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# *Correspondence Memorandum*

**Date:** November 5, 2020

**To:** Group Insurance Board

**From:** Jessica Rossner, Data & Compliance Lead
Renee Walk, Lead Policy Advisor
Office of Strategic Health Policy

**Subject:** November 2020 COVID-19 Update

**This memo is for informational purposes only. No Board action is required.**

## Background

Cases of COVID-19 nationwide continue to increase, though the shape of the pandemic has changed. Where the early pandemic was largely concentrated in urban areas, there has been an increasing shift in the distribution of cases toward more rural communities. In late September, the state of Wisconsin for the first time became one of the top five states for new coronavirus infections in the United States. As of the drafting of this memo, nearly all Wisconsin counties are reporting high levels of spread. Hospitals have also reported the highest numbers of active COVID-19 patients since the beginning of the pandemic.

This memo provides an update on issues related to the pandemic and the programs overseen by the Group Insurance Board (Board) that have arisen since the Board's last meeting in August of 2020. It also provides an initial overview of the impact to the Board's programs in terms of the Triple Aim.

## Legislative & Regulatory Update

As of the drafting of this memo, no additional relief bills have been passed at the federal level. President Trump has indicated a willingness to sign specific relief provisions into law, in particular provisions related to financial stimulus checks, but bills have not advanced through Congress.

In September, the Centers for Disease Control and Prevention (CDC) issued the *COVID-19 Vaccination Program Interim Playbook for Jurisdiction Operations (Version*

Reviewed and approved by Eileen K Mallow, Director, Office of Strategic Health Policy
Eileen K Mallow Electronically Signed 11/10/20

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*1.0)*[1]. The playbook provides a state-based framework for immunization, including a broad description of a phased approach to vaccine distribution, given the likely limited doses of a vaccine post-approval, beginning with healthcare workers and critical populations, then broadening to a wider population. The playbook states that initial supplies of a vaccine may be available in fall 2020, and that the federal government will determine the amount of vaccine that each jurisdiction is allocated. Vaccines and ancillary supplies (needles, alcohol prep pads, etc.) will be bought and distributed by the federal government at no cost to providers who enroll in the COVID-19 vaccination program through CDC. CDC will work directly with states and tribes to establish and implement plans.

In October, the Food and Drug Administration (FDA) issued guidance for emergency use authorization (EUA) for COVID-19 vaccine development[2]. The guidelines state that EUA requires at least one well-designed, Phase 3 clinical trial demonstrating safety and efficacy in a "clear and compelling manner." The guidelines require that data be provided for a median follow-up period of at least two months after the full vaccine regimen in a Phase 3 trial has been administered to help FDA evaluate the safety of a vaccine. Follow up data must include specific data on adverse reactions, as well as a minimum of five reported cases of severe COVID-19 in the placebo group. These help to determine effectiveness and risks of the vaccine.

As of October 23, 2020, the federal government also extended the public health emergency associated with the pandemic. The extension goes into effect on October 23, 2020 and will extend for another 90 days[3]. This change can impact deadlines for COBRA and other filing deadlines; the Board opted not to provide COBRA extensions at its June 2020 meeting due to the uncertain end of the federal national emergency (Ref. GIB | 6.29.20 | 4B). Some experts note that plans who adopted the change in deadlines are now struggling to determine how to adapt their plan documents and whether allowing the extremely long election periods will result in negative risk[4].

On Monday, November 3, the Trump Administration issued new regulations regarding COVID-19 treatment and coverage. The new regulations require most health plans to fully cover COVID-19 vaccines within 15 business days of receiving CDC recommendation. The regulations also urge COVID-19 test providers to publish prices and increase federal payments to hospitals caring for COVID-19 patients. These

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[1] Centers for Disease Control and Prevention. *COVID-19 Vaccination Program Interim Playbook for Jurisdiction Operations.* September 16, 2020. https://www.cdc.gov/vaccines/imz-managers/downloads/COVID-19-Vaccination-Program-Interim_Playbook.pdf
[2] U.S. Department of Health and Human Services, Food and Drug Administration. *Emergency Use Authorization for Vaccines to Prevent COVID-19 – Guidance for Industry.* October 2020. https://www.fda.gov/media/142749/download
[3] Azar, Alex M. Renewal of Determination That a Public Health Emergency Exists. https://www.phe.gov/emergency/news/healthactions/phe/Pages/covid19-2Oct2020.aspx
[4] Berg, Brenda. *I'm Just Waiting on an…End to the Extended ERISA Deadline Periods*. Holland and Hart. October 16, 2020. https://www.employeebenefitslawblog.com/im-just-waiting-on-an-end-to-the-extended-erisa-deadline-periods/

regulations implement parts of the Coronavirus Aid, Relief, and Economic Security (CARES) Act signed in March[5].

The main activity occurring at the state level has been via executive orders by Governor Evers, or emergency orders issued by the Department of Health Services (DHS). On October 1, 2020, DHS Secretary-designee Andrea Palm and Governor Evers issued Emergency Order #2 (EO #2). This order temporarily increases interstate license reciprocity for healthcare providers, as long as those providers are licensed in Wisconsin, any other state, or Canada. It also extends the expiration date of some credentials and reinstates credentials that have lapsed within the last five years.

EO #2 also expands providers available to Wisconsin residents. Historically, a provider seeing a patient in Wisconsin had to be licensed by the relevant licensing board in Wisconsin. Following EO #2, a provider can obtain a reciprocity license as described above before practicing or can notify the Department of Safety and Professional Services (DSPS) no more than 10 days after providing a service to a Wisconsin resident and provide proof of credentials. ETF is not aware of any members seeing a non-Wisconsin provider licensed through reciprocity to date but will monitor for any changes.

**Vaccine & Treatment Progress**

While frameworks now exist for both approval and distribution of a vaccine, there has not yet been an approved vaccine in the United States. Worldwide, only two vaccines have been approved, both in Russia. Experts have raised concerns about these vaccines since they were approved without entering Phase 3 clinical trials[6].

In the United States, there are four primary vaccine candidates that are currently undergoing Phase 3 trials. In October, Pfizer, the company whose vaccine has progressed the most in trials, said that it had not yet begun Phase 3 trial analysis. AstraZeneca, a second vaccine developer, had several of its Phase 3 trials placed on hold due to adverse participant symptoms, though as of October 30, the FDA has green-lit resuming late stage trials. Johnson & Johnson, whose vaccine is the only single-dose candidate, also delayed trials due to adverse participant symptoms. Its trial has since resumed in all countries. The final manufacturer, Novavax, has delayed its Phase 3 trial start date to the end of November[7]. As stated above, FDA has indicated that they will require completion of at least one well-designed Phase 3 trial before considering EUA for a vaccine.

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[5] Brill, E. *Trump Admin. Targets COVID-19 Care Through New Regs*. Law 360. Accessed November 4, 2020.

