetes, and care coordination with members’ PCPs and other community providers

Outstanding decisions from the Medical RFP

Care management programs – Aetna (continued)

- The Subcommittees saw value in a program that identifies more plan participants for engagement, at earlier points in their health care journey, and how doing so could lead to a better member experience, improved health outcomes and reduced cost
- Subcommittee members also felt that Aetna's presentation in January effectively outlined key differences in the degree of care advocacy and navigation support available to members through each option
- The availability of performance guarantees addressing member engagement and clinical outcomes, in addition to financial outcomes, was viewed favorably by Subcommittee members
- Based on the above, Subcommittee members agreed that the **Aetna One Advisor program ("Option 1")** would be better suited to identify, engage and support the health care needs of plan participants

Outstanding decisions from the Medical RFP (continued)

Care management programs – Highmark

Outstanding decision	Effective date of decision	Estimated FY23 Admin Cost / (Savings)
Highmark PPO and First State Basic plans: Choose which care management program to implement: ▪ Option 1 ("Well360 Clarity"): New program, targets more people, delivered in conjunction with partner, more steerage to high quality providers ▪ Option 2 ("CCMU"): In place today, targets fewer people, Highmark alone delivers program, WTW* provides clinical oversight on behalf of all mutual customers served by the CCMU Both programs offer performance guarantees.	7/1/2022 (SEBC must vote by 2/28)	**($0.6M)** – Option 1 **$0.1M** – Option 2 Savings are based on administrative costs only and do not factor in any potential savings from the performance guarantee.

- Highmark appeared before the Combined Subcommittees in January to present on key differences between these programs, using several member scenarios to illustrate how the member's experience would be different under each option, and answered questions from Subcommittee members, who were briefed on both options prior to this meeting
  - This briefing focused on information Highmark submitted in its response to the 2021 Medical RFP including descriptions of each program, fees, performance guarantees, outcomes achieved and case studies

- At the February Subcommittee meeting, follow-ups from Highmark's presentation were discussed; this included clarification of which functions of the Option 1 "Well360 Clarity" program would be managed by Highmark vs. its care management partner and further description of how both care management programs address components of the member experience such as members' social determinants of health, early identification of members with pre-diabetes, and care coordination with members' PCPs and other community providers

* WTW oversight consists of clinical audits, ongoing calls to discuss CCMU operations and review of outcomes reports and is provided by WTW's CCMU operations team, which includes WTW clinicians and is separate from the WTW team supporting the State of Delaware.

Outstanding decisions from the Medical RFP

Care management programs – Highmark (continued)

- Subcommittee members discussed key differences between each program's operations, mechanisms for engaging members and ability to influence members' site-of-care choices
- There was hesitation from Subcommittee members around adopting a program for which Highmark is using a new care management provider to deliver services to members
- Subcommittee members expressed concerns about an insufficient level of transparency into Highmark's broader relationship with its care management provider, despite multiple inquiries requesting further details
- There was deliberation about the fact that, in general, care management programs are not "locked in" throughout the life of a TPA contract and can be changed, unlike most core administrative components of the State's contracts with the TPAs
- Based on the above, Subcommittee members agreed that the **Highmark CCMU ("Option 2")** would be better suited to continue supporting plan participants for FY23. There was a willingness to consider reevaluating this decision throughout the subsequent years of the State's contract with Highmark

Outstanding decisions from the Medical RFP (continued)

Outstanding decision	Effective date of decision	Estimated FY23 Admin Cost / (Savings)
Aetna HMO plan: Maintain or waive current requirement for participants to select a primary care physician and obtain referrals	7/1/2022 (SEBC must vote by 2/28)	**$2.0M** if waived (though within margin of error of estimated discounts)

- Today, the State's HMO requires members to select a PCP upon enrollment and also requires referrals for members seeking specialty care
- Prompted by feedback from plan participants about the difficulty of finding a PCP or accessing primary care, the medical RFP included a request for alternative HMO designs that would remove this PCP selection/referral requirement
- The Subcommittees discussed the possible implications of removing this requirement on plan costs and on GHIP revenue through enrollment migration from the PPO to the HMO (i.e., lost contribution revenue for similar plan design, potential impact on Highmark performance guarantees and other elements of Highmark's financial proposal)
- Based on the above, Subcommittee members agreed that **maintaining the requirement for PCP selection and referrals** is preferable to waiting this requirement

Other FY23 opportunities for consideration

Recommended by Subcommittees for SEBC

- Combined Subcommittees revisited the FY23 opportunities that were previously recommended to the SEBC by Subcommittee members in December 2021, since no vote was taken at the 12/13 SEBC meeting
- There was a discussion several updates on these potential opportunities since December, with the exception of the CVS Drug Savings Review program, did not make them feasible for vote in February or March and in time to apply as savings against the FY23 deficit
  - There was agreement that telemedicine utilization would continue to be monitored with the feasibility of plan design changes reevaluated in the future
  - Further discussion of the CVS Transform Diabetes Care program will coincide with additional discussion of other condition-specific program opportunities available through the Medical RFP at the March Subcommittee meetings

FY23 Opportunity	Description	Est. # Members Impacted*	Est. FY23 Net Savings / Cost Avoided
Telemedicine copay changes	WTW modeled reinstatement of member cost sharing for telehealth visits with community providers	102,100 *(Commercial plans only)*	**$4.0M**, assuming future utilization mirrors pre-pandemic utilization
CVS Drug Savings Review	Program reviews Rx utilization to ensure that prescriptions follow evidence-based medical guidelines	102,100 *(Commercial plans only)*	**$1.0M** – **$2.8M,** assuming 7/1/22 effective date
CVS Transform Diabetes Care	Engages members with diabetes on actionable steps to address gaps in care, evaluate medical needs and facilitate overall wellness	Approximately 6,400 Commercial plan members who are currently participating in the Livongo diabetes management program	**$1.9M** *(impact on Medicfill plans addressed separately)*

*Based on enrollment as of August 2021.

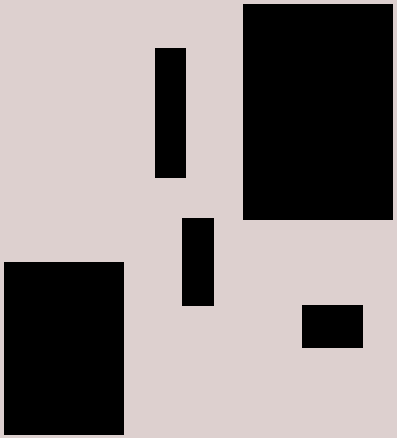
CVS Drug Savings Review

- There was discussion to gauge Subcommittee members' interest maintaining their earlier recommendation for the Drug Savings Review program to the SEBC
- Key elements of the program were discussed (see sidebar)
- Some Subcommittee members were concerned about whether this program was truly voluntary for providers and recalled requirements to change prescriptions with earlier PBM transition to CVS; clarification was provided about the differences between those situations and this program
- Discussed the State's ability to turn this program "On" / "Off" throughout the duration of the CVS contract
- Notwithstanding the above, the Subcommittees remain in support of the SEBC considering this program for FY23, but with continued monitoring of the member experience, physician engagement and program results throughout the first year of the program for reconsideration of continuing the program past FY23

CVS Drug Savings Review

- Identifies opportunities for improved prescribing and utilization based on evidence-based medical guidelines
- Program savings highly dependent on responsiveness and engagement of the medical provider community
  - CVS outreach to physicians with patient safety and savings opportunities; would request physician considers changing member's prescription therapy
  - Provider retains discretion over making any changes; if provider declines to change member's prescription, CVS will honor provider's clinical opinion
- Minimal impact to member outside of possible change in prescription(s)
- Program has a 3:1 minimum Return on Investment (ROI) guarantee
  - Monthly administrative fee applies
  - Est. annual net savings range (after member cost sharing): $1.0M – $2.8M

Updated long-term projections



GHIP long term health care cost projections (updated through Jan' 22)

Overview

- GHIP long-term projections have been updated to reflect all legislation signed into law and initiatives voted on by the SEBC as of February 24th, 2022 (see slide 21)
- Projections include assumed $24m in COVID-19 reimbursement funds based on COVID claims incurred in 2021; payment expected to be received during FY23
  - No additional COVID-19 funding relief reflected in projections as funding relief would offset COVID-19 related expenses
- EGWP revenue projections (direct subsidy, coverage gap discount payment and federal reinsurance) for CY23 based on estimates previously provided by ESI; CVS will provide revised projections by 2/25 and any material deviation from current projections will be updated for 2/28 SEBC meeting
- Rate action required to solve for FY23 deficit, and annual rate action in FY23, FY24 and FY25 required to target $0 deficit by end of FY25 are also provided
  - Member impact slides for various rate actions included beginning on slide 24
- On February 28th, 2022, the SEBC will vote on a Medicare plan option for 1/1/23
- On February 28th, 2022, the SEBC will also vote on a premium rate increase for FY23, based on a recommendation to be provided by the Financial Subcommittee

Financial Subcommittee recommendations to SEBC must consider:

- **Recommended Medicare plan option for 1/1/23**
- **Signed/pending legislation impacting future GHIP costs**
- **Impact of any proposed rate action on FY23 and beyond (i.e., one-time rate action for FY23, or target 3-year smoothed rate increase)**

GHIP long term health care cost projections (updated through Jan' 22)

FY23 legislation impacting the GHIP

- The following bills have either been signed or are anticipated to be signed with an effective date on or before the end of FY23; future cost estimates are not reflected in the updated long-term projections but are included below:

Bill	Effective Date	Description	Fiscal Year Cost (Savings)
Bills signed and/or enacted without signature from the Governor:			
SB 25	January 1, 2022	Chiropractor reimbursement not less than Medicare	**$0.5M-$1.0M***
SS 1 for SB 120	January 1, 2023; or as early as March/April 2022	Sustaining primary care through increased reimbursements	**$4.6M – $29.9M;** reflects cost estimate for Highmark population only
HB 219	Immediately	Provides enhanced oversight and transparency as it relates to PBMs	**$1.8M**
Bills anticipated to be passed during the 151st General Assembly:			
150th General Assembly HB 307	As early as January 1, 2023	Requires coverage of annual behavioral health well visits with a non-physician behavioral health provider	**$2.0M-$3.1M**
TBD	As early as January 1, 2023	Sponsored bill will require all insurers, including the GHIP, to provide supportive/maintenance chiropractic care	**>$1M**

- Potential FY23 Cost / (Savings): $9.9m - $36.8m

*Reflected in updated long-term projections due to 1/1/2022 effective date.

GHIP long term health care cost projections (updated through Jan' 22)

No premium increases FY22-FY26 (***move to Group MA, medical only, eff. 1/1/23***)

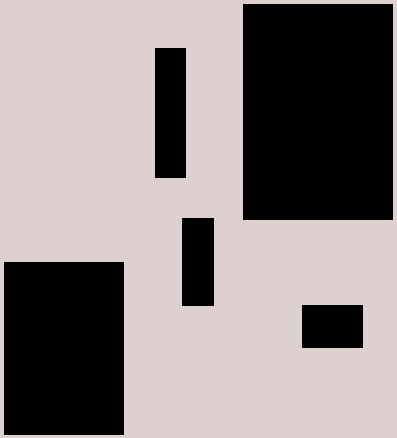
GHIP Costs ($ millions)	FY20 Actual	FY21 Actual	FY22 Projected[1]	FY23 Projected[1]	FY24 Projected[1]	FY25 Projected[1]	FY26 Projected[1]
Average Enrolled Members	128,531	129,768	130,158	131,460	132,775	134,103	135,444
GHIP Revenue							
Premium Contributions (Increasing with Enrollment)[2]	$830.8	$839.4	$839.4	$802.5	$764.8	$772.4	$781.1
Hold premium rates flat FY23 and beyond	-	-	$0.0	$0.0	$0.0	$0.0	$0.0
Other Revenues[3]	$122.8	$128.9	$188.3	$186.1	$219.7	$238.2	$258.2
Total Operating Revenues	**$953.7**	**$968.3**	**$1,027.7**	**$988.6**	**$984.5**	**$1,010.6**	**$1,039.3**
GHIP Expenses (Claims/Fees)							
Operating Expenses[4]	$927.7	$1,005.7	$1,064.6	$1,080.2	$1,136.7	$1,214.1	$1,299.1
% Change Per Member	*0.9%*	*7.4%*	*5.5%*	*0.5%*	*4.2%*	*5.8%*	*5.9%*
Adjusted Net Income (Revenue less Expense)	**$26.0**	**($37.4)**	**($36.9)**	**($91.6)**	**($152.2)**	**($203.5)**	**($259.8)**
Balance Forward	$163.8	$189.8	$152.3	$115.5	$23.9	($128.2)	($331.7)
Ending Balance	$189.8	$152.3	$115.5	$23.9	($128.2)	($331.7)	($591.5)
- Less Claims Liability[5]	*$57.5*	*$57.5*	*$61.0*	*$61.9*	*$65.1*	*$69.5*	*$74.4*
- Less Minimum Reserve[5]	*$24.3*	*$24.3*	*$24.3*	*$24.7*	*$26.0*	*$27.8*	*$29.7*
- Less COVID-19 Reserve[6]	-	-	-	-	-	-	-
GHIP Surplus (After Reserves/Deposits)	**$108.0**	**$70.5**	**$30.2**	**($62.7)**	**($219.3)**	**($429.0)**	**($695.6)**

- 8.67% rate increase needed to solve for FY23 deficit
- 8.98% annual increase in FY23, FY24, FY25 needed to target $0 deficit by end of FY25

It is evident that the COVID-19 pandemic will have an impact on health care costs. We have used available information and reasonable estimation techniques to develop health care cost estimates for the GHIP that reflect the impact of COVID-19. However due to the high degree of uncertainty associated with this pandemic, results may vary from the estimates provided.

Please refer to Appendix for FY17, FY18, and FY19 actual results (slide 30) and detailed projection footnotes (slide 31)

Member Impact Scenarios



FY23 monthly rates and employee/retiree contributions

Illustrative: 8.67% increase effective 7/1/2022

FY23 reflects employee contribution increases of $2.41 - $23.66 per employee per month ($28.92 - $283.92 per year) and State subsidy increases of $57.88 - $156.14 per employee per month ($694.56 - $1,873.68 per year) effective 7/1/2022

	Current Rates			FY 2023 with 8.67% Increase (effective 7/1/2022)			$ Change Employee/ Pensioner Contribution		$ Change State Subsidy	
	Rate	Employee Contribution	State Subsidy	Rate	Employee Contribution	State Subsidy	Monthly	Annual	Monthly	Annual
First State Basic										
Employee	$695.36	$27.84	$667.52	$755.65	$30.25	$725.40	$2.41	$28.92	$57.88	$694.56
Employee + Spouse	$1,438.68	$57.52	$1,381.16	$1,563.41	$62.51	$1,500.90	$4.99	$59.88	$119.74	$1,436.88
Employee + Child	$1,057.02	$42.26	$1,014.76	$1,148.66	$45.92	$1,102.74	$3.66	$43.92	$87.98	$1,055.76
Family	$1,798.42	$71.92	$1,726.50	$1,954.34	$78.16	$1,876.18	$6.24	$74.88	$149.68	$1,796.16
CDH Gold										
Employee	$719.68	$35.98	$683.70	$782.08	$39.10	$742.98	$3.12	$37.44	$59.28	$711.36
Employee + Spouse	$1,492.22	$74.58	$1,417.64	$1,621.60	$81.05	$1,540.55	$6.47	$77.64	$122.91	$1,474.92
Employee + Child	$1,099.56	$54.96	$1,044.60	$1,194.89	$59.73	$1,135.16	$4.77	$57.24	$90.56	$1,086.72
Family	$1,895.74	$94.78	$1,800.96	$2,060.10	$103.00	$1,957.10	$8.22	$98.64	$156.14	$1,873.68
Aetna HMO										
Employee	$725.94	$47.16	$678.78	$788.88	$51.25	$737.63	$4.09	$49.08	$58.85	$706.20
Employee + Spouse	$1,530.58	$99.50	$1,431.08	$1,663.28	$108.13	$1,555.15	$8.63	$103.56	$124.07	$1,488.84
Employee + Child	$1,110.52	$72.18	$1,038.34	$1,206.80	$78.44	$1,128.36	$6.26	$75.12	$90.02	$1,080.24
Family	$1,909.82	$124.12	$1,785.70	$2,075.40	$134.88	$1,940.52	$10.76	$129.12	$154.82	$1,857.84
Comprehensive PPO										
Employee	$793.86	$105.18	$688.68	$862.69	$114.30	$748.39	$9.12	$109.44	$59.71	$716.52
Employee + Spouse	$1,647.34	$218.26	$1,429.08	$1,790.16	$237.18	$1,552.98	$18.92	$227.04	$123.90	$1,486.80
Employee + Child	$1,223.46	$162.08	$1,061.38	$1,329.53	$176.13	$1,153.40	$14.05	$168.60	$92.02	$1,104.24
Family	$2,059.40	$272.86	$1,786.54	$2,237.95	$296.52	$1,941.43	$23.66	$283.92	$154.89	$1,858.68

Medicare Supplement – Special Medicfill

Rates effective January 1, 2022 – December 31, 2022

	Total Monthly Rate	State Share	Pensioner Pays
Highmark Delaware Medicare Supplement for Pensioners Retired On or Prior to July 1, 2012			
Special Medicfill with Prescription	$459.38	$459.38	$0.00
Special Medicfill without Prescription	$260.44	$260.44	$0.00
Highmark Delaware Medicare Supplement for Pensioners Retired After July 1, 2012			
Special Medicfill with Prescription	$459.38	$436.42	$22.96
Special Medicfill without Prescription	$260.44	$247.44	$13.00

- If you have less than 20 years of service and were first hired on or after July 1, 1991, the State does not pay the full state share but will pay a percentage of the state share of the cost of your coverage as explained in the charts below.