[6] Regulatory Affairs Professionals Society. *COVID-19 Vaccine Tracker.* October 15, 2020. https://www.raps.org/news-and-articles/news-articles/2020/3/covid-19-vaccine-tracker

[7] Branswell H. *It may be time to reset expectations on when we'll geta a Covid-19 vaccine.* StatNews, October 29, 2020. https://www.statnews.com/2020/10/29/it-may-be-time-to-reset-expectations-on-when-well-get-a-covid-19-vaccine/?utm_source=STAT+Newsletters&utm_campaign=24b03b272d-MR_COPY_13&utm_medium=email&utm_term=0_8cab1d7961-24b03b272d-151432481

In the realm of treatments, the United States has seen an overall decrease in the mortality rate from COVID-19 across demographic segments. This change is due in part to the ability of providers to treat the condition. While COVID-19 still presents a substantial risk to human health, a recent study suggests that providers are better able to recognize the risk of serious complications and mitigate them[8]. Remdesivir continues to be used and is now FDA-approved[9]. Other drugs are in development, including Regeneron, the experimental medication provided to President Trump during his illness in early October. Regeneron is a monoclonal antibody treatment and is currently undergoing clinical trials[10].

**Coverage Issues**

Given that the pandemic has continued through 2020 without evidence of abatement, health plans nationally have begun to discuss how to continue to handle cost sharing waivers for services. While no health plans have indicated to ETF that voluntary cost sharing waivers will change, there have been some questions regarding how to define telehealth services. ETF recommends that members continue to reach out to their health plans to determine which services will incur fees, but generally that they should expect providers who traditionally see patients in person to be subject to usual cost sharing. ETF is working with health plans, however, to determine better guidance for telehealth services and cost sharing. ETF will have further discussions with plans at the annual December medical directors' meeting and will present this guidance to the Board at their February 2021 meeting.

**Virtual Benefit Fairs, Flu Clinics, and Incentive Participation**

ETF found several ways to adapt to the pandemic during open enrollment and flu clinic season this fall. Since most employers opted not to hold in-person open enrollment benefit fairs this year, ETF offered a total of 50 webinar events for employees and retirees, as well as an additional 50 events for employers. Events included opportunities to ask ETF staff for information on how benefits work, as well as one-on-one sessions with benefit vendors to share any pertinent information on services being offered for 2021. Overall, these events were very well received; several respondents to the post-event surveys asked that ETF continue to host benefit webinars even after it is possible to hold in-person fairs again.

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[8] NPR. *Studies Point to Big Drop in COVID-19 Death Rates*. October 20, 2020. https://www.npr.org/sections/health-shots/2020/10/20/925441975/studies-point-to-big-drop-in-covid-19-death-rates

[9] FDA. *FDA Approves First Treatment for COVID-19.* October 22, 2020. https://www.fda.gov/news-events/press-announcements/fda-approves-first-treatment-covid-19

[10] PBS. *Can regular COVID-19 patients get Trump's treatments?* October 20, 2020. https://www.pbs.org/newshour/health/can-regular-covid-19-patients-get-trumps-treatments.

*Table 1. 2021 Open Enrollment Virtual Event Participation*

| Session Type | Attended | Registered | Attendance Rate |
|---|---|---|---|
| **ETF Benefits Staff Presentation for Members** | 1,796 | 2,467 | 73% |
| **Vendor Events for Employers** | 497 | 728 | 68% |
| **Vendor Events for Members** | 1,383 | 2,041 | 68% |
| **Total** | 3,676 | 5,236 | 70% |

ETF has also adapted its onsite employer flu clinics by offering drive-up opportunities. As of the drafting of this memo, these employer flu clinics have administered flu shots to 2,700 people at 61 different clinic events. In total, there are 123 clinics scheduled for this fall, with a total of 5,900 possible appointments. This number is slightly higher than the number of flu clinics provided in 2019 (122 clinics and 5,100 vaccines administered).

ETF has noticed a slight decrease in wellness incentive participation this year. 263 biometric screenings were canceled this year, impacting 20,411 members. Overall incentive participation rates are slightly reduced this year, and this trend is similar to other StayWell clients. See GIB Item 7B for more information.

**Health Impacts**

The outbreak in Wisconsin has been growing over recent months, with statewide positive cases reaching records for several days in October and November. Due to the increase, the state has set up a surge facility at the Wisconsin State Fair Park grounds that has begun to accept lower-acuity patients. Some hospitals have also begun to convert different parts of their operations into respiratory facilities to treat COVID-19 patients[11]. While initial case increases were often attributed to the re-opening of college campuses, new cases are now distributed across age groups and rising more in older segments.

Black and Latinx people also continue to be more heavily impacted by COVID-19 in the general Wisconsin population. According to the DHS website as of the drafting of this memo, Black Wisconsinites are 6.4% of the population in total, but represent 7.9% of all cases and 13.4% of all deaths. Latinx Wisconsinites represent 7.1% of the state population but account for 14.5% of all cases and 9.4% of deaths. ETF does not capture race or ethnic data at this time, but given that other population health trends tend to align with the state at large, it is reasonable to expect disparities to extend to the Board's membership as well. ETF will look to partner with agencies who manage payroll

[11] Mathew, Benita. *Coronavirus in Brown County: Bellin Health turns urgent care in Ashwaubenon to respiratory clinic*. October 8, 2020. https://www.greenbaypressgazette.com/story/news/2020/10/08/bellin-health-opens-respiratory-clinic-treat-more-covid-19-patients-hospitalizations-still-rise/5924511002/

and benefits systems that collect demographic data in order to enhance our ability to monitor trends and provide supportive benefits and services.
At the August Board meeting, ETF discussed concerns related to multi-system inflammatory syndrome in children (MIS-C), a rare condition recorded in children and adolescents who have had COVID-19. Several additional case reports have come to light of multi-system inflammatory syndrome in adults (MIS-A) associated with COVID-19. MIS-A patients generally require intensive care and can have fatal outcomes. While MIS-A is also rare, the CDC recommends both monitoring for this condition in adults, as well as redoubling prevention of COVID-19 infection to prevent further cases[12]. There is more evidence of the wide-ranging impacts of COVID-19 in the body beyond the lungs, including to brain health and cognitive functioning[13], heart rate, joints, and kidney function[14], and that these impacts can last months. ETF will continue to monitor utilization and to work with health plans to determine whether new chronic conditions should be monitored and supported for members who have been infected with the virus.

Using ETF's data warehouse, Data, Analytics, and Insights (DAISI), ETF has created dashboards and reports to monitor the Group Health Insurance Program (GHIP) for the presence of COVID-19 in membership and the direct impact of the coronavirus to member's health, utilization, and plan cost. Typically, a three-month lag is applied to all reporting to ensure all transactions in the reporting period are complete. However, to report on the most recent COVID-19 data and identify emerging diagnoses, this reporting includes service months with insufficient run-out for claims to be complete. The data includes health care services rendered from January through September 2020 and the reported data includes payments through September 2020.