Eligible Pensioners Hired By The State On Or After July 1, 1991 Through December 31, 2006 *(The following portion of the State Share will be paid by the State)* **(Except those receiving a disability pension or receiving an LTD benefit)**		
Less than 10 years service	0%	state share paid by state
10 years - less than 15 years service	50%	state share paid by state
15 years - less than 20 years service	75%	state share paid by state
20 years or more service	100%	state share paid by state
Eligible Pensioners Hired By The State On Or After January 1, 2007 *(The following portion of the State Share will be paid by the State)* **(Except those receiving a disability pension or receiving an LTD benefit)**		
Less than 15 years service	0%	state share paid by state
15 years - less than 17.5 years service	50%	state share paid by state
17.5 years - less than 20 years service	75%	state share paid by state
20 years or more service	100%	state share paid by state

Medicare Advantage

Rates effective January 1, 2023 – December 31, 2023

	Total Monthly Rate	State Share	Pensioner Pays
Highmark Delaware Medicare Supplement for Pensioners Retired On or Prior to July 1, 2012			
Special Medicfill with Prescription*	$216.19	$216.19	$0.00
Special Medicfill without Prescription*	$0.00	$0.00	$0.00
Highmark Delaware Medicare Supplement for Pensioners Retired After July 1, 2012			
Special Medicfill with Prescription**	$216.19	$205.38	$10.81
Special Medicfill without Prescription	$0.00	$0.00	$0.00

*Rates reflect Medicare Advantage plan recommended by Combined Subcommittee on 2/24/2022, which are pending SEBC vote on 2/28/2022

- If you have less than 20 years of service and were first hired on or after July 1, 1991, the State does not pay the full state share but will pay a percentage of the state share of the cost of your coverage as explained in the charts below.

Eligible Pensioners Hired By The State On Or After July 1, 1991 Through December 31, 2006 *(The following portion of the State Share will be paid by the State)* **(Except those receiving a disability pension or receiving an LTD benefit)**		
Less than 10 years service	0%	state share paid by state
10 years - less than 15 years service	50%	state share paid by state
15 years - less than 20 years service	75%	state share paid by state
20 years or more service	100%	state share paid by state
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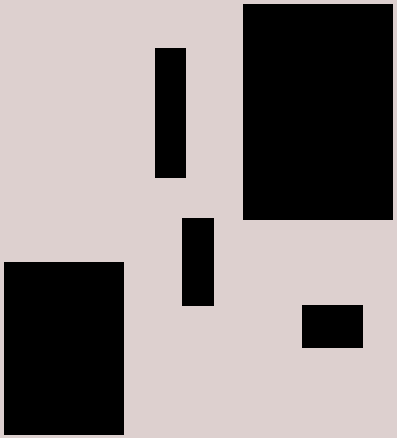
Less than 15 years service	0%	state share paid by state
15 years - less than 17.5 years service	50%	state share paid by state
17.5 years - less than 20 years service	75%	state share paid by state
20 years or more service	100%	state share paid by state

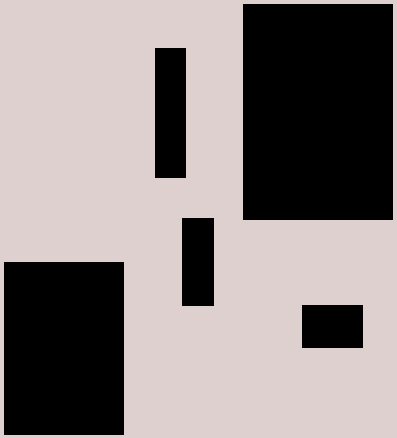
Next Steps



Outstanding decisions for 2/28 SEBC vote

- The SEBC must vote on the Subcommittee recommendations from the February 24th, 2022 Combined and Financial Subcommittee meetings; Subcommittee recommendations are summarized below:
  - Medicare plan option:
    - Subcommittees recommend moving to Group Medicare Advantage plan (medical only), effective 1/1/2023, administered by Highmark, and to continue offering drug coverage through CVS EGWP
  - Care Management program decisions:
    - HMO and CDH Gold plans: Subcommittees recommend Aetna One Advisor
    - PPO and First State Basic plans: Subcommittees recommend Highmark CCMU
  - Aetna HMO:
    - Subcommittees recommend retaining requirement for PCP selection and referrals
  - CVS Drug Savings Review Program:
    - Subcommittees remain in support of the SEBC considering this program for FY23, but with continued monitoring of the member experience, physician engagement and program results throughout the first year of the program for reconsideration of continuing the program past FY23
  - FY23 rate action:
    - Financial Subcommittee recommends an 8.67% rate increase effective 7/1/2022 to solve for the projected FY23 deficit of $62.7M

Appendix



GHIP historical health care fund information

FY17-FY19

GHIP Costs ($ millions)	FY17 Actual	FY18 Actual	FY19 Actual
Average Enrolled Members	123,132	125,488	126,360
GHIP Revenue			
Premium Contributions (Increasing with Enrollment)[2]	$799.0	$810.9	$817.4
Hold premium rates flat FY21+)	-	-	-
Other Revenues[3]	$81.6	$92.1	$98.5
Total Operating Revenues	**$880.6**	**$903.0**	**$915.9**
GHIP Expenses (Claims/Fees)			
Operating Expenses[4]	$816.8	$853.9	$904.0
% Change Per Member		*2.6%*	*5.1%*
Excise Tax Liability[5]			
Adjusted Net Income (Revenue less Expense)	**$63.8**	**$49.1**	**$11.9**
Balance Forward	$38.9	$102.7	$151.8
Ending Balance	$102.7	$151.8	$163.8
- Less Claims Liability[6]	*$54.0*	*$58.9*	*$58.8*
- Less Minimum Reserve[6]	*$24.0*	*$24.0*	*$24.3*
GHIP Surplus (After Reserves/Deposits)	**$24.7**	**$68.9**	**$80.7**

GHIP long term health care cost projection footnotes

Note: FY17-FY21 actuals based on final June Fund Equity reports for respective fiscal year; FY22+ projected operating expenses and enrollment based on experience through October 2021 with adjustments due to COVID-19 financial impact; assumed 1% annual enrollment growth; numbers in table may not add up due to rounding

1. Includes approved design changes effective 7/1/2019 including implementation of SurgeryPlus COE ($0.5m annual savings), site-of-care steerage ($6.9m), Highmark infusion therapy program ($2.0m) and implementation of Livongo ($0.7m); FY21 reflects implementation of Highmark radiation therapy authorization program ($633k annual savings per Highmark); FY22-FY26 projections based on 5% medical, 8% pharmacy baseline trend; assumes 1% annual growth in GHIP membership; FY22 projection reflects impact of COVID-19; assumes no other program changes in FY22 and beyond.
2. Includes State and employee/pensioner premium contributions; assumes 1% annual enrollment growth for FY22-FY26
3. Includes Rx rebates, EGWP payments, other revenues based on when revenues will be received; FY22 and beyond includes estimated improvements in Rx rebates based on result of PBM award to CVS Health; rebates assumed to be paid 60 days after the quarter adjudicated; includes fees for participating non-State groups (assumed to increase proportionally with membership and premium growth); FY22 includes projected $8.4m CY2020 CMS financial reconciliation payment to be received Jan. 2022.
4. FY22 and beyond includes estimated reduction in pharmacy claims as a result of PBM award to CVS Health
5. FY20 Minimum Reserve levels updated with data through June 2019; FY20 Claim Liability updated with lag factors as of Dec 2019 and claims data through December 2019; FY21 reserves assumed to remain at FY20 levels; FY22 claim liability and future years assumed to increase with overall GHIP claims growth; FY22 minimum reserve assumed to remain at FY21 level.
6. One-time COVID-19 reserve as approved by SEBC on July 27th, 2020; released at the end of FY21

It is evident that the COVID-19 pandemic will have an impact on health care costs. We have used available information and reasonable estimation techniques to develop health care cost estimates for the GHIP that reflect the impact of COVID-19. However due to the high degree of uncertainty associated with this pandemic, results may vary from the estimates provided.

EXHIBIT F

MINUTES FROM THE MEETING OF THE STATE EMPLOYEE BENEFITS COMMITTEE
FEBRUARY 28, 2022

The State Employee Benefits Committee (the "Committee") met at 2:00 p.m. on February 28, 2022. 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.

Committee Members Represented or in Attendance:

Director Cerron Cade, Office of Management & Budget ("OMB"), SEBC Co-Chair
Secretary Claire DeMatteis, Department of Human Resources ("DHR"), Co-Chair
The Honorable Colleen Davis, State Treasurer, Office of the State Treasurer ("OST")
The Honorable Trinidad Navarro, Insurance Commissioner, Department of Insurance ("DOI")
The Honorable Chief Justice Collins Seitz, Delaware Supreme Court
Controller General Ruth Ann Jones, Office of the Controller General ("OCG")
Secretary Molly Magarik, Department of Health & Social Services ("DHSS")
Mr. Jeff Taschner, Executive Director, Delaware State Education Association ("DSEA")
Mr. Keith Warren, Chief of Staff, Office of the Lieutenant Governor (Designee OBO The Honorable Bethany Hall-Long, Lieutenant Governor)
Ms. Ashley Tucker, Deputy State Court Administrator, Admin Office of the Courts (Designee OBO The Honorable Chief Justice Collins Seitz, Delaware Supreme Court

Others in Attendance

Director Faith Rentz, Statewide Benefits Office ("SBO"), DHR
Deputy Director Leighann Hinkle, SBO, DHR
Ms. Nina Figueroa, SBO, DHR
Deputy Attorney General Adria Martinelli, Dept. of Justice ("DOJ"), SEBC Legal Counsel
Mr. Chris Giovannello, Willis Towers Watson ("WTW")
Ms. Jaclyn Iglesias, WTW
Ms. Rebecca Warnken, WTW
Ms. Gabby Costagliola, WTW
Ms. Joanna Adams, Pension Administrator, Office of Pensions ("OPen")
Ms. Judy Anderson, DSEA
Ms. Wendy Beck, Highmark Delaware
Mr. Ken Bronke, Highmark Delaware
Ms. Christina Bryan, Delaware Healthcare Association
Mr. Randall Bryniarski, CVS Health
Ms. Rebecca Byrd, ByrdGomes
Ms. Michelle Carpenter, PHRST
Ms. Julie Caynor, Aetna
Ms. Marian Coker, Information Resource Specialist, Department of State
Dr. Jessilene Corbett, Deputy Secretary, DHR
Mr. Steven Costantino, Dir. Healthcare Reform, DHSS
Ms. Sue Dahms, Highmark Delaware
Ms. Cherie Dodge Biron, Deputy Principal Asst., DHR
Ms. Sara Dunlevy, CVS Health
Mr. John Ficaro, Aetna
Ms. Darcell Griffith, University of Delaware
Ms. Rishika Gupta, CVS Health
Ms. Jeanette Hammon, Sr. Fiscal Policy Analyst, OMB
Ms. Sandy Hart, IBM Watson Health
Mr. John Hintz, Christiana School District, retiree
Ms. Charlene Hrivnak, CVS Health
Ms. Katherine Impellizzeri, Aetna
Dr. Mark Jacobson, Highmark Delaware
Mr. Kollin Jensen, Teladoc Health
Ms. Heather Johnson, Controller, DHR
Mr. Jamie Johnstone, Deputy Principal Assistant, Dept. of Finance ("DOF")
Mr. Adam Knox, Highmark Delaware
Ms. Lisa Mantegna, Highmark Delaware
Mr. Walt Mateja, IBM Watson Health
Ms. Gisela McKenzie, University of Delaware

Mr. Sean McNeeley, Director of Bond Finance, DOF
Mr. Nick Moriello, Highmark Delaware
Ms. Kathy Nedelka, HRIS Specialist, PHRST, OMB
Ms. Brooke Nedza, Aetna
Ms. Evelyn Nestlerode, Deputy State Court Administrator, CFO, AOC
Mr. Michael North, Aetna
Ms. Megan Richards, Aetna
Ms. Paula Roy, Roy Associates
Ms. Elizabeth Sampo, Aetna
Mr. Bill Sarniak, Highmark Delaware
Ms. Carrie Schiavo, Delta Dental
Ms. Christine Schiltz, Parkowski Guerke & Swayze, P.A.
Mr. Robert Scoglietti, Deputy Controller General, OCG
Mr. Mike Shipley, Highmark Delaware
Mr. Charles Simons, Highmark Delaware
Ms. Jacqueline Faulcon, READAAMs. Martha Sturtevant, Exec. Sec., SBO, DHR
Ms. Carole Mick, SBO, DHR – Recorder

CALLED TO ORDER – DIRECTOR CADE, CO-CHAIR
Director Cade called the meeting to order at 2:00 p.m.

APPROVAL OF MINUTES – DIRECTOR FAITH RENTZ, DHR, SBO
A MOTION was made by Secretary Magarik and seconded by Controller General Jones to approve the minutes from the January 24, 2022, meeting of the State Employee Benefits Committee.
MOTION ADOPTED UNANIMOUSLY

DIRECTOR'S REPORT – DIRECTOR FAITH RENTZ, DHR, SBO

Medicare Part D – EGWP Transition Updates
Through 1/31/22, 70% (19,612) of the State's average eligible Medicare members (27,886) utilized the pharmacy benefit through CVS/SilverScript. Over 66,000 claims were processed at a total amount paid of $13.7M, almost$13M of this was paid by the State's plan (94%) and 6% paid by Medicare retirees. Call volume increased somewhat in early February; however, this has leveled off in the last 2 weeks. There were common themes in calls and customer service tickets being tracked by the SBO and Pension Office. The first common theme is Medicare Part B vs Part D Coordination for Immunosuppressants. Some members were denied coverage when transitioning to SilverScript, due to CMS records not being updated correctly. The SBO has been providing exception overrides while this information gets updated between CMS and SilverScript. Another issue concerning members is a copay increase due to members prescriptions not being on the drug formulary. Members can request SilverScript to cover a drug due to medical necessity. If a drug does become covered, it will be covered at the Tier Three Copay for Non-Formulary Drugs. SilverScript does offer preferred drug alternatives on the formulary. Formulary changes occur several times throughout the year due to re-contracting that the Pharmacy Benefits Manager (PBM) goes through with drug manufacturers, so members will see disruptions regardless of the change in PBM. Lastly, members are facing challenges with obtaining prior authorizations for prescriptions with the transition to SilverScript. Affected Medicare retirees were notified in early December about the transition to SilverScript and informed that they would need a new prior authorization and offered a 31-day transition fill for their first fill after January 1st, 2022. Medicare Part D members do have five levels of appeals to request consideration for prescription medication.

2021 HEALTH THIRD PARTY ADMINISTRATIVE SERVICE RFP RECOMMENDATIONS – MR. CHRIS GIOVANNELLO, WTW and MS. JACLYN IGLESIAS, WTW

Medicare Plan Option
Mr. Giovannello stated that in November the Proposal Review Committee (PRC) voted on the recommendations related to the Medicare plan options. The PRC determined that both Highmark Delaware and Aetna were qualified to administer both a Special Medicfill Medicare Supplement plan and a Group Medicare Advantage (Group MA) product to the Medicare pensioner population. The scoring of the two vendors ultimately determined that Highmark Delaware's Medicare Advantage product scored higher than Aetna's offering. The PRC

recommended that the State Employee Benefits Committee (SEBC) should reach a decision not later than March 31, 2022, in order to provide sufficient time for implementation of the plan option before the current Special Medicfill Medicare Supplement plan contract terminates on December 31, 2022.

Discussion was had regarding the options that have been proposed compared to what is currently being administered today, including review of the key components of group MA plans, the federal subsidies available to the GHIP under each option and considerations for including Part D drug coverage in a group MA offering.

Mr. Giovannello commented that compared to the current Medicfill plan there would not be any plan design changes if the State moved to a Group MA plan and the provider network would not change from a passive PPO network.

Mr. Taschner inquired which line item on the reported invoices would be eliminated if the Group Medicare Advantage with Prescription plan was selected. Mr. Giovannello responded all rebate payments that are related to the EGWP program, as well as EGWP related revenues (direct subsidy, coverage gap discount payment and federal reinsurance) would discontinue and any items that are related to the active/pre65 population would remain.

Mr. Giovannello summarized the key decision points for the SEBC: maintain Medicfill plan or move to Group MA product, effective 1/1/23 (or later); select Aetna or Highmark Delaware as the plan administrator; and include or exclude Part D drug coverage as part of the Group MA product.

Mr. Taschner expressed concern that moving to a Group MA product will reduce the revenue to the GHIP, considerably reduce the amount that the State must contribute to the GHIP, and the retiree population may have difficulty switching and understanding a transition to a Group MA offering. He asked Director Cade if there is a way to hold the actives/pre65 retirees harmless in order to make sure the move to a Group MA program does not result directly in a net increase to that group.

Director Cade commented that he shares Mr. Taschner's concerns that communication must be strategically implemented for the retiree population if the decision is to move forward with a Group MA product. However, there are not material changes to the plan. He commented that the vendors included transition credits in their proposals that could be used to cover the cost of communication and education materials and inquired what the dollar amount is that Highmark and Aetna offered as a transition credit. Ms. Rentz commented that she will follow up directly with committee members due to the proprietary nature of that information.

Mr. Giovannello concluded this portion of the presentation with a recap of the joint Subcommittees recommendation regarding a Medicare plan: Effective January 1, 2023, move to a Group MA plan, award administration of the plan to Highmark, and maintain existing self-funded EGWP coverage.

Active/Non-Medicare Plan Considerations

Ms. Iglesias explained that for the active/non-Medicare plan considerations for FY23, Subcommittee members discussed the following programs and formed recommendations for discussion during last week's meeting and is ultimately asking for the SEBC to take a vote based off Subcommittee member recommendations. These programs include the care management program option for each medical vendor, the PCP election/referral requirement of the Aetna HMO plan, and other FY23 opportunities for consideration.

Regarding the care management programs, Aetna has proposed two care management options for the State Group Health plan. Aetna's first program is called, "One Advisor", which targets more people, engages with them earlier, and uses more advanced technology. The second program is called, "One Flex", which targets fewer people, uses less advanced technology, however, is lower cost than "One Advisor". Both programs are new to the State Group Health plan, and both offer performance guarantees. Financially, the estimated cost savings for FY23

admin cost for the "One Advisor" would $0.6M and "One Flex" the estimated cost savings for FY23 admin cost is $1.7M. The combined Subcommittees met with Aetna in January to understand the key differences between the programs - focusing on the descriptions of each program, fees, performance guarantees, and outcomes achieved from case studies. Based on the deliberation among Subcommittee members, they ultimately agreed that the Aetna "One Advisor" program would be the best option for the State Group Health plan. They saw value in that the program would be able to identify more plan participants and engage with participants earlier, which would lead to a better member experience and improved health outcomes.

Highmark also proposed two care management options for the State Group Health plan. Highmark's first program is called, "Well360 Clarity", and is a new program that targets more people, is delivered in conjunction with a care management partner and offers more steerage of plan participants to high quality providers. The second option proposed is what the State Group Health plan has today and is called the "CCMU" (Custom Care Management Unit) program, which targets fewer people and includes clinical oversight provided by a different team of WTW resources on behalf of all mutual customers served by the CCMU. Financially, the estimated savings on FY23 admin fees for the "Well360 Clarity" would be $0.6M, whereas the CCMU would increase estimated FY23 admin fees by $0.1M. Both programs offer performance guarantees related to program outcomes. Highmark met with Subcommittee members in January to demonstrate the differences between the proposed programs and illustrate member scenarios under each option. After deliberation, the Combined Subcommittees agreed that the "CCMU" program would be better suited to continue supporting the State Group Health plan participants for FY23, with a willingness to consider reevaluating this decision throughout the subsequent years of the State's contract with Highmark. Subcommittee members were concerned about adopting a program for which Highmark is using a new care management provider to deliver services to members and the lack of transparency into Highmark's broader relationship with its care management provider, despite multiple inquiries requesting further details.

Pivoting to the next outstanding decision related to the Aetna HMO plan, today the State of Delaware's Aetna HMO plan requires members to select a PCP upon enrollment and requires referrals for members seeking specialty care. In addition to maintaining the current HMO as it is administered today, Aetna's proposal also included an option for the State to waive the current requirements for participants to select a primary care physician and obtain referrals. The Subcommittees discussed the possible implications of removing this requirement on plan costs and on GHIP revenue through enrollment migration from the PPO to the HMO plan (i.e., lost contribution of revenue for similar plan design, plus the potential impact on Highmark's performance guarantees and other elements of Highmark's financial proposal). Ultimately, Subcommittee members agreed that maintaining the requirement for the PCP selection and referrals is preferable to waiving this requirement.

Finally, Subcommittee members reviewed other FY23 opportunities that had previously been discussed at the Subcommittee level, but because no vote was taken at the December SEBC meeting, there was an opportunity to revisit the recommended options for consideration of whether these should be reintroduced at the SEBC level for evaluation and a potential vote. At last Thursday's Subcommittee meeting, there was a discussion about how several updates to some FY23 opportunities had taken place since December and did not make them feasible for a vote in February or March in time to apply as savings against the FY23 deficit. These updates included discussion on foregoing any changes to telemedicine copays in FY23 with agreement to monitor ongoing utilization for the possibility of revisiting changes in the future, and discussion of the CVS Transform Diabetes Care program being considered alongside of other diabetes programs through the medical RFP, which will be discussed at the March Subcommittee meeting.

The CVS Drugs Savings Review program was also discussed on Thursday to gauge interest from Subcommittee members' in maintaining the earlier recommendation to the SEBC to consider this program for FY23. The goals and key elements of the program were reviewed, which centers around identifying opportunities for improved prescribing practices and improved prescription drug utilization based on evidence-based medicine guidelines. This program involves outreach from CVS to prescribing physicians on behalf of specific members enrolled in the

State Group Health plan, with recommendations to those physicians on other opportunities to improve patient safety or help members save money on their prescriptions to potentially make changes for the betterment of the patient in their prescribing regimen. Providers would retain complete discretion over making any changes to their patients' prescriptions, so if a physician decides against making any changes to a member's prescription, then CVS will honor that physician's clinical opinion. This program has minimal member impact, which is only felt if the prescriber decided to change the patient's prescription drug regimen, underscoring the importance of provider engagement in driving the Return on Investment (ROI) and clinical impact of this particular program. It has a 3:1 minimum ROI guarantee (annual net saving range after member cost sharing $1M-$2.8). Discussion with the Subcommittee members about whether this program was truly voluntary for provider and recalled requirements to change prescriptions with the earlier PBM transition from Express Scripts to CVS. Ultimately, clarification was provided about the differences between those earlier situations where members may have had to change their prescriptions due to formulary differences and this program which would truly be voluntary for providers to determine whether a prescription would be changed. Further discussion also took place about the State of Delaware's ability to turn this program "On" or "Off" throughout the duration of the CVS contract if member experience wasn't meeting expectations. With this information provided, Subcommittee members remained in support of the SEBC considering the Drug Savings Review Program for FY23, with the additional caveat that monitoring should take place to ensure that the member experience, the provider community's engagement, and the program's first year results are all meeting expectations so that future years of the program could be reevaluated if those expectations are not met.

FINANCIALS – MR. CHRIS GIOVANNELLO, WTW

January Fund Report

The January Fund Report was reviewed. Mr. Giovannello clarified for Mr. Taschner the EGWP revenue items that would no longer be provided if the EGWP plan were to be removed. Overall, for the month of January, revenues came in close to what was expected. January claims ran favorable to budget, $80.5M paid vs $86.3M expected ($5.8M surplus). The January surplus was in part driven by the transition of the EGWP plan from Express Scripts to CVS Health effective 1/1/22, which led to lighter than expected pharmacy invoices during the month. Overall, year to date budget through January is a $35.1M surplus in claims. All in January fund experience generated net income of $2.9M and ending fund equity balance is $167.1M (variance to budget is $31.4M).

FY22 Q2 Financial Report

The quarterly financial report based on claims through December was reviewed; the report analyzes claims through the first six months of the plan year relative to the first six months of the prior fiscal year, and relative to budget. Gross claims for FY22 are trending higher when compared to FY21 (increased 3.7%). The total program cost is roughly flat (increased 0.5%), driven by overall favorable claims experience for the State of Delaware fund as well as increased pharmacy rebates. Per employee and per member per year program cost is down 0.2% and up 0.6% respectively. The FY22 actual experience relative to budget saw a decrease of 8.8% on total program cost and 8.6% on total per employee per year, and this was based on the favorable claims experience through December, as well as timing differences in the Fund and budget amounts relative to the vendor reports used in the quarterly financial report.

Mr. Giovannello pointed out that the loss ratios for Medicare retirees is 78%, for actives is 100%, and non-Medicare retirees is 134%. No concerns based on these ratios as it is typical to see pre-Medicare retirees generate more claims, and the budget rates for Medicare retirees are set higher than the cost of the program, as has been discussed previously with the SEBC.

Based on IBM Watson's quarterly dashboards, there was nothing unusual in the utilization data looking at the most recent 12 months ending December 2021 compared to the prior 12-month period. There are a few items that Mr. Giovannello did mention such as changes in well care and preventative visits (decreased 8.6% for well child and increase of 11.4% for preventative adult visits). Increased screening rates for colon cancer, breast

cancer, cervical cancer, and cholesterol. The State Group Health plan additionally saw an increase in the number of inpatient admissions and an increase in the severity of those admissions, which WTW is continuing to monitor. Pharmacy claims cost increased 7%, and utilization of all prescriptions increased 1.4%. Specialty medications make up 49% of pharmacy spend and saw a 0.9% increase in utilization.

Secretary Magarik queried, when a member is inpatient and utilizes medications dispensed by the hospital, whether that cost is incurred on the medical plan or on the pharmaceutical plan. Mr. Mateja confirmed that it is incurred on the medical plan.

FY23 GHIP Projections

The projections for FY23 have been updated to include $24 million in COVID-19 reimbursement funds. The payment for these claims is expected to be received during FY23 based on claims that were attributable to calendar year 2021. No additional COVID-19 funding relief is reflected in the projections as funding relief would offset COVID-19 related expenses.

Mr. Giovannello made note that the GHIP long-term projections have been updated to reflect all legislation signed into law and initiatives voted on by the SEBC as of February 24th, 2022. GHIP long term health care cost projections for FY23 are reflected with the following legislative impact factored in: Senate Bill 25, which pertains to chiropractor reimbursement not less than Medicare, went into effect January 1, 2022, and has been included in the projections for FY22 with an added cost of $0.5 million in FY22 and FY23. Other legislation either anticipated to be passed or passed with an effective date on or before the end of FY23 are not currently built into the projections. Most notably, Senate Bill 120, the primary care reimbursement bill, which Highmark estimates a fiscal year impact of $4.6M - $29.9M per year for the Highmark population only, is not built into the projections. Aetna has not provided a similar estimate. While these costs are not built into the projections, they should be considered when discussing potential rate action for FY23.

FY22 projection of $30.2 million surplus will be fully depleted during the subsequent plan year, resulting in a $62.7 million deficit projected for FY23. The one-time rate action needed to solve for the $62.7 million deficit in one year would be 8.67%. Smoothing the rate increase over three years to target $0 deficit by the end of FY25 requires an 8.98% annual rate increase in FY23-FY25. Discussion was had on the member impact scenarios tied to each rate action that illustrated the monthly and annual increases by medical plan and coverage tier.

Mr. Taschner asked about the 8.67% rate increase, per Mr. Taschner's analysis and calculation he found that 7.41% rate increase would be the rate action needed to solve for this deficit if the rate changed proportionally with the change in deficit; Mr. Taschner questioned how Mr. Giovannello reached the 8.67% rate increase. Mr. Giovannello responded that the calculation comes down to the subsidization that was previously discussed. The 8.67% rate increase is now based on moving to a Group Medicare Advantage plan and for the first six months of FY23, the State will have the increased subsidization of the current Medicfill rates on the pre-65 and active population rates. Then on January 1, 2023, the subsidization will decrease as the Medicfill rate for medical will convert to the fully insured rate. Historically WTW has not factored in the move to a Group Medicare Advantage Plan and the lost subsidy when presenting the rate increases needed to solve for the projected deficits. Additionally, in the scenarios where Medicfill would be maintained, the Medicfill subsidization would carry forward for the first six months of the fiscal year. Mr. Taschner asked if there is any way that a smoother transition of rates could happen as 7.41% is more favorable than 8.67% from a plan member increase standpoint. Director Cade responded that if the SEBC were just looking at FY23, then they might consider this, but the fact that they are considering the impact of this rate action on future deficits and rate actions makes the decision more complex. Further, there has not been a rate increase since FY17. That's theoretically the concern we run into that whenever we talk about a rate increase, we try to balance that with the impact it will have on employees, in real dollars. Even when we're just looking at this year, we're recommending a significant pay increase for State employees which should absorb a portion of the rate increase. Mr. Taschner acknowledged that he is not opposed to a rate increase as the State of Delaware has had a favorable five-year period and hasn't

raised the rates since FY17. Mr. Taschner indicated he was not convinced that the 8.67% rate increase is what is needed at this point.

Secretary DeMatteis commented that the overall cost of the rate increase to employees, even considering the Governor's proposed salary increases, ranges between $26 and $250 annually. Recognizing that rates are increasing along with inflation driving up all other costs as well, she suggested that the Committee think about the increase in terms of dollar amounts, not just percentages. Mr. Taschner reiterated his understanding that an increase is needed, but again not convinced that an 8.67% rate increase is the right amount. He referenced earlier discussions of potential savings with the SEBC in December 2021 related to the site of steerage in the range of $30-$33M. Mr. Taschner expressed concerns that if this rate increase is to take place, it will take the pressure off the potential to reduce overall plan cost in other potential areas of medical and pharmaceutical spend that would be beneficial to plan participants, the State and Delaware taxpayers. Ultimately, he wanted to focus on solutions that lower the overall cost of the plan rather than jumping to increasing rates by 8.67%.