There are two different types Covid-19 of tests—diagnostic and antibody. A diagnostic test will show if someone has an active coronavirus infection and should take proper care and isolation measures from others; diagnostic tests can either be molecular (using complex lab equipment) or antigen (rapid tests sometimes done on site). An antibody test will show if someone has been infected by the coronavirus in the past. At this time, researchers do not know if the presence of antibodies means someone will be immune to the coronavirus in the future. Additional information on the different types of COVID-19 tests can be found in Table 2.

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[12] Morris SB, Schwartz NG, Patel P, et al. Case Series of Multisystem Inflammatory Syndrome in Adults Associated with SARS-CoV-2 Infection – United Kingdom and United States, March – August 2020. MMWR Morb Mortal Wkly Rep 2020;69:1450-1456. DOI: http://dx.doi.org/10.15585/mmwr.mm6940e1.
[13] Budson A. *The hidden long-term cognitive effects of COVID-19*. October 8, 2020. Harvard Health Blog. https://www.health.harvard.edu/blog/the-hidden-long-term-cognitive-effects-of-covid-2020100821133
[14] Couzin-Frankel J. *From 'brain fog' to heart damage, COVID-19's lingering problems alarm scientists*. July 31, 2020. https://www.sciencemag.org/news/2020/07/brain-fog-heart-damage-covid-19-s-lingering-problems-alarm-scientists

*Table 2. COVID-19 Test Types and Key Features*

| Test Type | Molecular/ Diagnostic Test | Antigen Diagnostic Test | Antibody Test |
|---|---|---|---|
| **How the sample is taken...** | Nasal or throat swab (most tests) Saliva (a few tests) | Nasal or throat swab | Finger stick or blood draw |
| **How long does it take to get results...** | Up to a week | One hour or less | 1-3 days |
| **Is another test needed...** | This test typically is highly accurate and usually does not need to be repeated | Positive results are usually highly accurate, but negative results may need to be confirmed with a molecular test | Sometimes a second antibody test is needed for accurate results |
| **What it shows...** | Diagnoses active coronavirus infection | Diagnoses active coronavirus infection | Shows if a member has been infected by the coronavirus in the past |
| **What it cannot do...** | Show if a member has ever had COVID-19 in the past | Definitively rule out active coronavirus infection, or determine if a member has ever had COVID-19 | Diagnose active COVID-19 at the time of the test |

*Resource: https://www.fda.gov/media/140161/download*

To identify the ongoing or past presence of COVID-19, ETF analyzed data from health care claims to identify COVID-19 positive cases, utilization of COVID-19 services, and their associated costs. It is possible that the COVID-19 positive members, testing, and admissions reported are significantly lower than actual due to claims processing times by plans causing delay, as well as members receiving tests at testing sites that are not covered by Uniform Benefits (e.g., employer site, public health testing, etc.).

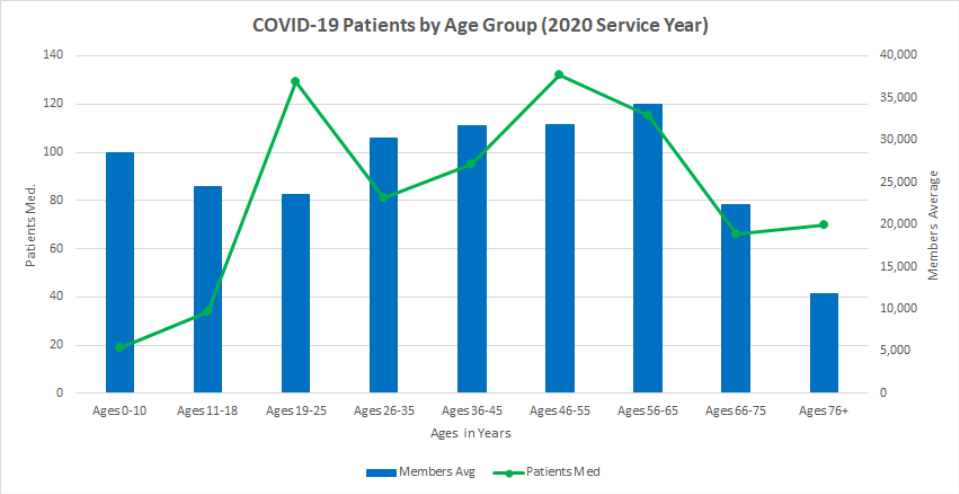
*Table 3. COVID-19 Testing Experience*

| COVID-19 Test | Members | Average Cost Per Member | Total Allowed Amount |
|---|---|---|---|
| **Molecular Test** | 17,153 | $138 | $2,375,362 |
| **Antigen Test** | 13 | $86 | $1,114 |
| **Antibody Test** | 8,745 | $70 | $616,295 |

*Based on medical claims incurred January – September 2020, payments made through September.*

Based on DAISI data, a total of 745 GHIP members have tested positive for COVID-19. Chart 1 shows the total average members in the GHIP by age group. The trend line indicates the number of members with COVID-19. As you can see, there is a higher prevalence of COVID-19 amongst the 19-25 and 46-55 age groups.

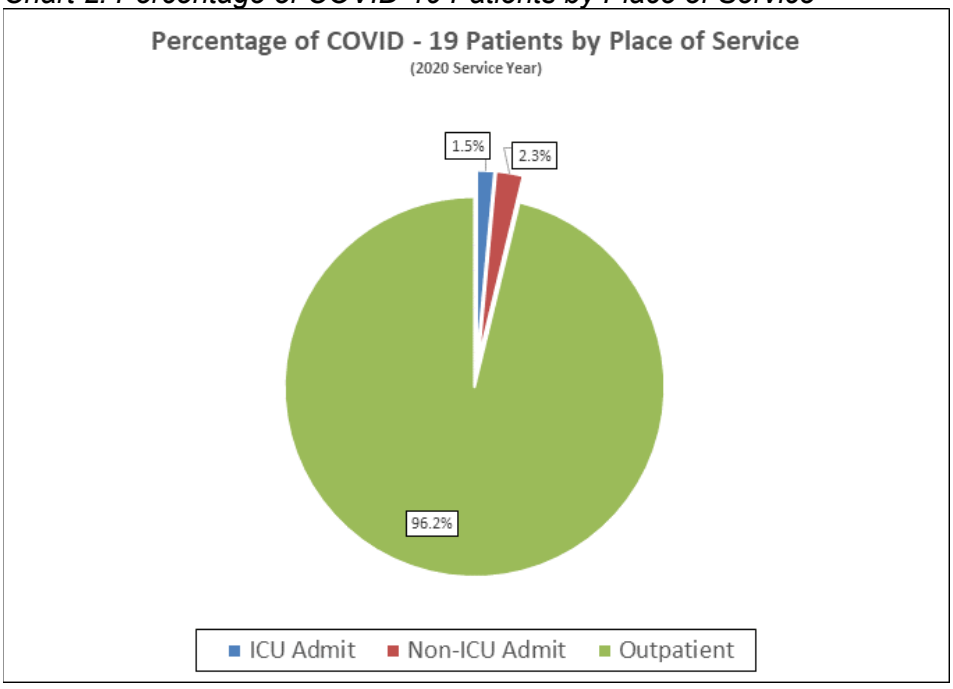
*Chart 1. COVID-19 Patients by Age Group*




*Based on medical claims incurred January – September 2020, payments made through September.*

Most COVID-19 patients receive medical services on an outpatient basis. About 3.8% of patients received inpatient medical care and of those, only 1.5% required intensive care unit (ICU) medical services. The majority of COVID-19 related costs were for patients requiring inpatient medical care.