Secretary Magarik commented that part of the challenge is that many of the other actions the SEBC could take to drive costs down (which they have discussed as a Committee) are many years into the future such as reference-based pricing. While several other measures have been taken, they seem to be largely incremental and don't dramatically affect the trend. Other remaining actions the Committee could take are not things that could be undertaken quickly enough to realize FY23 savings that would warrant putting off a rate increase. She acknowledged that she agreed with Mr. Taschner, that we must continue to put pressure on the vendors and look for ways to reduce overall plan cost because the cost of healthcare inflation is unyielding, but the SEBC also needed to implement a rate increase to solve for the FY23 deficit in the short term.

Director Cade added that the SEBC and its Subcommittees have looked at other cost reduction options at the end of last year, however no other options were enticing either because the effort to make the change wouldn't produce meaningful savings or because there were concerns about disruption to members. He agreed with Secretary Magarik that the conversation about medical cost reductions is one that must continue in the future and those solutions either will not yield immediate savings that would address the deficit in FY23 or FY24 or will produce near-term savings that are negligible. Mr. Taschner responded that he wants the SEBC to start making progress towards evaluating those future opportunities for longer-term savings and noted that even the site of care changes discussed in December could achieve some significant cost savings now if State Group Health Plan could drive the members to a different provider. Mr. Taschner added that, for example, while he understands that not every visit to an emergency room may be appropriate to redirect to an urgent care center, based on data presented at the December Subcommittee meeting, the GHIP could have saved $13.2M in FY21 if emergency room visits were redirected to urgent care, and that savings likely carries through year after year. He questioned what the SEBC needed to do to drive those emergency room visits to urgent care (i.e., those that can be moved into the urgent care setting) and for those non-emergent conditions that do get treated at an emergency care setting, whether there is a significant increase in cost compared to an urgent care setting and why is that. Mr. Taschner ultimately wanted to ensure that the SEBC doesn't lose sight of site-of-care steerage opportunities like that example and ensuring that what whatever the State is paying is the appropriate premium and driving cost down to the extent we can.

As there were no further comments on this topic, the presentation turned to the member impact scenarios associated with an 8.67% increase effective 7/1/2022. This reflects an employee contribution increase ranging between $2.41 - $23.66 per employee per month ($28.92 - $283.92 per year) and State subsidy increases of $57.88 - $156.14 per employee per month ($694.56 - $1,873.68 per year) effective 7/1/2022. The State picks up a much larger piece of this increase, so anytime that the SEBC opts to forego a potential premium increase, it more significantly reduces the revenue input by the State. To Mr. Taschner's point, regarding the dollar difference in the required premium increase after a move to Group MA vs. maintaining Medicfill, the value of the additional Medicfill subsidy is worth about 2% of the overall rate increase, which on the high side is worth about

$65 for an employee with Family coverage in the Comprehensive PPO plan, which is baked into the $283.92 increase.

Also discussed were the current premium rates for Medicfill that would remain in effect through the first six months of FY23, along with the premium rates under the Subcommittees' recommended plan option (Highmark group Medicare Advantage, medical only, retaining the CVS EGWP). With maintaining the EGWP Rx benefit under CVS, the premium rate for drug coverage will maintain some of the Medicfill subsidization that we're seeing happen today since the Rx rate is also higher than the cost of the plan. There would be no change to the structure in terms of how retirees contribute toward that premium. The presentation walked through an example of a pensioner that has retired after July 1, 2012. All Medicfill premium rates would reduce under the new rate structure.

Chief Justice Seitz left the meeting.

OTHER BUSINESS
No new business was presented.

PUBLIC COMMENT
A retiree expressed concern about the GHIP's recent transition to the new PBM. The retiree's specialty medication has been denied for medical necessity when it was previously covered under ESI's formulary. Insurance Commissioner Navarro commented that there is an appeal process through the State that the retiree could consider, and this isn't a challenge with the insurance company per se; rather, it has to do with the drug manufacturer may not be tied to SilverScript. The SBO could assist the retiree with obtaining information about the State's appeal process.

FY23 HEALTH PLAN PREMIUM RECOMMENDATIONS*
Medicare Plan Option – DIRECTOR CADE, CO-CHAIR
Subcommittees recommend moving to Group Medicare Advantage plan (medical only), effective 1/1/2023, administered by Highmark, and to continue offering drug coverage through CVS EGWP.

A MOTION was made by Secretary DeMatteis and seconded by Secretary Magarik to accept the Subcommittees' recommendation for moving to a Group Medicare Advantage plan (medical only), effective 1/1/2023, administered by Highmark, and to continue offering drug coverage through CVS EGWP.

MOTION ADOPTED UNANIMOUSLY
Ashley Tucker is voting on behalf of Chief Justice Seitz.
Keith Warren is voting on behalf of The Lieutenant Governor.

Care Management program decisions – DIRECTOR CADE, CO-CHAIR
HMO and CDH Gold plans: Subcommittees recommend Aetna One Advisor.

A MOTION was made by Secretary Magarik and seconded by Secretary DeMatteis to accept the Subcommittees' recommendation to adopt Aetna One Advisor ("Option 1") for the HMO and CDH Gold plans.

MOTION ADOPTED UNANIMOUSLY
Ashley Tucker is voting on behalf of Chief Justice Seitz.
Keith Warren is voting on behalf of The Lieutenant Governor.

Comprehensive PPO and First State Basic plans: Subcommittees recommend continuing with the Highmark CCMU.

A MOTION was made by Secretary DeMatteis and seconded by Secretary Magarik to accept the Subcommittees' recommendation to continue with the Highmark CCMU for the Comprehensive PPO and First State Basic plans, and in addition to this MOTION Highmark should provide additional transparency into its relationship with its care management partner for the Well360 Clarity care management program, which is not being recommended by the Subcommittees at this time but would potentially be considered in future years.

MOTION ADOPTED UNANIMOUSLY
Ashley Tucker is voting on behalf of Chief Justice Seitz.
Keith Warren is voting on behalf of The Lieutenant Governor.

Aetna HMO – DIRECTOR CADE, CO-CHAIR
Subcommittees recommend retaining the requirement for PCP selection and referrals.

A MOTION was made by Secretary DeMatteis and seconded by Secretary Magarik to accept the Subcommittees' recommendation for retaining the HMO plan's requirement for PCP selection and referrals.

MOTION ADOPTED UNANIMOUSLY
Ashley Tucker is voting on behalf of Chief Justice Seitz.
Keith Warren is voting on behalf of The Lieutenant Governor.

CVS Drug Savings Review Program – DIRECTOR CADE, CO-CHAIR
Subcommittees remain in support of the SEBC considering this program for FY23, but with continued monitoring of the member experience, physician engagement and program results throughout the first year of the program for reconsideration of continuing the program past FY23.

A MOTION was made by Secretary Magarik and seconded by Secretary DeMatteis to accept the Subcommittees' recommendation for adopting this program for FY23, but with continued monitoring of the member experience, physician engagement and program results throughout the first year of the program for reconsideration of continuing the program past FY23.

MOTION ADOPTED UNANIMOUSLY
Ashley Tucker is voting on behalf of Chief Justice Seitz.
Keith Warren is voting on behalf of The Lieutenant Governor.

FY23 Rate Action – DIRECTOR CADE, CO-CHAIR
Financial Subcommittee recommends an 8.67% rate increase effective 7/1/2022 to solve for the projected FY23 deficit of $62.7M

A MOTION was made by Secretary DeMatteis and seconded by Secretary Magarik to accept the Financial Subcommittee's recommendation of an 8.67% rate increase effective 7/1/2022 to solve for the projected FY23 deficit of $62.7M.

MOTION FOR DISCUSSION
Mr. Taschner stated that for the reasons he discussed earlier, he will be voting "No" because he is not convinced that an 8.67% increase is necessary though he does support some level of increase. He also voiced concerns about this being characterized as a "recommendation" from the Subcommittee since as he understood it, there was no vote taken by the Subcommittee but rather a discussion on this topic in which some Subcommittee members acknowledged the necessity of a rate increase, but others did not voice an opinion. He did not believe that there was an affirmative recommendation from the majority of Subcommittee members. Ms. Rentz responded that she has had additional discussions with the majority of Subcommittee members and a number of SEBC members since Thursday's meetings and addressed questions and concerns coming out of those

discussions. Additionally, as the SEBC is aware, the Subcommittees are not voting bodies and only put forth recommendations.

Controller General Jones acknowledged that Mr. Taschner's statement is right, that a large portion of the rate increase is still funded by the General Fund, when we talk about the State's share. Regarding the Governor's Recommended Budget including a one-time amount of $82.8M for the Group Health Insurance Plan, Controller General Jones inquired about the intent of how that funding would be used for the Plan. Director Cade responded that the one-time funding in the Governor's Recommended Budget would not be needed as that was a "worst case scenario" if nothing was solved by the SEBC. The concern, if the SEBC chose against implementing a rate increase in FY23 and tapped into the one-time funding, there would be a larger rate increase required to cover the deficit in FY24. Controller General Jones asked for confirmation that there is nothing in the Governor's Recommended Budget to cover the rate increase, to which Director Cade responded no, this is something that they will need to reconcile during mark-up.

Secretary Magarik indicated that we must be good stewards of taxpayers' dollars, however these scenarios continue to get worse if we don't take a rate action this year. Respectfully, if action is not taken to increase the rates by 8.67% for FY23 and take other actions to solve for savings longer term, the deficit will be dramatically worse in the future. Moving people away from emergency departments is not a quick fix and there are other actions that the SEBC can take. Secretary DeMatteis supports Secretary Magarik's comments and indicated that the deficit has also been mitigated by an influx of federal dollars associated with COVID treatment costs and therefore believes this is a responsible rate increase. Insurance Commissioner Navarro added that no one wants to implement a rate increase, but this action is the prudent thing to do at this point. Mr. Taschner commented that he is not against a rate increase, but not convinced the 8.67% is what is needed. Director Cade responded that at this point the State Group Health plan must act in order to be ready for Open Enrollment but agreed with Mr. Taschner that the rate increase has decreased consistently over the last several financial updates. Secretary DeMatteis added that the recommended salary increase also mitigates the impact of the rate increase, understanding that all costs are going up right now. Treasurer Davis expressed concern that any site of steerage changes must be made carefully to avoid any negative effects on a member's medical needs.

MOTION NOT ADOPTED UNANIMOUSLY – ALL IN FAVOR EXCEPT FOR MR. TASCHNER
Ashley Tucker is voting on behalf of Chief Justice Seitz.
Keith Warren is voting on behalf of The Lieutenant Governor.

ADJOURNMENT
A MOTION was made by Mr. Taschner and seconded by Secretary Magarik to adjourn the Public Session at 4:17 p.m.
MOTION ADOPTED UNANIMOUSLY

Respectfully submitted,

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

State of Delaware

DEPARTMENT OF HUMAN RESOURCES

March 2, 2022

via e-mail

Ms. Wendy Beck, Executive Client Manager
Highmark Delaware
800 Delaware Avenue
Wilmington, DE 19801

Re: Request for Proposal for a Medical Third-Party Administrator for the Group Health Insurance Program (GHIP)

Dear Ms. Beck:

On February 28, 2022, pursuant to the terms listed in the Request for Proposal (RFP) and based on the recommendation of the Financial and Health Policy & Planning Subcommittees, the State Employees Benefits Committee (SEBC) voted in favor of the following:

1. Implementation of a fully insured Group Medicare Advantage plan (medical only) in place of the existing Special Medicfill Supplement plan, effective January 1, 2023, administered by Highmark and continuing to offer drug coverage through the CVS/SilverScript EGWP plan.

2. Continuation of the CCMU care management program for the PPO and First State Basic plans on July 1, 2022.

Thank you for your work to provide the Subcommittees additional information in recent weeks. The Subcommittees and the SEBC continue to evaluate disease management, behavioral health and other chronic disease and conditions programs. Decisions on these programs are expected to be made at the April 2022 SEBC meeting.

In the meantime, we look forward to working together to begin discussions on the implementation of the Group Medicare Advantage plan and appreciate our continued partnership. Willis Towers will be outreaching soon to coordinate a Medicare Advantage implementation kick off call.

Respectfully,

Faith L. Rentz

Faith L. Rentz, Deputy Director
Statewide Benefits Office and Insurance Coverage Office

cc: File

State of Delaware

DEPARTMENT OF HUMAN RESOURCES

March 2, 2022

via e-mail

Ms. Katherine Impellizzeri, Account Director
Aetna
1425 Union Meeting Road
Blue Bell, PA 19422

Re: Request for Proposal for a Medical Third-Party Administrator for the Group Health Insurance Program (GHIP)

Dear Ms. Impellizzeri:

On February 28, 2022, pursuant to the terms listed in the Request for Proposal (RFP) and based on the recommendation of the Financial and Health Policy & Planning Subcommittees, the State Employee Benefits Committee (SEBC) voted in favor of the following:

1. Implementation of the Aetna One Advisor care management program for the HMO and CDH Gold plans effective July 1, 2022.

2. Maintain the requirement for PCP selection and referrals for the Aetna HMO plan effective July 1, 2022.

Thank you for your work to provide the Subcommittees additional information in recent weeks. The Subcommittees and the SEBC continue to evaluate disease management, behavioral health and other chronic disease and conditions programs. Decisions on these programs are expected to be made at the April 2022 SEBC meeting.

In the meantime, we look forward to working together to implement the Aetna One Advisor program and appreciate our continued partnership.

Respectfully,

Faith L. Rentz

Faith L. Rentz, Deputy Director
Statewide Benefits Office and Insurance Coverage Office

cc: File

EXHIBIT G

State of Delaware Pensioners | September 2022

Welcome to your new **Medicare Advantage plan from Highmark**



HIGHMARK. DELAWARE

Agenda

HIGHMARK DELAWARE

Today we're going to discuss:

- How Freedom Blue PPO Works
- Plan Benefit Highlights
- Concierge Member Service Team
- Enrollment Process

How Freedom Blue PPO works.