*Chart 2. Percentage of COVID-19 Patients by Place of Service*




*Based on medical claims incurred January – September 2020, payments made through September.*

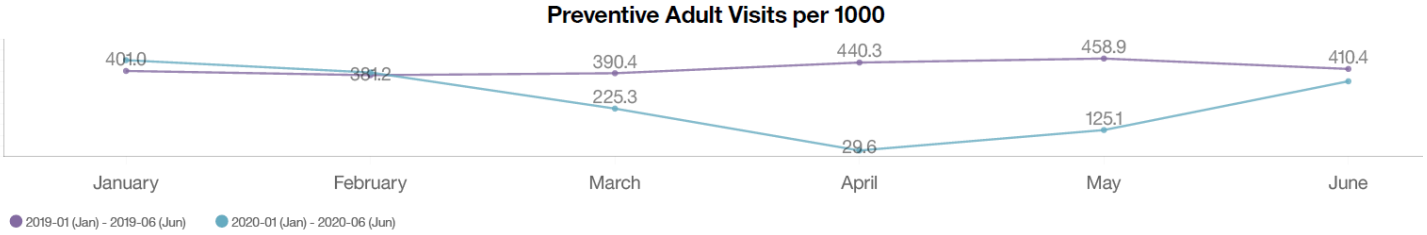
Within the Board's population, mortality rates from COVID-19 continue to increase. As of October 27, 2020, Securian, the Board's life insurance vendor, reported a total of 34

claims related to COVID-19. Six of these deaths were active employees, 25 were retirees, and three were spouses or dependents. 13 member-decedents were female and 21 were male. Their ages ranged from 22 to 94 years old at time of death. These claims only reflect deaths that have been reported as being caused by the virus itself or health impacts related to having COVID-19.

Increasingly, researchers are quantifying the mortality related to the coronavirus pandemic in terms of "excess deaths"—that is, the number of deaths that is above what would have been reasonably projected based upon prior years before the pandemic began. A recent release from the CDC estimates that an excess 299,028 deaths occurred nationwide between January 1 and October 3, 2020[15]. Excess deaths include those caused directly by COVID-19, as well as deaths from deferred care and deaths of despair (e.g., suicide, overdose, etc.) which many reports state have risen over the past few months[16]. ETF continues to work with health plans to ensure members have the most current information on access to both chronic condition management and behavioral health counseling and treatment services.

ETF is also using DAISI to monitor how the pandemic has impacted health engagement and utilization of health care services. Charts 3 through 6 show a marked drop in preventive visits and screenings from March through May, with utilization starting to normalize to pre-COVID-19 rates starting in June. The data below is based on claims incurred from January 2020 to June 2020, compared to the same period in the year prior.

*Chart 3. Preventive Visits Per 1000 members*

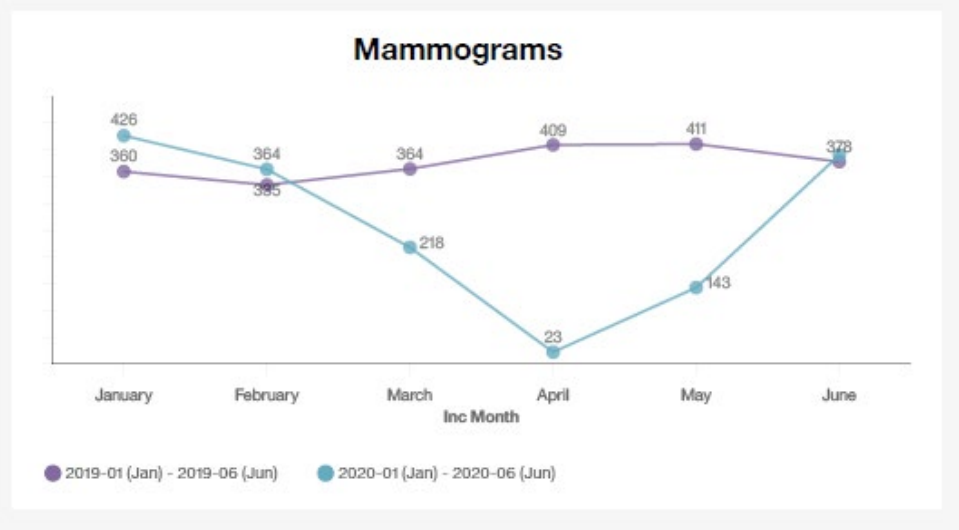



*Based on medical claims incurred January 2020 - June 2020, compared to medical claims incurred January 2019 through June 2019. The reported data includes payments made through September 2020.*

[15] Rossen LM, Branum AM, Ahmad, FB, Sutton P, Anderson RN. Excess Deaths Associated with COVID-19, by Age and Race and Ethnicity—United States, January 26 – October 3, 2020. MMWR Morb Mortal Wkly Rep 2020;69:1522-1527. DOI: http://dx.doi.org/10.15585/mmwr.mm6942e2

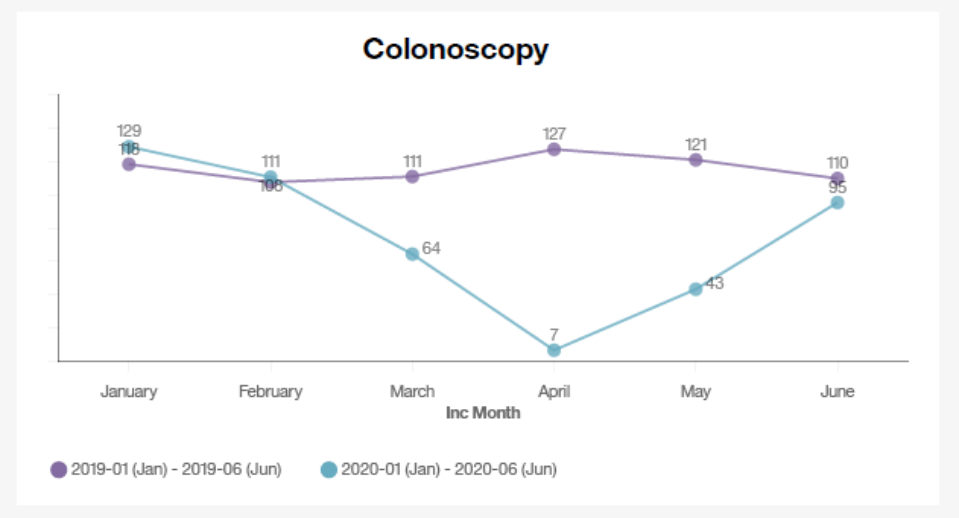
[16] Wahlberg D. "Suicides up in Dane County, mental health experts see link to COVID-19." October 18, 2020. https://madison.com/wsj/news/local/health-med-fit/suicides-up-in-dane-county-mental-health-experts-see-link-to-covid-19/article_5d89645a-6aa1-5a5f-a4a0-6e90ed11e938.html#tracking-source=in-article