HIGHMARK DELAWARE

State of Delaware Medicare Coverage today (2022)

Medicare Part A

- Inpatient hospital care
- Skilled nursing care
- Home health and
- hospice

Medicare Part B

- Doctor visits and preventive care
- Testing and lab
- Ambulance and outpatient services
- Durable medical equipment

Highmark Special Medicfill

=

2022 State of DE Medicare Medical Coverage

SilverScript Part D (optional 2022 ONLY)

Freedom Blue PPO

New 2023 State of Delaware Medicare Coverage

Medicare Part A

- Inpatient hospital care
- Skilled nursing care
- Home health
- Hospice

Medicare Part B

- Doctor visits and preventive care
- Testing and lab
- Ambulance and outpatient services
- Durable medical equipment

Highmark Special Medicfill

Freedom Blue Medicare Advantage PPO

Combines all the All the benefits Medicare Original Medicare
+ coverage of the Highmark Special Medicfill plan

SilverScript Part D (required in 2023)

Freedom Blue PPO

How does your Freedom Blue Medicare Advantage PPO plan work

The **Freedom Blue Medicare Advantage** plan assumes responsibility to provide ALL benefits of Original Medicare Parts A (Hospital) and Part B (Outpatient) benefits

The plan combines all original Medicare benefits plus the additional coverage provided by the **Specifical Medicfill** plan into one plan

National service area member can reside **anywhere in the US**

For all covered medical benefits within the United States, members have **100% coverage** when seeking care from contracted **"In Network"** as well as non-contracted **"Out of Network"** providers anywhere within the US

Members must continue enrollment in both **Medicare Part A & Part B** and continue to pay monthly **Medicare Part B premiums**

Starting in January 1st, you will no longer use your Original Medicare (red, white, and blue) card when seeking any medical service – only your Highmark **Freedom Blue Medicare Advantage PPO ID card**

Freedom Blue PPO

What you need to know about your health plan

Starting on January 1st, all medical claims submitted to Highmark (coverage for the Medicare Advantage Plan only) and NOT to Medicare

- Members will receive one Explanation Of Benefits (EOB) from Highmark for all Medical claims

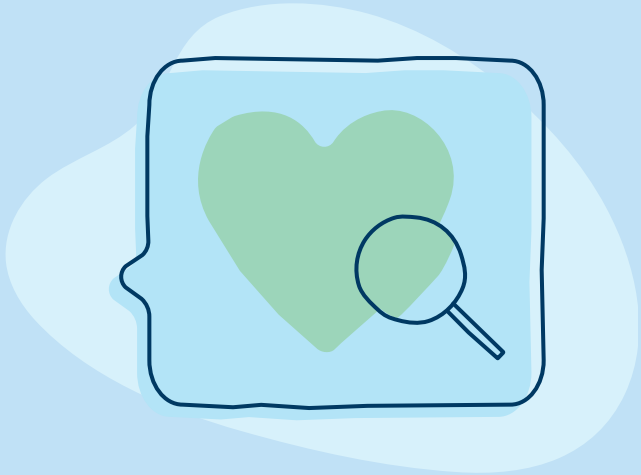
No referrals to see a specialist or other providers

Members do not need to select a PCP (although it is highly encouraged)

Prior Authorizations may apply to certain services such as Inpatient Hospital Services, Skilled Nursing Facility Stays, and Advanced Images (e.g., CT/PET Scan).

- Contracted “In Network” providers are responsible to submit to Highmark for approval.
- When seeking care from non-network providers members, ask for a pre-visit coverage decision to confirm that the services you are getting are covered and are medically necessary.

Let’s look at your Highmark Medicare benefits.



HIGHMARK DELAWARE

Highmark Medical Benefits

Benefit Design

Plan Wide Cost Sharing	Freedom Blue PPO Member Pays (In Network and Out of Network)
Deductible	**$0**
Member Out of Pocket Maximum ***Applies to Part A, Part B, and outpatient professional services outside of the United States. Excludes Private Duty Nursing cost sharing.***	**$1,000** **(Combined INN & OON)**

Highmark Medical Benefits

Benefit Design

Medical Benefits	Freedom Blue PPO Member Pays (In Network and Out of Network)
PCP Office Visit	**$0**
Specialist Office Visit	**$0**
Therapies (Speech, Physical, Occupational)	**$0**
Inpatient Hospital	**$0**
Skilled Nursing Facility (up to 100 days per benefit period)	**$0**

Highmark Medical Benefits

Benefit Design

Medical Benefits	Freedom Blue PPO Member Pays (In Network and Out of Network)
Outpatient Surgery	$0
Emergency Room	$0
Urgent Care	$0
Ambulance	$0
Diagnostic Services (Lab and Images)	$0
Durable Medical Equipment	$0
Part B Rx	$0

Highmark Medical Benefits

Benefit Design

Medical Benefits	Freedom Blue PPO Member Pays
Inpatient or Outpatient facility coverage outside of the United States*	$0 if urgent or emergent care and non urgent or emergent care
Outpatient professional services outside of the United States*	$0 if urgent or emergent care. 80% for routine (non urgent or emergent care)
Private Duty Nursing *When inpatient in acute care hospital*	20% of the allowable charges and 100% of charges after the 240-hour maximum is met. *Member cost sharing is excluded from the Out of Pocket Maximum.*

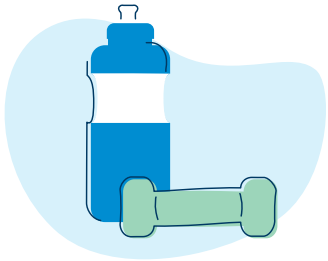
*Services defined as coverable under Medicare policy guidelines within the United States

Highmark Medical Benefits

Even more **benefits** from **Highmark:**

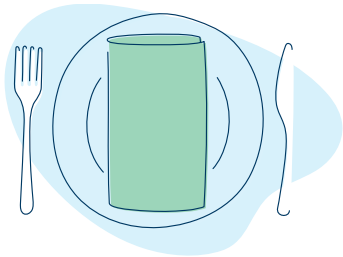
Clinical Care Team

Experts to help you manage your health.



Wellness Program

A wellness and rewards program tailored to your health and well-being.



Post-discharge Meals

Make your return from the hospital easier by having pre-made, frozen meals delivered directly to your doorstep — at no cost to you.*

*Post-discharge meal program covers two meals per day or 14 days.

Highmark Medical Benefits

The **SilverSneakers** Program

Exclusive Member Portal
The member portal provides fresh, relevant content around fitness, brain health, nutrition and more!

SilverSneakers On-Demand™
Follow-along videos and programs with various formats to support cardiovascular strength, endurance, flexibility and mental health

Live Interactive Classes
SilverSneakers LIVE™ classes and workshops are offered daily, and are focused of exercise and overall wellbeing

SilverSneakers GO™
This mobile app is the SilverSneakers on the go companion, providing exercise guidance that can be adjusted based on ability

Access to Nationwide Fitness Locations
A free fitness benefit with access to thousands of fitness locations nationwide[1]

National Reciprocity
The ability to enroll at multiple locations at the same time – no limit to the number of locations where you participate

Signature SilverSneakers Classes
Proprietary programming for older adults to accommodate a wide range of physical activity interests and ability levels – even group activities and classes[2] offered outside the traditional fitness center setting

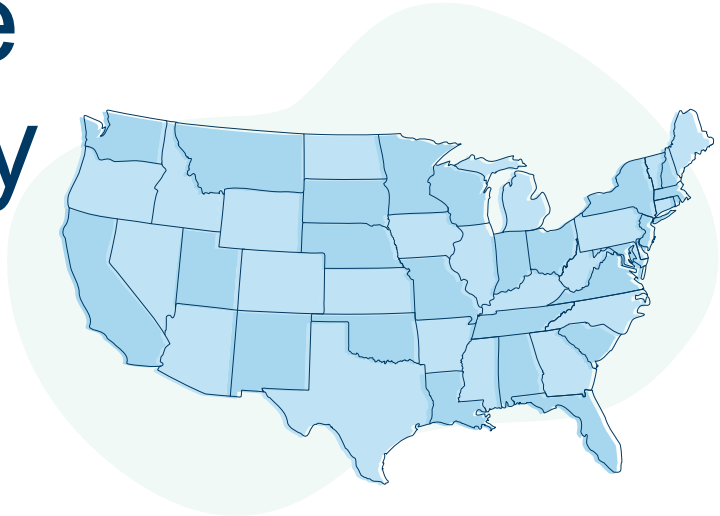
Social Connections
Social connectivity solutions where you can form genuine connections with other members

1. Participating locations ("PL") are not owned or operated by Tivity Health, Inc. or its affiliates. Use of PL facilities and amenities is limited to terms and conditions of PL basic membership. Facilities and amenities vary by PL.

2. Membership includes SilverSneakers instructor-led group fitness classes. Some locations offer members additional classes. Classes vary by location.

Highmark Medical Benefits

Access to Medicare Providers Nationally



Members can reside anywhere in the United States or US territories

Freedom Blue PPO offers a large national network of contracted “In Network” Medicare Advantage PPO providers

Members can see out-of-network providers who accept Original Medicare and the plan

To find or confirm contracted In Network Providers, members can call your State of Delaware Medicare Advantage Concierge service team

Members can always use our online provider finder directory, too.

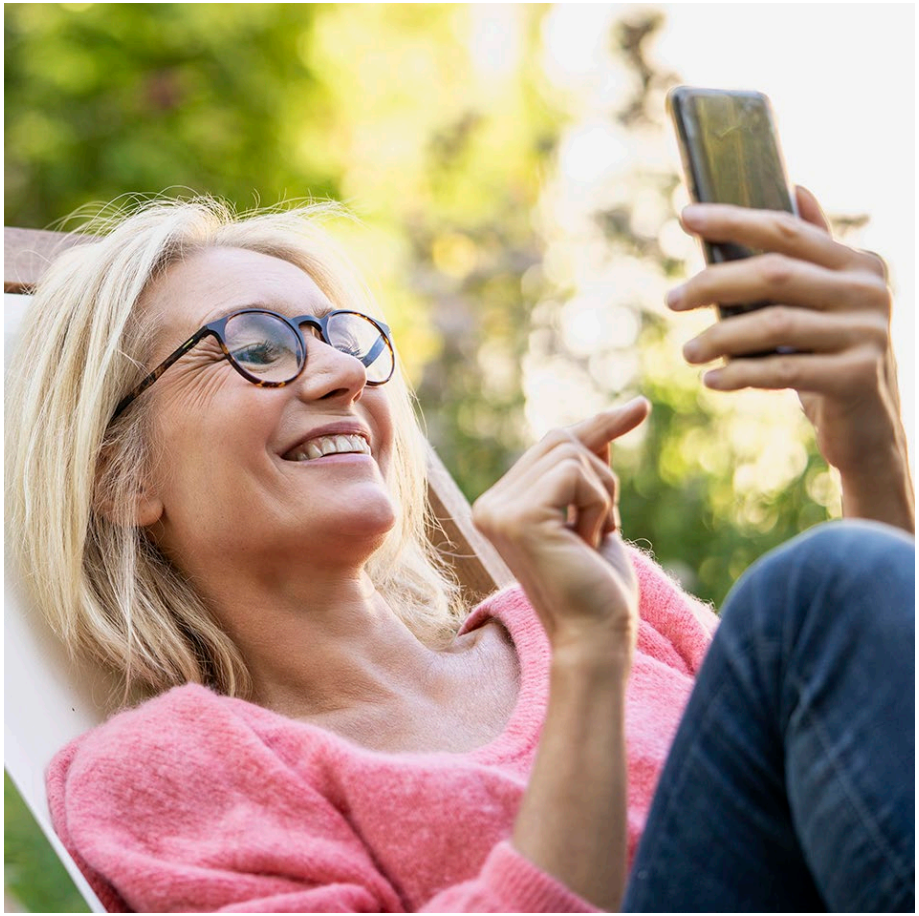
To find a local doctor (in Delaware)

- Visit **highmarkbcbsde.com/find-a-doctor**.
- Click on “**Medical**.”
- Click “**Network**” and find “**Freedom Blue PPO**.”
- Type in the city, state, and ZIP code to find a provider.
- Enter the provider or facility you’re looking for and click “**Search**.”

Freedom Blue PPO Concierge Service Team

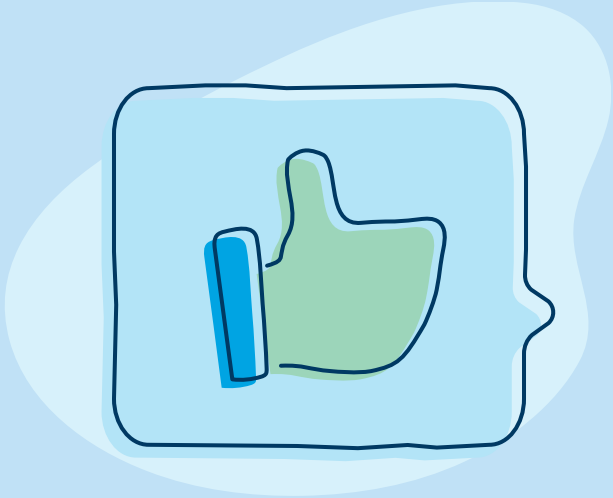
If you have questions about Medicare or how your new Freedom Blue PPO Medicare Advantage plan works, call 1-888-328-2960, 8 a.m. - 8 p.m., seven days a week (TTY call 711)

- Addressing coverage/claims questions
- Assistance finding providers
- Confirm status of Prior Authorization
- Requests pre-visit coverage decision
- Assistance with scheduling appointments
- Medical record transfer support



Let’s talk about how you will get enrolled.

Open Enrollment takes place October 3 to October 24.



HIGHMARK DELAWARE

Getting enrolled

What to **expect** and **when**

You are here!

September
In-person
Town Halls/
Information Sessions

Late September

You'll receive enrollment mailings that contain all the details about your new plan and steps to take to enroll.

October 3rd – October 24th

Open Enrollment period

Mid-November – January 2023

You'll receive a welcome call and kit, your new ID cards, and more information about your new Medicare Advantage plan.

Thank you!

If you have questions about Medicare or how your new Freedom Blue PPO Medicare Advantage plan works, call 1-888-328-2960, 8 a.m. - 8 p.m., seven days a week (TTY call 711). Or visit DelawarePensions.com.

With **Highmark,** you're getting so much more than just **Medicare.**

2022 Benefits Review Meeting

HIGHMARK®

Legislative Town Hall

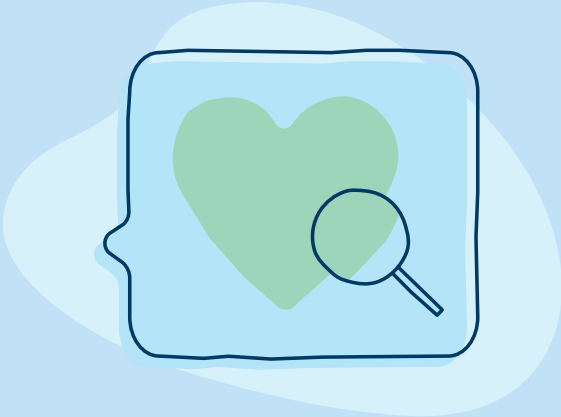
September 22, 2022

Medicare Advantage Transition

When will this change to a Medicare Advantage plan occur?

Beginning **January 1, 2023**, the State of Delaware Group Health Insurance Plan will offer one Medicare plan option - **Highmark Blue Cross Blue Shield (BCBS) Delaware's Freedom Blue PPO Medicare Advantage Plan (with Part D prescription through SilverScript).**

Let’s look at your Highmark Medicare benefits.



HIGHMARK. DELAWARE

Highmark Medical Benefits

Benefit Design

Plan Wide Cost Sharing	Freedom Blue PPO Member Pays (In Network and Out of Network)
Deductible	**$0**
Member Out of Pocket Maximum ***Applies to Part A, Part B, and outpatient professional services outside of the United States. Excludes Private Duty Nursing cost sharing.***	**$1,000** **(Combined INN & OON)**

Highmark Medical Benefits

Benefit Design

Medical Benefits	Freedom Blue PPO Member Pays (In Network and Out of Network)
PCP Office Visit	$0
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Highmark Medical Benefits

Benefit Design

Medical Benefits	Freedom Blue PPO Member Pays (In Network and Out of Network)
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Highmark Medical Benefits

Benefit Design

Medical Benefits	Freedom Blue PPO Member Pays
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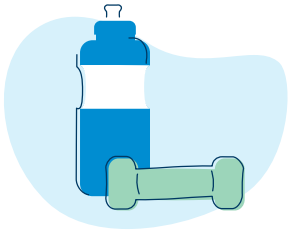
***Services defined as coverable under Medicare policy guidelines within the United States**

Highmark Medical Benefits

Even more **benefits** from **Highmark:**

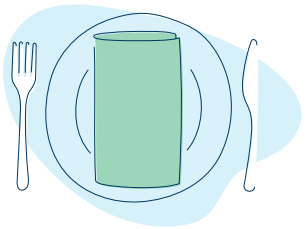
Clinical Care Team

Experts to help you manage your health.



Wellness Program

A wellness and rewards program tailored to your health and well-being.



Post-discharge Meals

Make your return from the hospital easier by having pre-made, frozen meals delivered directly to your doorstep — at no cost to you.*

*Post-discharge meal program covers two meals per day or 14 days.

Why the change?