*Chart 4 Mammogram Screenings Per 1000 Members*



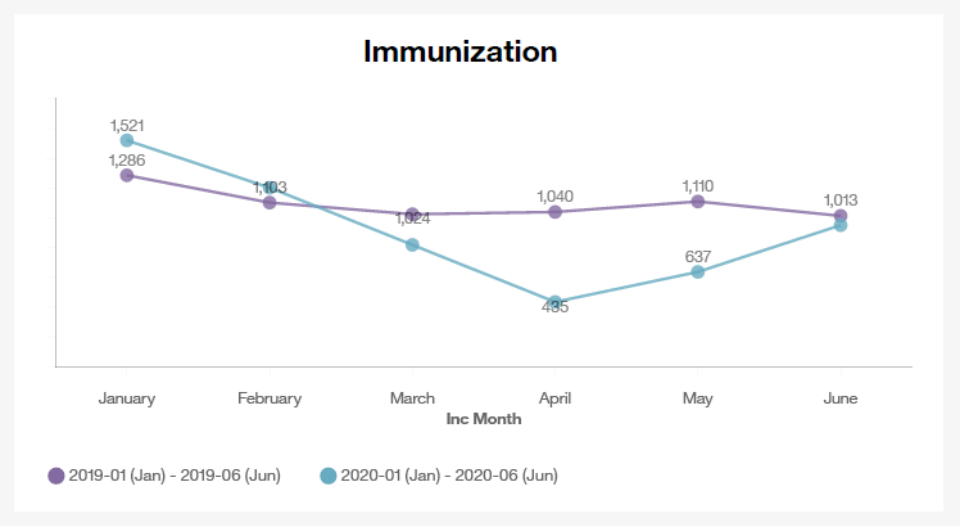

*Based on medical claims incurred January 2020 - June 2020, compared to medical claims incurred January 2019 through June 2019. The reported data includes payments made through September 2020.*

*Chart 5. Colonoscopy Screenings Per 1000 Members*




*Based on medical claims incurred January 2020 - June 2020, compared to medical claims incurred January 2019 through June 2019. The reported data includes payments made through September 2020.*

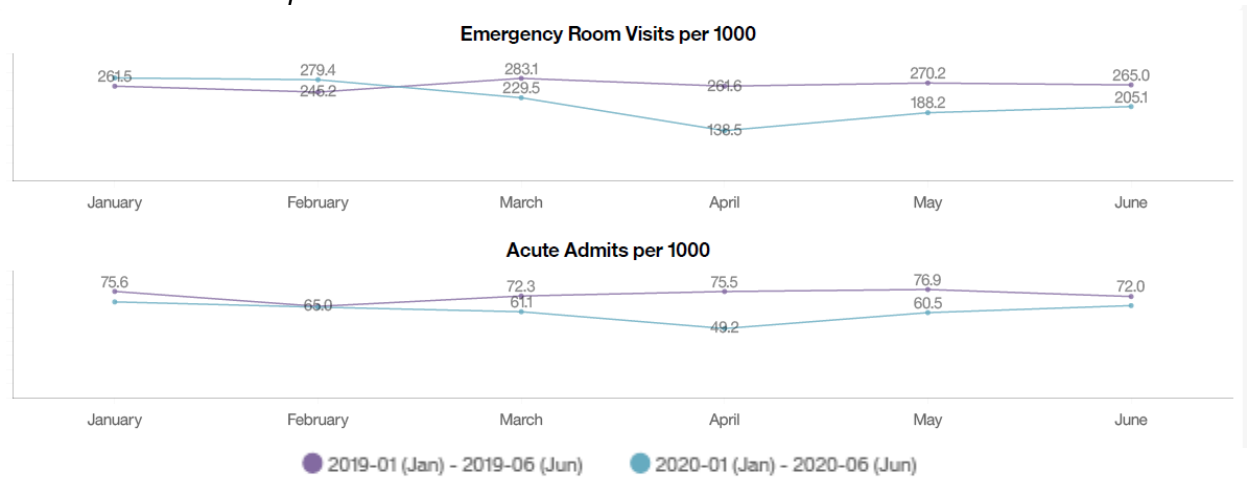
*Chart 6. Immunizations Per 1000 Members*




*Based on medical claims incurred January 2020 - June 2020, compared to medical claims incurred January 2019 through June 2019. The reported data includes payments made through September 2020.*

There is also a marked decrease in the utilization rates for emergency room and acute hospital admits starting in March, which continues to trend slightly below 2019 rates.

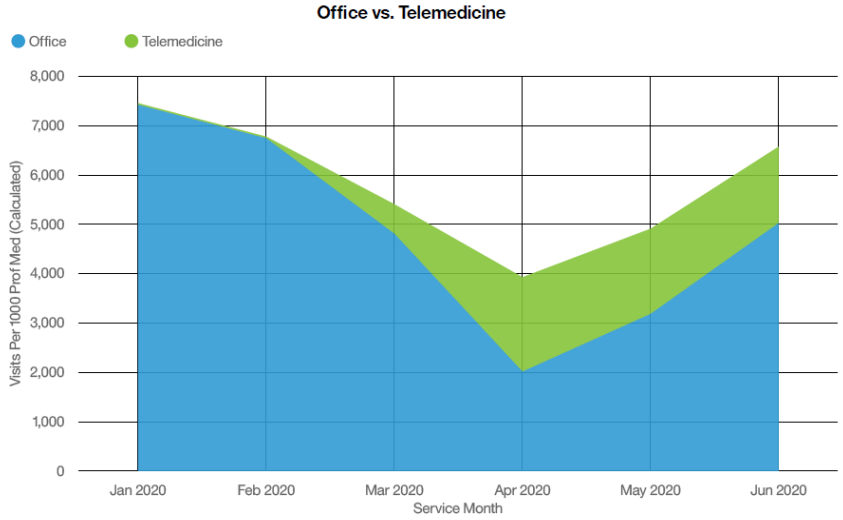
*Chart 7. COVID-19 Impact on Total Utilization Rates*




*Based on medical claims incurred January 2020 - June 2020, compared to medical claims incurred January 2019 through June 2019. The reported data includes payments made through September 2020.*

A positive impact of the pandemic has been the increase in telemedicine use by members. Though there is a decrease in overall use, the substantial increase in telemedicine claims shows that members are finding ways to continue their care, and that they have learned to take advantage of the benefits offered by the Board.