- State Employee Benefits Committee (SEBC) routinely reviews benefit options as required by procurement process
- Part of a broader review with the Retirement Benefits Study Committee (RBSC)
- New plan matches benefits and out-of-pocket costs for old plan, with added benefits and lower costs

What is a Medicare Advantage Plan?

- AKA Medicare Part C
- All-in-one alternative to Original Medicare
- Includes Medicare Part A (Hospital), Medicare Part B (Medical) and many include Medicare Part D (Prescription)
- Medicare approves and pays insurance company, which must follow Medicare rules

Is the new plan like other M.A. plans?

This plan is only available to SOD Pensioners and has been specifically designed to provide the same coverage as the old plan.

Are the requirements for Medicare Parts A and B changing?

Enrollment in the new plan does NOT impact eligibility or enrollment requirements for Medicare Parts A and B.

Does enrolllment in Medicare Advantage mean giving up Medicare?

Enrollment in MA means Highmark assumes responsibility for all Medicare Part A & B services as long as the pensioner pays their Part B premium.

Can a Pensioner also enroll in other M.A. or Part D coverage?

Pensioners enrolled in another M.A. or Part D plan should contact the Pension Office.

Pensioners enrolled in Special Medicfill without Prescription will receive instructions from the Pension Office.

What if Medicare Part A or B coverage changes?

- The new plan will be required to cover all services approved and available under Medicare Parts A and B throughout the 3-year contract period.
- Prescription benefits will continue to be handled by SilverScripts.

Are covered services the same as the old plan?

The new plan has been specifically designed to cover the same services as the old plan and includes the same SilverScript prescription coverage.

Can Pensioners keep current doctors?

Pensioners can see in-network or out-of-network (i.e. non contracted) providers eligible to participate in Medicare that accept the plan.

. Pensioners should call Highmark with questions about providers.

Is a Primary Care provider required?

It is highly encouraged to help coordinate health care needs, but a Primary Care doctor is not required.

Are referrals required to see a specialist?

Referrals are not required for specialist care. Pensioners can see any specialist in-network or out-of-network eligible to participate in Medicare that accept the plan.

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(A referral is not the same as a prior authorization.)

What if a provider doesn't accept the new plan?

- Pensioners can still see the provider as an out-of-network provider
- The plan will reimburse in-network providers at contracted amount and out-of-network providers at the Medicare approved amount (up to the Medicare limiting amount)
- Most providers accept the plan, and Highmark is outreaching to DE providers to minimize disruption
- Pensioners should call the Pension Office or Statewide Benefits Office if their provider says they are not accepting the new plan

How does reimbursement work if the provider is out-of-network?

- Providers can bill Highmark (or when out of State the local Blue Cross Blue Shield plan) for covered services.
- If the member is required to pay upfront, the member can submit the claim to Highmark for reimbursement of covered benefits.

Is prior approval for care or services required?

- **In some cases, yes.**
- The services requiring prior approval are detailed in the materials coming from Highmark
- Approval rate is 92%
- Turnaround times for expedited cases: under 2 days
- Turnaround times for standard cases: under 5 days
- Not required for emergency care
- Not applicable for outpatient services until May 1
- Members can appeal if prior approval is denied

What if the pensioners does not live in Delaware?

- The network is national
- Pensioners can see all in-network (contracted) Providers or out-of-network (i.e. non contracted) providers eligible to participate in Medicare that accept the plan.

- Show the provider the ID card
- Call Highmark for help finding a provider and determining network status
- Providers send prior authorization requests and pre-visit coverage decisions directly to Highmark regardless of location

Can the pensioner choose not to enroll in the new plan?

Yes, pensioners can opt out during Open Enrollment by contacting the Pension Office, **BUT**…

- The new plan will be the ONLY SOD Medicare health plan option
- Pensioners should not opt out if SOD is their only coverage
- Pensioners will not receive the value of the premium for use in purchasing another plan
- Dependents might lose coverage eligibility

When is SOD Medicare Open Enrollment?

October 3 -24, 2022

for benefits effective

January 1, 2023

When will pensioners receive more information?

Open Enrollment packets from the Pension Office were mailed on September 15th.

More information, including a Summary of Benefits and a Medical Benefits Chart is coming from Highmark and will arrive in Pensioner mailboxes in late September. These mailings are already posted on the Highmark Medicare Advantage website.

Open Enrollment Sessions to be held in each county during Open Enrollment

If a pensioner does not enroll this year, will they be able to later?

- Opportunity to enroll or disenroll every year during Medicare Open Enrollment
- Pensioners who enroll during this year's Open Enrollment will not be required to go through medical underwriting or refused enrollment because of pre-existing conditions

If a spouse has other Medicare coverage from a previous employer, are they eligible for the new plan?

- If a spouse is Medicare eligible and offered a Medicare Advantage plan (or cash in lieu of coverage) by their former employer, they will be able to keep their current coverage or enroll in SOD's Medicare Advantage Plan.
- If a spouse is enrolled in an employer sponsored Special Medicfill plan through a former employer, contact the Pension Office to discuss options.

What ID cards will the Pensioner receive/use?

- No longer use red, white, and blue Medicare card
- Pensioners will receive a Highmark Advantage PPO ID card from Highmark in December 2022 to use for all medical care
- Use SilverScript ID card for prescriptions
  - Keep if Pensioner already has one
  - If not currently enrolled in Part D, Pensioner will receive one in December 2022

When will the contract be available?

- The contract and performance guarantees (PGs) are being finalized
- Both will be posted publicly once finalized
- PGs will include detailed monthly reporting on prior approvals and denials and appeals with financial penalties if not met

Why is the premium so much lower?

- Broad network of high-quality physicians share a commitment to preventive care and screenings
- Member engagement in care and disease management programs to help members reach health goals
- Tools and resources to help navigate care so members receive appropriate care in appropriate settings
- SEBC set the premiums for all State plans based upon projected health and prescription plan expenses.

Medicare Advantage Resources

Medicare Advantage Resources

- Statewide Benefits Office Highmark Delaware Medicare Advantage webpage (also accessible from the Office of Pensions site)
- Medicare Advantage October Open Enrollment Sessions
- Medicare Advantage Frequently Asked Questions
- Highmark Medicare Advantage Pre-OE Mailer
- Medicare Advantage Medical Benefits Chart
- State of Delaware Medicare Advantage Mailings/Events Timeline
- Pensioners may contact Highmark BCBS Delaware at **1-888-328-2960 (TTY call 711), seven days a week, 8 a.m. to 8 p.m.** with questions about the Highmark BCBS Delaware Freedom Blue PPO Medicare Advantage plan.
- Pensioners with questions about their enrollment or the State of Delaware Medicare benefits may also contact the Office of Pensions at **1-302-739-4208** or **1-800-722-7300**.

Thank You

Phone: 1-800-489-8933

Email: benefits@delaware.gov

Website: de.gov/statewidebenefits

Like us on Facebook: delawarestatewidebenefits

Medicare Advantage Transition Legislative Town Halls

October 10, 2022

Medicare Advantage Transition

When will this change to a Medicare Advantage (M.A.) plan occur?

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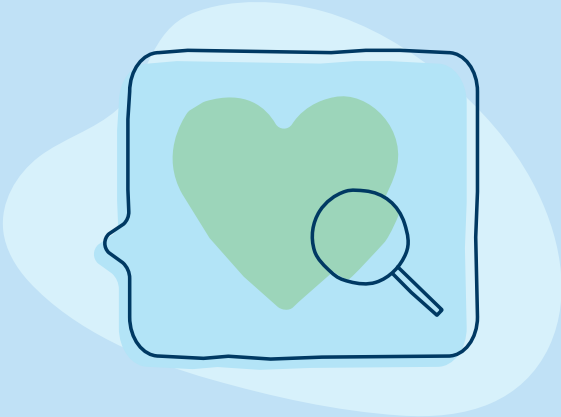

HIGHMARK. DELAWARE

Highmark Medical Benefits

Benefit Design

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Highmark Medical Benefits

Benefit Design

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Primary Care Provider Office Visit	$0
Specialist Office Visit	$0
Therapies (Speech, Physical, Occupational)	$0
Inpatient Hospital	$0
Skilled Nursing Facility (up to 100 days per benefit period)	$0

Highmark Medical Benefits

Benefit Design

Medical Benefits	Freedom Blue PPO Member Pays (In Network and Out of Network)
Outpatient Surgery	$0
Emergency Room	$0
Urgent Care	$0
Ambulance	$0
Diagnostic Services (Lab and Images)	$0
Durable Medical Equipment	$0
Part B Rx	$0

Highmark Medical Benefits

Benefit Design

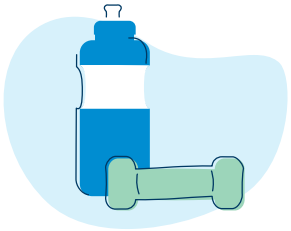
Medical Benefits	Freedom Blue PPO Member Pays
Inpatient or Outpatient facility coverage outside of the United States*	**$0 if urgent or emergent care and non urgent or emergent care**
Outpatient professional services outside of the United States*	**$0 if urgent or emergent care. 80% for routine (non urgent or emergent care)**
Private Duty Nursing ***When inpatient in acute care hospital***	**20% of the allowable charges and 100% of charges after the 240-hour maximum is met.** ***Member cost sharing is excluded from the Out of Pocket Maximum.***

***Services defined as coverable under Medicare policy guidelines within the United States**

Even more **benefits** from **Highmark:**

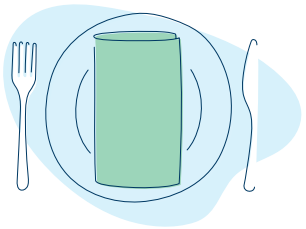
Clinical Care Team

Experts to help you manage your health.



Wellness Program

A wellness and rewards program tailored to your health and well-being.



Post-discharge Meals

Make your return from the hospital easier by having pre-made, frozen meals delivered directly to your doorstep — at no cost to you.*

*Post-discharge meal program covers two meals per day or 14 days.

Why the change?

- State Employee Benefits Committee (SEBC) routinely reviews benefit options as required by procurement process
- Part of a broader review with the Retirement Benefits Study Committee (RBSC)
- New plan matches benefits and out-of-pocket costs for old plan, with added benefits and lower costs

What is a Medicare Advantage Plan?

- Also know as Medicare Part C
- All-in-one alternative to Original Medicare
- Includes Medicare Part A (Hospital), Medicare Part B (Medical) and many include Medicare Part D (Prescription)
- Medicare approves and pays insurance company, which must follow Medicare rules

Is the new plan like other M.A. plans?

This plan is only available to State of Delaware pensioners and has been specifically designed to provide the same coverage as the old plan.

Are the requirements for Medicare Parts A and B changing?

Enrollment in the new plan does NOT impact eligibility or enrollment requirements for Medicare Parts A and B.

Does enrollment in Medicare Advantage mean giving up Medicare?

Enrollment in M.A. means Highmark assumes responsibility for all Medicare Part A & B services as long as the pensioner pays their Part B premium.

Can a pensioner also enroll in other M.A. or Part D coverage?

Pensioners enrolled in another M.A. or Part D plan should contact the Pension Office.

Pensioners enrolled in Special Medicfill without Prescription will receive instructions from the Pension Office.

What if Medicare Part A or B coverage changes?

- The new plan will be required to cover all services approved and available under Medicare Parts A and B throughout the 3-year contract period.
- Prescription benefits will continue to be handled by SilverScript.

Are covered services the same as the old plan?

The new plan has been specifically designed to cover the same services as the old plan and includes the same SilverScript prescription coverage.

Is a Primary Care provider required?

It is highly encouraged to help coordinate health care needs, but a Primary Care doctor is not required.

Are referrals required to see a specialist?

Referrals are not required for specialist care. Pensioners can see any specialist in-network or out-of-network eligible to participate in Medicare and accept the plan.

(A referral is not the same as a prior authorization.)

Can pensioners keep their current doctors?

Pensioners can see in-network or out-of-network (i.e. non contracted) providers eligible to participate in Medicare and accept the plan.

Pensioners should call Highmark with questions about providers.

What if the pensioner does not live in Delaware?

- The network is national
- Pensioners can see all in-network (contracted) providers or out-of-network (non contracted) providers eligible to participate in Medicare and accept the plan.
- Show the provider the ID card
- Call Highmark for help finding a provider and determining network status
- Providers send prior authorization requests and pre-visit coverage decisions directly to Highmark regardless of location

What if a provider doesn't accept the new plan?

- Pensioners can still see the provider as an out-of-network provider
- The plan will reimburse in-network providers at contracted amount and out-of-network providers at the Medicare approved amount (up to the Medicare limiting amount)
- Most providers accept the plan, and Highmark is outreaching to DE providers to minimize disruption
- Pensioners should call the Pension Office or Statewide Benefits Office if their provider says they are not accepting the new plan

How does reimbursement work if the provider is out-of-network?

- Providers can bill Highmark (or when out of State the local Blue Cross Blue Shield plan) for covered services.
- If the member is required to pay upfront, the member can submit the claim to Highmark for reimbursement of covered benefits.

Is prior approval for care or services required?

- **In some cases, yes.**
- The services requiring prior approval are detailed in the materials coming from Highmark
- Approval rate is 92%
- Turnaround times for expedited cases: under 2 days
- Turnaround times for standard cases: under 5 days
- **Not required for emergency care**
- Not applicable for outpatient services until May 1
- Members can appeal if prior approval is denied

Can a pensioner appeal a denial of services?

- Centers for Medicare & Medicaid (CMS) mandates a five-level appeals process for Medicare Advantage plans
  - Level 1 – reconsideration by Highmark from different physician than the physician who made the initial coverage decision
  - Level 2 – an Independent Review Entity (IRE) hired by CMS
  - Level 3 – an Administrative Law Judge Hearing with the Office of Medicare Hearings and Appeals
  - Level 4 – Medicare Appeals Council
  - Level 5 – Federal District Court

- Details of the Highmark Medicare Advantage appeals process and how to request assistance are outlined in the Medicare Advantage Evidence of Coverage document that will be available in early October for all State of Delaware pensioners.

Can the pensioner choose not to enroll in the new plan?

Yes, pensioners can opt out during Open Enrollment by contacting the Pension Office, **BUT**…

- The new plan will be the ONLY State of Delaware Medicare health plan option
- Pensioners should not opt out if State of Delaware is their only coverage
- Pensioners will not receive the value of the premium for use in purchasing another plan
- Dependents might lose coverage eligibility

When is State of Delaware Medicare Open Enrollment?

October 3 -24, 2022

for benefits effective

January 1, 2023

When will pensioners receive more information?

Open Enrollment packets from the Pension Office were mailed on September 15th.

More information, including a Summary of Benefits and a Medical Benefits Chart is coming from Highmark and arrived in Pensioner mailboxes in late September. These mailings are already posted on the Highmark Medicare Advantage website.

Open Enrollment Sessions to be held in each county during Open Enrollment

If a pensioner does not enroll this year, will they be able to later?

- Opportunity to enroll or disenroll every year during Medicare Open Enrollment
- Pensioners who enroll during Open Enrollment will not be required to go through medical underwriting or refused enrollment because of pre-existing conditions

If a spouse has other Medicare coverage from a previous employer, are they eligible for the new plan?

- If a spouse is Medicare eligible and offered a Medicare Advantage plan (or cash in lieu of coverage) by their former employer, they will be able to keep their current coverage or enroll in SOD's Medicare Advantage Plan.
- If a spouse is enrolled in an employer sponsored Special Medicfill plan through a former employer, contact the Pension Office to discuss options.

What ID cards will the pensioner receive/use?

- No longer use red, white, and blue Medicare card
- Pensioners will receive a Highmark Advantage PPO ID card from Highmark in December 2022 to use for all medical care
- Use SilverScript ID card for prescriptions
  - Keep if Pensioner already has one
  - If not currently enrolled in Part D, Pensioner will receive one in December 2022

When will the contract be available?