*Chart 8. COVID-19 Impact on Total Utilization Rate*




*Based on medical claims incurred January – June 2020, payments made through September.*

## Quality Impacts

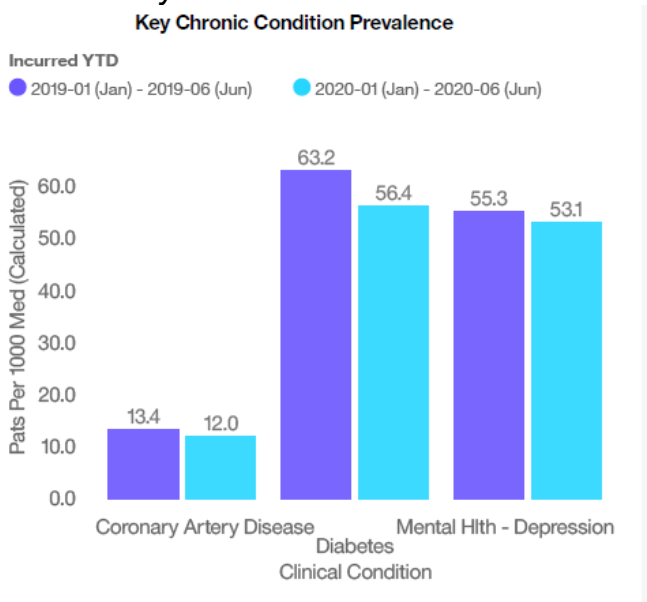
According to the CDC, an estimated 41% of U.S. adults had delayed or avoided medical care including urgent or emergency care (12%) and routine care (32%)[17]. Avoidance of urgent or emergency care was more prevalent among unpaid caregivers for adults, persons with underlying medical conditions, Black adults, Hispanic adults, young adults, and persons with disabilities. Delayed or avoided medical care might increase morbidity and mortality associated with both chronic and acute health conditions.

As mentioned earlier and in past memos, ETF is not able to capture social determinants of health in its current data warehouse that have a substantial impact on member outcomes such as race, civil service classifications, and wage data. Early research has affirmed the connection between these factors and healthcare quality outcomes related to COVID-19 and health in general. ETF continues to pursue options to incorporate this data into its analyses in order to better understand how the social gradient impacts members' health and wellbeing.

Through the data now available in DAISI, ETF did note a decrease in the number of visits associated with chronic conditions beginning in March of 2020. This indicates reduced engagement with chronic condition care and will be monitored going forward. Specific trends in utilization related to the chronic conditions in Chart 9 below are displayed in a larger format in Appendix A.

[17] Czeisler MÉ, Marynak K, Clarke KE, et al. Delay or Avoidance of Medical Care Because of COVID-19–Related Concerns — United States, June 2020. MMWR Morb Mortal Wkly Rep 2020;69:1250–1257. DOI: http://dx.doi.org/10.15585/mmwr.mm6936a4external icon.

*Chart 9. Key Chronic Conditions Prevalence*




*Based on medical claims incurred January 2020 - June 2020 (current period), compared to medical claims incurred January 2019 through June 2019 (previous period). The reported data includes payments made through September 2020.*

## Cost Impacts

COVID-19 has substantially impacted state revenues, and this has in turn impacted income stability for active employee members. The University of Wisconsin (UW) System issued an initial round of furloughs and layoffs during the summer and announced an additional round for the fall into winter. ETF continues to work with the UW System to determine the impact of those layoffs on employee eligibility for health benefits coverage.

In terms of program costs, much of the utilization returned to somewhat normal rates over the middle to later part of the year. Pharmacy benefit utilization began to normalize in June and July, following an increase in March and April that ETF attributed to many taking advantage of three-month fills early in the pandemic. Dental utilization had returned to normal but has recently begun to decline again. As of the week of November 2, the number of dental claims paid was down 14.9% from the same week last year, though was still up 20% over the prior week.

*Table 4. 2019 v. 2020 Dental Claims Paid Year to Date*

| | 2019 | 2020 |
|---|---|---|
| **Year-to-Date Claims Paid** | $45,793,955 | $39,667,910 |
| **Year-to-Date Number of Claims** | 351,978 | 285,896 |

As mentioned earlier in this memo, Securian has reported a total of 34 death claims at the time of this memo's drafting. This has resulted in a total of $1,355,250 in claims paid related to COVID-19 since the start of the pandemic.

The total allowed amount (billed amount for services less the health plan's negotiated discount) spent on members with COVID-19 from January through June 2020 was about $2.5 million. Most COVID-19-related costs were for members requiring inpatient medical care.

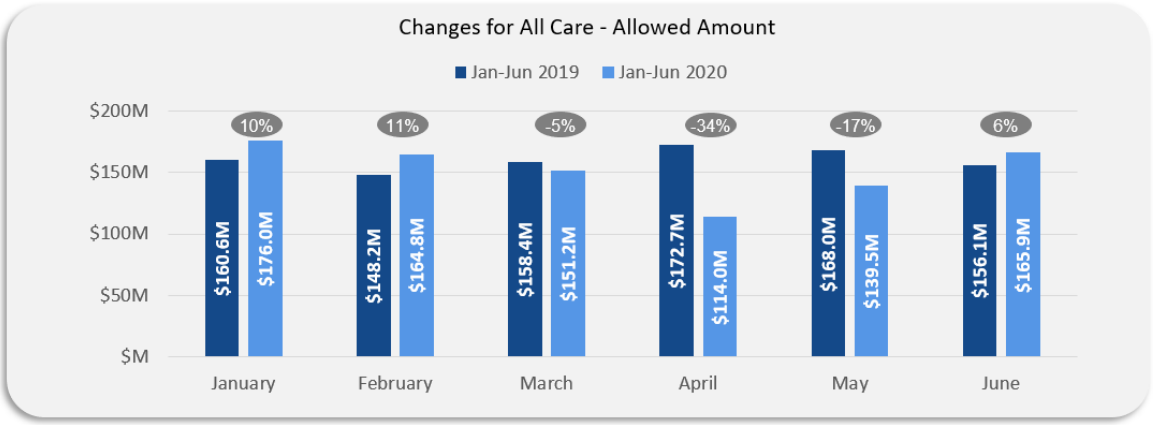
*Table 5. Members Positive for COVID-19 and Costs*

| COVID-19 Members | Average Cost Per Member | Total Allowed Amount |
|---|---|---|
| 745 | $3,384.27 | $2,521,277.47 |

*Based on medical claims incurred January – September 2020, payments made through September.*

There was a 5.5% reduction in cost trend for the first six months of 2020 versus 2019. The increases in January and February are typical for Year over Year (YoY) trends. The decrease in total allowed amount starts in March and is largest in April but begins to return to the expected increase YoY in June.

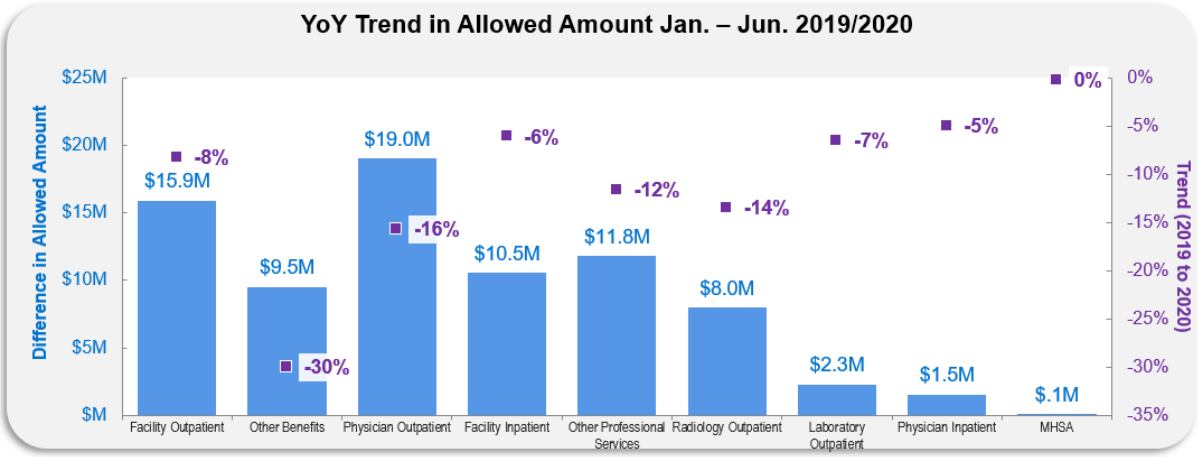
*Chart 10. Changes for All Care – Total Allowed Amount*




*Based on medical claims incurred January 2020 - June 2020, compared to medical claims incurred January 2019 through June 2019. The reported data includes payments made through September 2020.*

The below chart reflects the YoY difference in total allowed amount by service category from January through June. Outpatient services, physician and facility have the steepest drop in total allowed amount for all care types at approximately $35 million. The largest percentage drop in "Other Benefits" is largely represented by dental services. The cost of mental health and substance abuse related services are comparable for both 2019 and 2020.

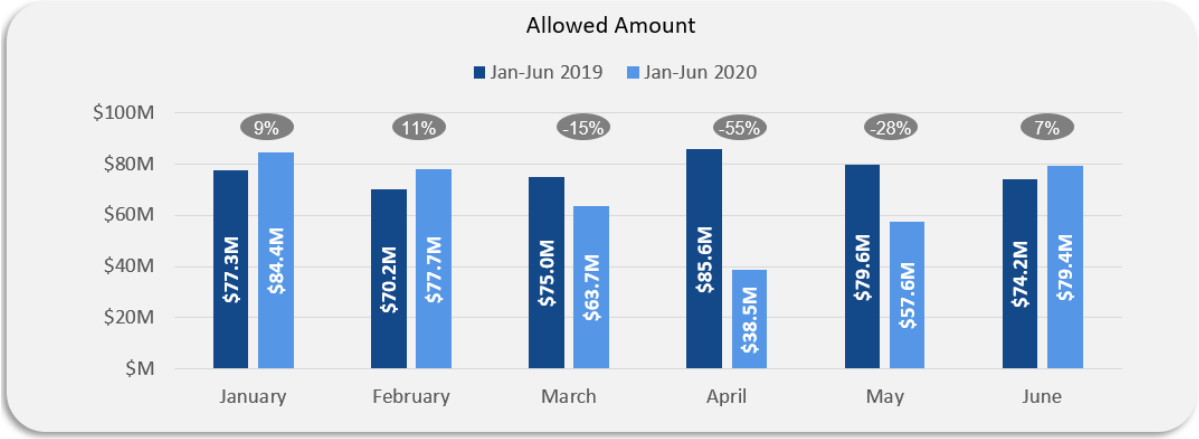
*Chart 11. Changes in All Care by Service Category*




*Based on medical claims incurred January 2020 - June 2020, compared to medical claims incurred January 2019 through June 2019. The reported data includes payments made through September 2020.*

The reduction in cost trend for elective care between 2019 and 2020 was 13.1%, much larger than the decrease in overall care. Allowed amount returns to the expected increase YoY in June and is slightly larger than for all care, indicating a more rapid make-up rate for delayed elective care when compared to all care.

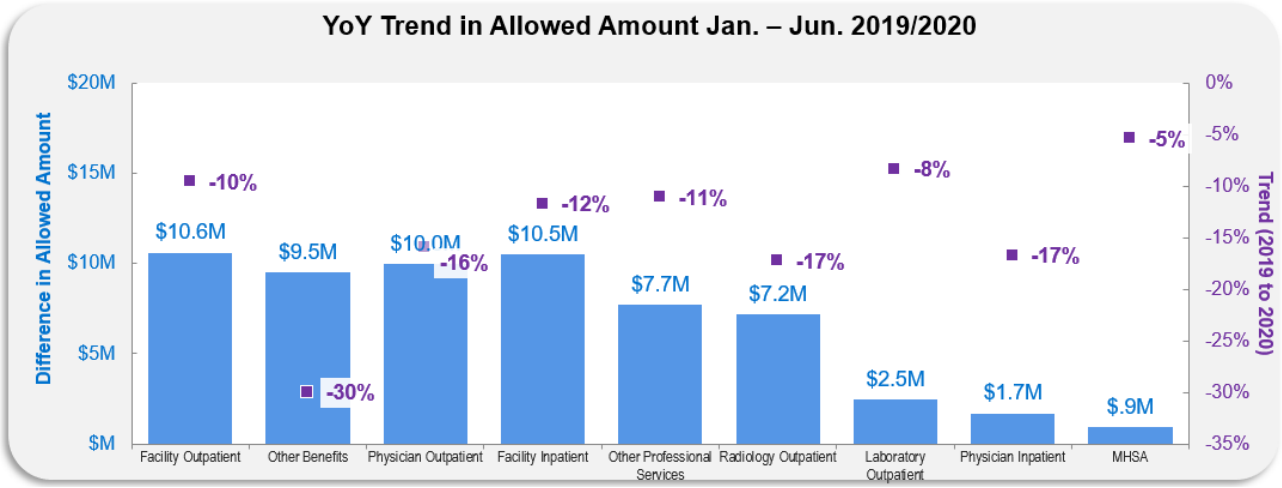
*Chart 12. Changes for Elective Care – Allowed Amount*




*Based on medical claims incurred January 2020 - June 2020, compared to medical claims incurred January 2019 through June 2019. The reported data includes payments made through September 2020.*

Outpatient services, physician services, and facility charges have the steepest drop in allowed amount for elective care at approximately $21 million. The largest percentage drop of 30% in “Other Benefits” represents elective dental services and is comparable to the all care drop. There is a 5% drop in the cost of mental and substance abuse related services, compared to the flat trend for all care types in this category.