- The contract and 21mperformance guarantees (PGs) are finalized
- Both are posted publicly on DHR website
- PGs include detailed monthly reporting on prior approvals and denials and appeals with financial penalties if not met

Why is the premium so much lower?

- Broad network of high-quality physicians share a commitment to preventive care and screenings
- Member engagement in care and disease management programs to help members reach health goals
- Tools and resources to help navigate care so members receive appropriate care in appropriate settings
- SEBC set the premiums for all State plans based upon projected health and prescription plan expenses.

Medicare Advantage Resources

Medicare Advantage Resources

- Statewide Benefits Office Highmark Delaware Medicare Advantage webpage (https://dhr.delaware.gov/benefits/medicare/medicare-advantage.shtml) to review:
- Medicare Advantage October Open Enrollment Sessions
- Medicare Advantage Frequently Asked Questions
- Highmark Medicare Advantage Pre-OE Mailer
- Medicare Advantage Medical Benefits Chart
- State of Delaware Medicare Advantage Mailings/Events Timeline

- Pensioners may contact Highmark BCBS Delaware at **1-888-328-2960 (TTY call 711), seven days a week, 8 a.m. to 8 p.m.** with questions about the Highmark BCBS Delaware Freedom Blue PPO Medicare Advantage plan.

- Office of Pensions webpage (https://open.omb.delaware.gov)
- Pensioners with questions about their enrollment or the State of Delaware Medicare benefits may also contact the Office of Pensions at **1-302-739-4208** or **1-800-722-7300**.

Thank You

Phone: 1-800-489-8933

Email: benefits@delaware.gov

Website: de.gov/statewidebenefits

Like us on Facebook: delawarestatewidebenefits

EXHIBIT H

Medicare Advantage Rates Effective January 1, 2023 – December 31, 2023

	Total Monthly Rate	State Share	Pensioner Pays
Highmark Delaware Medicare Advantage for Pensioners Retired On or Prior to July 1, 2012			
Highmark BCBS Delaware Freedom Blue PPO Medicare Advantage Plan*	$216.18	$216.18	$0.00
Highmark Delaware Medicare Advantage for Pensioners Retired After July 1, 2012			
Highmark BCBS Delaware Freedom Blue PPO Medicare Advantage Plan*	$216.18	$205.38	$10.80

*Rates reflect Medicare Advantage plan with Part D prescription coverage through SilverScript®. Medicare-eligible Participating Group members must contact their HR/Benefits Office for rate information.

- If you have less than 20 years of service and were first hired on or after July 1, 1991, the State does not pay the full state share but will pay a percentage of the state share of the cost of your coverage as explained in the charts below.

Eligible Pensioners Hired By The State On Or After July 1, 1991 Through December 31, 2006 ***(The following portion of the State Share will be paid by the State)*** **(Except those receiving a disability pension or receiving an LTD benefit)**		
Less than 10 years service	0%	state share paid by state
10 years - less than 15 years service	50%	state share paid by state
15 years - less than 20 years service	75%	state share paid by state
20 years or more service	100%	state share paid by state
Eligible Pensioners Hired By The State On Or After January 1, 2007 ***(The following portion of the State Share will be paid by the State)*** **(Except those receiving a disability pension or receiving an LTD benefit)**		
Less than 15 years service	0%	state share paid by state
15 years - less than 17.5 years service	50%	state share paid by state
17.5 years - less than 20 years service	75%	state share paid by state
20 years or more service	100%	state share paid by state

IN THE SUPERIOR COURT OF THE STATE OF DELAWARE

RISEDELAWARE INC., *et al.*,	)	
	)	
Plaintiffs,	)	
v.	)	
	)	
Secretary Claire DeMatteis, in her official capacity as Secretary of the Delaware Department of Human Resources and Co-Chair of the State Employee Benefits Committee, *et al*.,	)	C.A. No. N22C-09-526 CLS
	)	
Defendants.	)	

STATE OF DELAWARE)
NEW CASTLE COUNTY)

DECLARATION OF CLAIRE DEMATTEIS IN OPPOSITION TO PLAINTIFFS' PETITION FOR ATTORNEYS' FEES

I, Claire DeMatteis, hereby depose and state as follows:

1. I am the Secretary of the State of Delaware Department of Human Resources (DHR).

2. I am over the age of 18 years and am competent to testify.

3. As early as August 18, 2022, litigation regarding the proposed Medicare Advantage contract was threatened. Copies of relevant communications are attached hereto as Exhibit A. Specifically, Rep. John Kowalko stated via email on August 18, 2022, "Class action lawsuit is a possibility. This has happened in New York City." Ex. A.

4. In response, several communications were passed between myself and various stakeholders, including elected officials, regarding the timing of the execution of the Medicare Advantage contract. *See e.g.*, Ex. B-C.

5. It was announced at a town hall meeting, and everyone was aware, that the anticipated timeline for execution of the contract was the end of September 2022. Similar statements were also made on calls with State legislators.

6. Members of Plaintiffs' group, including but not limited to Plaintiff Karen Peterson, were or should have been aware that the contract would be executed in late September. I know this because we discussed the timing for execution of the contract on a September 14, 2022, Zoom, which Karen Peterson attended.

7. Accurate information regarding an estimate for completion of the contract was also provided by DHR Communications Director Karen Smith to Rep. John Kowalko on September 26, 2022 in a written communication that I was copied on—before the Complaint in this action was filed. Ex. B.

8. After the contract was executed on September 28, 2022, it was publicly posted to the SEBC's website the next business day.

9. The Highmark Medicare Advantage contract was executed in accordance with the timeline disclosed, so that open enrollment under the plan could be completed and implemented by January 1, 2023.

10. The negotiation of a contract of this size (over 180 pages) and the timing of execution was conducted in the normal course of business and clearly communicated.

11. After the Highmark Medicare Advantage contract was signed, it was my view that the Medicare Advantage contract could not be rescinded without the State incurring substantial damages.

12. However, following this Court's October 19, 2022 Order staying implementation of the contract, it created a critical need within the meaning of 29 *Del. C.*§ 6907(b), thereby allowing the waiver of the State's competitive bidding requirements and extension of the current Medicfill contract through 2023.

I declare under the penalty of perjury under the laws of Delaware that the foregoing is true and correct to the best of my knowledge, information, and belief.

EXECUTED this the 22 day of November 2022.

Claire M. DeMatteis

Exhibit A

From: Kowalko, John (LegHall) <John.Kowalko@delaware.gov>
Date: Thursday, August 18, 2022 at 4:35 PM
To: Adams, Joanna (OPen) <joanna.adams@delaware.gov>, Geisenberger, Rick J (Finance) <Rick.Geisenberger@delaware.gov>, Cade, Cerron (OMB) <Cerron.Cade@delaware.gov>, Grant, Suzanne (OPen) <Suzanne.Grant@delaware.gov>, Agra, Arturo (OPen) <Arturo.Agra@delaware.gov>, Shevock, Nancy (OPen) <Nancy.Shevock@delaware.gov>, Simpler, Ken (OPen) <ken.simpler@delaware.gov>, Stafford, Harold (OPen) <harold.stafford@delaware.gov>
Cc: Baumbach, Paul (LegHall) <Paul.Baumbach@delaware.gov>, Bennett, Andria (LegHall) <andria.bennett@delaware.gov>, Bentz, David (LegHall) <David.Bentz@delaware.gov>, Bolden, StephanieT (LegHall) <StephanieT.Bolden@delaware.gov>, Bush, William (LegHall) <william.bush@delaware.gov>, Carson, William (LegHall) <William.Carson@delaware.gov>, Chukwuocha, Nnamdi (LegHall) <Nnamdi.Chukwuocha@delaware.gov>, Cooke, Franklin D (LegHall) <FranklinD.Cooke@delaware.gov>, DorseyWalker, Sherry (LegHall) <Sherry.DorseyWalker@delaware.gov>, Freel, Bud (LegHall) <Bud.Freel@delaware.gov>, Griffith, Krista (LegHall) <Krista.Griffith@delaware.gov>, Heffernan, Debra (LegHall) <Debra.Heffernan@delaware.gov>, Johnson, Kendra (LegHall) <Kendra.Johnson@delaware.gov>, Kowalko, John (LegHall) <John.Kowalko@delaware.gov>, Lambert, Larry (LegHall) <Larry.Lambert@delaware.gov>, Longhurst, Valerie (LegHall) <Valerie.Longhurst@delaware.gov>, Lynn, Sean M (LegHall) <Sean.Lynn@delaware.gov>, Matthews, Sean (LegHall) <Sean.Matthews@delaware.gov>, MinorBrown, Melissa C (LegHall) <Melissa.MinorBrown@delaware.gov>, Mitchell, John L (LegHall) <John.L.Mitchell@delaware.gov>, Moore, Rae (LegHall) <Rae.Moore@delaware.gov>, Morrison, Eric (LegHall) <Eric.Morrison@delaware.gov>, Osienski, Edward (LegHall) <Edward.Osienski@delaware.gov>, Schwartzkopf, Peter (LegHall) <Peter.Schwartzkopf@delaware.gov>, Williams, Kimberly (LegHall) <Kimberly.Williams@delaware.gov>, Wilson-Anton, Madinah (LegHall) <Madinah.Wilson-Anton@delaware.gov>, Bonini, Colin (LegHall) <Colin.Bonini@delaware.gov>, Delcollo, Anthony (LegHall) <Anthony.Delcollo@delaware.gov>, Hocker, Gerald (LegHall) <Gerald.Hocker@delaware.gov>, Lawson, Dave (LegHall) <Dave.Lawson@delaware.gov>, Lopez, Ernesto B (LegHall) <Ernesto.Lopez@delaware.gov>, Pettyjohn, Brian (LegHall) <Brian.Pettyjohn@delaware.gov>, Richardson, Bryant L (LegHall) <Bryant.Richardson@delaware.gov>, Wilson, David L (LegHall) <David.L.Wilson@delaware.gov>, BriggsKing, Ruth (LegHall) <Ruth.BriggsKing@delaware.gov>, Collins, Rich G (LegHall) <Rich.Collins@delaware.gov>, Dukes, Timothy (LegHall) <Timothy.Dukes@delaware.gov>, Gray, Ronald (LegHall) <Ronald.Gray@delaware.gov>, Hensley, Kevin S (LegHall) <Kevin.Hensley@delaware.gov>, Morris, Shannon (LegHall) <Shannon.Morris@delaware.gov>, Postles, Charles (LegHall) <Charles.Postles@delaware.gov>, Ramone, Michael (LegHall) <Michael.Ramone@delaware.gov>, Short, Daniel (LegHall) <Daniel.Short@delaware.gov>, Shupe, Bryan (LegHall) <Bryan.Shupe@delaware.gov>, Smith, Michael (LegHall) <Michael.F.Smith@delaware.gov>, Smyk, Steve (LegHall) <Steve.Smyk@delaware.gov>, Spiegelman, Jeff (LegHall) <Jeff.Spiegelman@delaware.gov>, Vanderwende, Jesse (LegHall) <Jesse.Vanderwende@delaware.gov>, Yearick, Lyndon D (LegHall) <Lyndon.Yearick@delaware.gov>, Brown, Darius (LegHall) <Darius.Brown@delaware.gov>, Ennis, Bruce (LegHall) <Bruce.Ennis@delaware.gov>, Gay, Kyle E (LegHall) <Kyle.Gay@delaware.gov>, Hansen, Stephanie (LegHall) <Stephanie.Hansen@delaware.gov>, Lockman, Elizabeth (LegHall) <Elizabeth.Lockman@delaware.gov>, Mantzavinos, Spiros (LegHall) <Spiros.Mantzavinos@delaware.gov>, McBride, Sarah (LegHall) <Sarah.McBride@delaware.gov>, Paradee, Trey (LegHall) <Trey.Paradee@delaware.gov>, Pinkney, Marie (LegHall) <Marie.Pinkney@delaware.gov>, Poore, Nicole (LegHall) <Nicole.Poore@delaware.gov>, Sokola, David (LegHall) <David.Sokola@delaware.gov>, Sturgeon, Laura (LegHall) <Laura.Sturgeon@delaware.gov>, Townsend, Bryan (LegHall)

<Bryan.Townsend@delaware.gov>, Walsh, John (LegHall) <John.Walsh@delaware.gov>, Carney, Governor (Governor) <Governor.Carney@delaware.gov>, Starkey, Jonathan (Governor) <jonathan.starkey@delaware.gov>, Hall-Long, Bethany (Lt Governor) <Bethany.Hall-Long@delaware.gov>, Navarro, Trinidad (DOI) <Trinidad.Navarro@delaware.gov>, DeMatteis, Claire (DHR) <Claire.DeMatteis@delaware.gov>, Rentz, Faith L. (DHR) <faith.l.rentz@delaware.gov>
Subject: Medicare Advantage questions and requests

Dear members of the Pension Benefits board and colleagues,

As promised here is the list of questions that I raised on the recent zoom meeting. I expect a response to all of my questions ASAP and also that those responses be sent to all sitting legislators copied on this email. Please also note that during the meeting I requested an in-person meeting with the entire Pension Benefits board and to include any of my colleagues who wish to participate.

Representative Kowalko Legislative Medicare Advantage Briefing Questions:

1. We need a detailed timeline of when and how this dramatic change in program was proposed and approved. I would like a timeline listing every meeting with minutes and attendees.

2. This proposal affects thousands of retirees in this state. I would like a total number of retirees affected as well as a breakdown of those numbers in the following categories:

Retirees from the SOD pension plans:

Retirees from the University of Delaware who are not in the SOD pension plan.

Retirees from school districts by each school district in the state.

Retirees from Delaware State University

Retirees from Delaware Technical and Community College

Police?

3. How much is the state of Delaware anticipating in saving with this program change? How much would it cost to keep people in the current program?

4. Why was this plan rolled out after the end of the legislative session?

5. Also, why were retirees not informed during the sign-up period in May for the Medicfill program.

6. Why are retirees being told that nothing will change when this is a total change from a federally funded program to privatized insurance? There is no "Miscommunication" there is a lack of transparency.

7. Why were there no alternatives included in this proposal? Why only Medicare Advantage. For example, could retirees be given the ability to pay additional funds to purchase the Medicfull system?

8. Why is the State od Delaware trying to destroy the traditional Medicare program, probably the most important federal program to keep seniors healthy, by privatizing seniors health insurance? Our Retirees worked for this insurance and deserve better than this plan.

9. It was stated that 92% of people were approved for requested services. That means 8%, almost a tenth, were turned down for services approved by their doctors. Of the 92%, how many had multiple attempts to obtain approval for services. For example, if you have 100 retirees and 92 get their services provided but out of that 92, 50 had two or more attempts to get the services approved, that tells a different story. So, the devil is in the details as to how long it took how many times providers had to ask for those 92 people to receive and services. Also, of those 8% who failed to receive services, I would like to know why they were turned down. What procedures were the 8% requesting?

9. How do pensioners appeal MA denials – for both pre-authorization requests and payment denials (after the fact)? Does the MA plan make those decisions? So, do the same people who denied the claim rule on the appeals?

I am reiterating my formal request that we put this plan on hold and return all retirees to the Medicfill program until we know more about how and why this was decided.

Class action lawsuit is a possibility. This has happened in New York City.

Exhibit B

From: DeMatteis, Claire (DHR) <Claire.DeMatteis@delaware.gov>
Date: Thursday, September 1, 2022 at 10:31 AM
To: Davis, Anna (DHR) <Anna.Davis@delaware.gov>, Baumbach, Paul (LegHall) <Paul.Baumbach@delaware.gov>, Bennett, Andria (LegHall) <andria.bennett@delaware.gov>, Bentz, David (LegHall) <David.Bentz@delaware.gov>, Bolden, StephanieT (LegHall) <StephanieT.Bolden@delaware.gov>, Bonini, Colin (LegHall) <Colin.Bonini@delaware.gov>, BriggsKing, Ruth (LegHall) <Ruth.BriggsKing@delaware.gov>, Brown, Darius (LegHall) <Darius.Brown@delaware.gov>, Bush, William (LegHall) <william.bush@delaware.gov>, Carson, William (LegHall) <William.Carson@delaware.gov>, Chukwuocha, Nnamdi (LegHall) <Nnamdi.Chukwuocha@delaware.gov>, Collins, Rich G (LegHall) <Rich.Collins@delaware.gov>, Cooke, Franklin D (LegHall) <FranklinD.Cooke@delaware.gov>, DorseyWalker, Sherry (LegHall) <Sherry.DorseyWalker@delaware.gov>, Dukes, Timothy (LegHall) <Timothy.Dukes@delaware.gov>, Ennis, Bruce (LegHall) <Bruce.Ennis@delaware.gov>, Freel, Bud (LegHall) <Bud.Freel@delaware.gov>, Gay, Kyle E (LegHall) <Kyle.Gay@delaware.gov>, Gray, Ronald (LegHall) <Ronald.Gray@delaware.gov>, Griffith, Krista (LegHall) <Krista.Griffith@delaware.gov>, Hansen, Stephanie (LegHall) <Stephanie.Hansen@delaware.gov>, Heffernan, Debra (LegHall) <Debra.Heffernan@delaware.gov>, Hensley, Kevin S (LegHall) <Kevin.Hensley@delaware.gov>, Hocker, Gerald (LegHall) <Gerald.Hocker@delaware.gov>, Johnson, Kendra (LegHall) <Kendra.Johnson@delaware.gov>, Kowalko, John (LegHall) <John.Kowalko@delaware.gov>, Lambert, Larry (LegHall) <Larry.Lambert@delaware.gov>, Lawson, Dave (LegHall) <Dave.Lawson@delaware.gov>, Lockman, Elizabeth (LegHall) <Elizabeth.Lockman@delaware.gov>, Longhurst, Valerie (LegHall) <Valerie.Longhurst@delaware.gov>, Lopez, Ernesto B (LegHall) <Ernesto.Lopez@delaware.gov>, Lynn, Sean M (LegHall) <Sean.Lynn@delaware.gov>, Mantzavinos, Spiros (LegHall) <Spiros.Mantzavinos@delaware.gov>, Matthews, Sean (LegHall) <Sean.Matthews@delaware.gov>, McBride, Sarah (LegHall) <Sarah.McBride@delaware.gov>, MinorBrown, Melissa C (LegHall) <Melissa.MinorBrown@delaware.gov>, Mitchell, John L (LegHall) <John.L.Mitchell@delaware.gov>, Moore, Rae (LegHall) <Rae.Moore@delaware.gov>, Morris, Shannon (LegHall) <Shannon.Morris@delaware.gov>, Morrison, Eric (LegHall) <Eric.Morrison@delaware.gov>, Osienski, Edward (LegHall) <Edward.Osienski@delaware.gov>, Paradee, Trey (LegHall) <Trey.Paradee@delaware.gov>, Pettyjohn, Brian (LegHall) <Brian.Pettyjohn@delaware.gov>, Pinkney, Marie (LegHall) <Marie.Pinkney@delaware.gov>, Poore, Nicole (LegHall) <Nicole.Poore@delaware.gov>, Postles, Charles (LegHall) <Charles.Postles@delaware.gov>, Ramone, Michael (LegHall) <Michael.Ramone@delaware.gov>, Richardson, Bryant L (LegHall) <Bryant.Richardson@delaware.gov>, Schwartzkopf, Peter (LegHall) <Peter.Schwartzkopf@delaware.gov>, Short, Daniel (LegHall) <Daniel.Short@delaware.gov>, Shupe, Bryan (LegHall) <Bryan.Shupe@delaware.gov>, Smith, Michael (LegHall) <Michael.F.Smith@delaware.gov>, Smyk, Steve (LegHall) <Steve.Smyk@delaware.gov>, Sokola, David (LegHall) <David.Sokola@delaware.gov>, Spiegelman, Jeff (LegHall) <Jeff.Spiegelman@delaware.gov>, Sturgeon, Laura (LegHall) <Laura.Sturgeon@delaware.gov>, Townsend, Bryan (LegHall) <Bryan.Townsend@delaware.gov>, Vanderwende, Jesse (LegHall) <Jesse.Vanderwende@delaware.gov>, Walsh, John (LegHall) <John.Walsh@delaware.gov>, Williams, Kimberly (LegHall) <Kimberly.Williams@delaware.gov>, Wilson, David L (LegHall) <David.L.Wilson@delaware.gov>, Wilson-Anton, Madinah (LegHall) <Madinah.Wilson-Anton@delaware.gov>, Yearick, Lyndon D (LegHall) <Lyndon.Yearick@delaware.gov>, Jones, Ruth A (LegHall) <RuthA.Jones@delaware.gov>, Scoglietti, Robert (LegHall) <Robert.Scoglietti@delaware.gov>, Starkey, Jonathan (Governor) <jonathan.starkey@delaware.gov>, Corbett, Jessilene E (DHR) <jessilene.corbett@delaware.gov>, Criscenzo, Natalie (Governor) <Natalie.Criscenzo@delaware.gov>, Cade, Cerron (OMB) <Cerron.Cade@delaware.gov>, Geisenberger, Rick J (Finance)

<Rick.Geisenberger@delaware.gov>, Rentz, Faith L. (DHR) <faith.l.rentz@delaware.gov>, Adams, Joanna (OPen) <joanna.adams@delaware.gov>, Mazer, Tara (Governor) <Tara.Mazer@delaware.gov>
Cc: Moriello, Nick (He/Him) (Highmark BCBSD Inc) <Nicholas.Moriello@highmark.com>, Hinkle, Leighann (DHR) <Leighann.Hinkle@delaware.gov>, ashley.love@willistowerswatson.com <Ashley.Love@willistowerswatson.com>, Love, Ashley (Cleveland) <Ashley.Love@wtwco.com>, Sokola Senator Dave <senatordave@live.com>, Martin-Pettaway, Carolyn (LegHall) <carolyn.martin-pettaway@delaware.gov>, McCartan, Valerie (LegHall) <Valerie.McCartan@delaware.gov>, Chadderdon, Jesse (LegHall) <Jesse.Chadderdon@delaware.gov>, Killen, Deanna (LegHall) <Deanna.Killen@delaware.gov>, Revel, Matthew (LegHall) <Matthew.Revel@delaware.gov>, Wright, Christy (LegHall) <Christy.Wright@delaware.gov>, COLIN BONINI <senator-colin@prodigy.net>, Colin Bonini <colinbonini@gmail.com>, Dave Wilson <sendavewilson18@aol.com>, Deputy, David (LegHall) <David.Deputy@delaware.gov>, Vella, Lauren (LegHall) <Lauren.Vella@delaware.gov>, Bryk, Jacqueline (LegHall) <Jacqueline.Bryk@delaware.gov>, Cade, Tiphani (LegHall) <Tiphani.Cade@delaware.gov>, Denison, Douglas (LegHall) <Douglas.Denison@delaware.gov>, Diaz-Rivera, Felicita (LegHall) <Felicita.Diaz-Rivera@delaware.gov>, Harper, Rylene (LegHall) <Rylene.Harper@delaware.gov>, Hastings, Eric (LegHall) <Eric.Hastings@delaware.gov>, Jones, Chelsea (LegHall) <Chelsea.Jones@delaware.gov>, Klapp, Christine (LegHall) <Christine.Klapp@delaware.gov>, Patterson, Jon (LegHall) <Jon.Patterson@delaware.gov>, Polston, Nichelle (LegHall) <Nichelle.Polston@delaware.gov>, Rhodes, Leilani (LegHall) <Leilani.Rhodes@delaware.gov>, Richards, Justin (LegHall) <Justin.Richards@delaware.gov>, Schwab, Kyle (LegHall) <Kyle.Schwab@delaware.gov>, Scoglietti, Alexa (LegHall) <Alexa.Scoglietti@delaware.gov>, Sheridan, Michael (LegHall) <Michael.Sheridan@delaware.gov>, Sparco, Alexandra (LegHall) <Alexandra.Sparco@delaware.gov>, Tepper, Dylan (LegHall) <Dylan.Tepper@delaware.gov>, Vassar, Sophia (LegHall) <Sophia.Vassar@delaware.gov>, Volturo, Drew (LegHall) <Drew.Volturo@delaware.gov>, Wallace, Bridget C (LegHall) <bridget.wallace@delaware.gov>, Williams, Brandon (LegHall) <BrandonF.Williams@delaware.gov>, Wootten, Sarah (LegHall) <sarah.wootten@delaware.gov>, Worley, Jenevieve (LegHall) <jenevieve.worley@delaware.gov>, Wilson, Kay (LegHall) <kay.wilson@delaware.gov>, Richardson, Annie (LegHall) <Annie.Richardson@delaware.gov>, Hopkins, Dawn (LegHall) <Dawn.Hopkins@delaware.gov>, Kanich, Tammie (LegHall) <Tammie.Kanich@delaware.gov>, Becker, Stephanie (LegHall) <Stephanie.Becker@delaware.gov>, Fulgham, Joseph (LegHall) <Joseph.Fulgham@delaware.gov>, Jamison, Alexis F (LegHall) <Alexis.F.Jamison@delaware.gov>, Ruberto, Nancy (LegHall) <Nancy.Ruberto@delaware.gov>, Yerkes, Janice (LegHall) <Janice.Yerkes@delaware.gov>, Warnken, Rebecca (Philadephia) <rebecca.warnken@wtwco.com>, Shields, Anna (LegHall) <Anna.Shields@delaware.gov>, Scoglietti, Robert (LegHall) <Robert.Scoglietti@delaware.gov>, Jones, Ruth A (LegHall) <RuthA.Jones@delaware.gov>
Subject: Medicare Advantage Transition Updates

Dear Senators and Representatives,
As you requested during our Zoom briefing, please find attached more details on the Highmark BCBS prior authorization process for the State of Delaware Medicare Advantage plan, including specific examples of non-emergency services that may require prior approval.

Please also note that based on input over the past several months, Highmark BCBS Delaware has agreed to the following measures for a seamless transition and implementation of the Medicare Advantage Plan for state pensioners and their dependents:

1. Highmark will suspend the prior authorization process for outpatient services for the first four months of the contract. With this change, prior approval for non-emergency outpatient services will not take effect until May 1, 2023.

2. For the life of the 3-year contract, if a State of Delaware pensioner's physician has not joined the Highmark BCBS Medicare Advantage network, the pensioner is eligible to see that physician as an out-of-network provider as long as the physician is eligible to participate in Medicare and accepts the plan. Non-contracted out of network providers will be reimbursed at 100% of the Medicare approved amount for providers that accept Medicare assignment and up to the Medicare limiting amount (115% of the Medicare approved amount) for providers that do not accept a Medicare assigned rate.

3. The performance guarantees for the Medicare Advantage contract effective 1/1/23 will include the requirement that Highmark BCBS Delaware provide quarterly reporting on plan performance that includes services subject to prior authorization and detailing denial/approval rates, turn-around-times for first time approvals of prior authorization, and requests and percentages of prior authorizations initially denied and appealed.

4. Highmark BCBS Delaware will add additional customer service personnel and resources to strengthen its concierge services for pensioners to help them navigate the transition to Medicare Advantage.

Additionally, the Statewide Benefits Office and Office of Pensions is increasing our efforts to hire 10 more people to our Medicare Member Support Team. Earlier this summer, we identified a total of 12 casual seasonal positions to help retirees with the Medicare Advantage transition, and to date have filled 2 of these 12 positions.

We look forward to continuing our efforts to be responsive to you and our state pensioners during this transition to ensure that our retired state employees have access to premium healthcare for decades to come.

Best regards,
Claire

Exhibit C

From: Smith, Karen M. (DHR) <Karen.M.Smith@delaware.gov>
Sent: Monday, September 26, 2022 4:24 PM
To: Kowalko, John (LegHall) <John.Kowalko@delaware.gov>
Cc: DeMatteis, Claire (DHR) <Claire.DeMatteis@delaware.gov>; Rentz, Faith L. (DHR) <faith.l.rentz@delaware.gov>
Subject: RE: Formal request for documents

Good afternoon, Representative Kowalko,

Thank you for contacting the Department of Human Resources (DHR) with your request for information pursuant to the Delaware Freedom of Information Act, 29 Del. C. §§ 10001-10007. DHR has processed your request for documents related to the *Highmark Blue Cross Blue Shield (BCBS) Delaware's Freedom Blue PPO Medicare Advantage Plan*.

Due to the amount of responsive information provided, available public records have been saved to a file on Google Drive: https://drive.google.com/drive/folders/1YUTN4CZrELOG_0d-12OWt_nONSbcjTDj?usp=sharing. If you have difficulty accessing this information, please let me know and I will arrange for another way to deliver it to you.

Please note that your FOIA request remains active with DHR because two of the documents requested are not yet available but will be soon. The Highmark Blue Cross Blue Shield contract will be made publicly available and posted online after it has been fully executed, which is expected in the coming week. The Highmark Blue Cross Blue Shield (BCBS) Delaware's Freedom Blue PPO Medicare Advantage Plan Evidence of Coverage document also will be posted online when available by early October. DHR will provide you with the link to the contract and the Evidence of Coverage as soon as they are posted online.

Additional information related to the Medicare Advantage Plan can be found on the Statewide Benefits Office website and the Office of Pensions website.

Thank you.
Karen

Karen M. Smith, Communications Director, FOIA Coordinator
Department of Human Resources
820 N. French Street, Wilmington, DE 19801
Office 302-577-8793 | Fax 302-739-3000
dhr.delaware.gov | statejobs.delaware.gov

From: Smith, Karen M. (DHR)
Sent: Tuesday, September 6, 2022 5:19 PM
To: Kowalko, John (LegHall) <John.Kowalko@delaware.gov>
Cc: DeMatteis, Claire (DHR) <Claire.DeMatteis@delaware.gov>; Rentz, Faith L. (DHR) <faith.l.rentz@delaware.gov>
Subject: RE: Formal request for documents

Good afternoon, Representative Kowalko,

Thank you for your request for additional information on the transition to the Highmark Blue Cross Blue Shield Medicare Advantage plan for State of Delaware pensioners and their dependents. On Tuesday, September 6, 2022, the Department of Human Resources' Freedom of Information Act (FOIA) coordinator received your FOIA request for information related to the transition of pensioner health care to the Medicare Advantage plan.

Your FOIA request is being processed by DHR. We will respond to your request timely within the statutory 15 business days of receipt of the request. Please note that State Employee Benefits Committee minutes and materials are available publicly online at https://dhr.delaware.gov/benefits/sebc/sebc-materials.shtml.

Best regards,
Karen

Karen M. Smith, Communications Director, FOIA Coordinator
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From: Kowalko, John (LegHall) <John.Kowalko@delaware.gov>
Date: Thursday, September 1, 2022 at 5:04 PM
To: DeMatteis, Claire (DHR) <Claire.DeMatteis@delaware.gov>, Rentz, Faith L. (DHR) <faith.l.rentz@delaware.gov>
Cc: Cutrona, Mark J (LegHall) <Mark.Cutrona@delaware.gov>, Gottschalk, Deborah I (LegHall) <Deborah.Gottschalk@delaware.gov>, Scoglietti, Robert (LegHall) <Robert.Scoglietti@delaware.gov>
Subject: Formal request for documents

Dear Ms. DeMatteis and Ms. Rentz,

In addition to my three previous requests for a copy of the state contract with Highmark Blue Cross Blue Shield for the Medicare Advantage Plan and a copy of the Evidence of Coverage of Insurance, I am requesting those documents for a fourth time. All these requests should be considered both formal requests by a member of the General Assembly as well as formal FOIA requests. I also had a phone conversation with Deputy Controller General Scoglietti this morning and he informed me that he had spoken with you about this request.

Representative Kowalko