*Chart 13. Changes For Elective Care By Service Category*




*Based on medical claims incurred January 2020 - June 2020, compared to medical claims incurred January 2019 through June 2019. The reported data includes payments made through September 2020.*

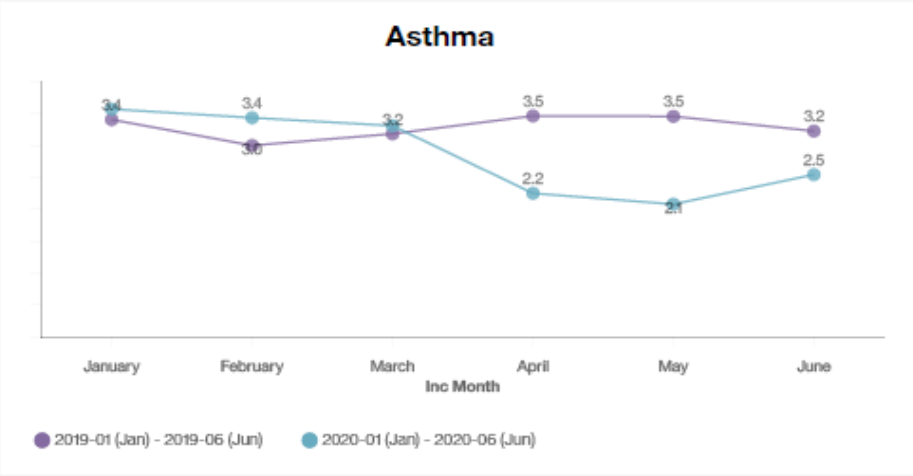
## Conclusion

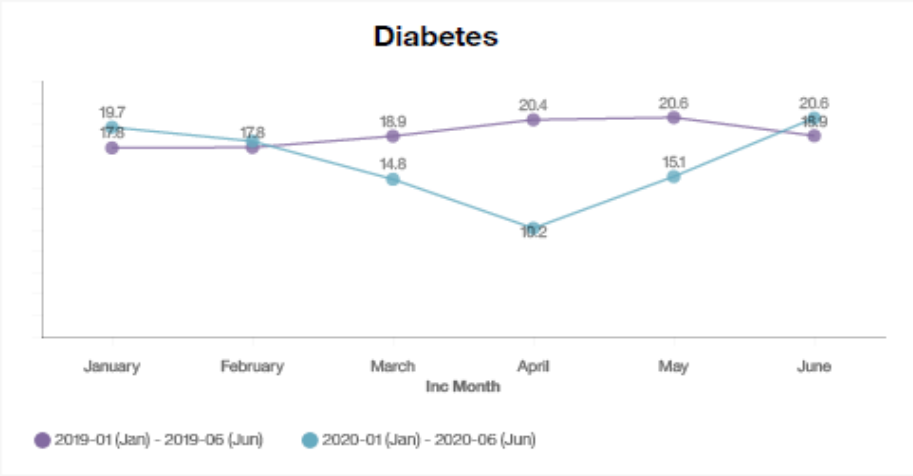
While ETF staff are beginning to be able to quantify what the impact of COVID-19 has been on members, the accelerating rates of infection statewide leave questions regarding how health, quality, and cost will be impacted for the coming months. ETF will also begin to look deeper at the non-COVID-related costs of the pandemic and methods of supporting members in maintaining their physical and mental health. ETF will continue to report to the Board as these issues and other develop.

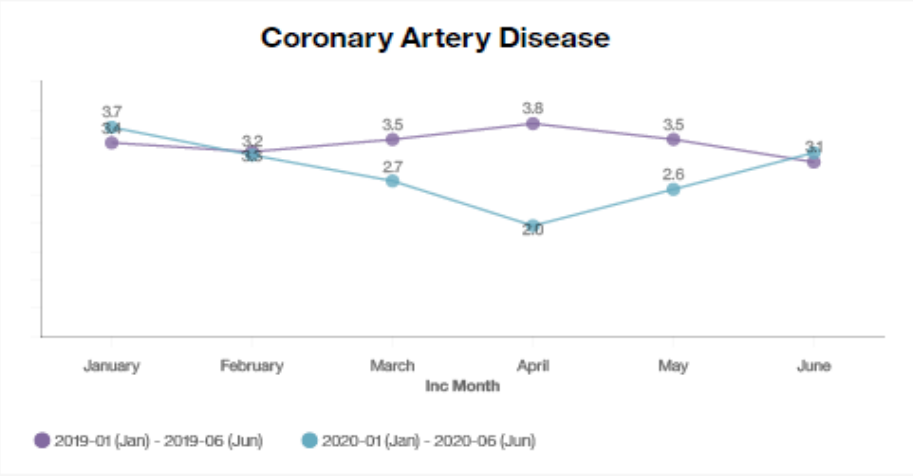
Staff will be available at the Board meeting to answer any questions.

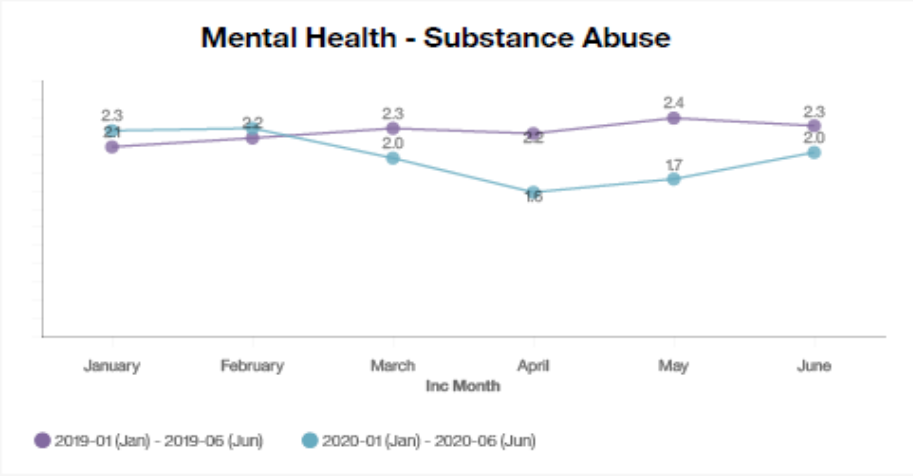
**Appendix A.**

Chronic Condition Rates Reported as **Patients Per 1000 Members (Med + Rx)**(Previous vs Current Incurred YTD)




*Based on medical claims incurred January 2020 - June 2020, compared to medical claims incurred April 2019 through June 2019. The reported data includes payments made through September 2020.*

| Board | Mtg Date | Item # |
|---|---|---|
| GIB | 11.18.20 | 3 |