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Correspondence Memorandum

Date: October 21, 2021

To: Group Insurance Board

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

Subject: November COVID-19 Update

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

Background

November 2021 will mark the twentieth month of the federal public health emergency declared due to the COVID-19 pandemic. This memo provides a review of events that have occurred related to the pandemic since August of 2021 and provides a lookback at the impact of the pandemic on the Group Health Insurance Program (GHIP).

Legislative & Regulatory Changes

No new legislation directly related to the pandemic has been passed either by state or federal officials since the August Board meeting. Several interpretations, however, have been issued by various agencies as it relates to employer vaccine mandates, incentives for vaccination, and booster vaccines.

The Equal Employment Opportunity Commission (EEOC) has issued and continues to update guidance for employers on how to handle various work and pandemic-related issues. On October 13, 2021, the EEOC updated its guidelines pertaining to vaccine requirements in the workplace. Per EEOC, federal laws do not prevent an employer from requiring all employees physically entering a worksite to be vaccinated against COVID-19; in some circumstances, reasonable accommodations must be provided if individuals cannot be vaccinated because of disability or sincerely held religious belief, practice, or observance, unless accommodation would pose an undue hardship to the employer. Information on employee vaccination status is considered confidential and must be held separately from the employee's personnel files.[1]

[1] Equal Employment Opportunity Commission. *What You Should Know About COVID-19 and the ADA, the Rehabilitation Act, and other EEO Laws.* October 13, 2021. https://www.eeoc.gov/wysk/what-you-should-know-about-covid-19-and-ada-rehabilitation-act-and-other-eeo-laws

Reviewed and approved by Eileen K Mallow, Director, Office of Strategic Health Policy Electronically Signed 11/05/2021

Eileen K Mallow

Board	Mtg Date	Item #
GIB	11.17.21	3

EEOC's guidance also clarifies requirements related to employer incentives for vaccination. Per the October 13 guidance update, employers may offer incentives for vaccination, and neither the Americans with Disabilities Act (ADA) nor the Genetic Information Nondisclosure Act (GINA) limit the amount of those incentives if the vaccine is not provided by the employer or its agent. If the employer offers an incentive for a vaccine provided by the employer or its agent, the ADA's rules apply, and the incentive value must not be large enough to be considered coercive[2].

On October 20, 2021, the Food and Drug Administration (FDA) provided authorization to booster vaccines for the Johnson & Johnson and Moderna vaccines. FDA had already authorized boosters of the Pfizer vaccine. In addition, FDA has also stated that any vaccine may be used as a booster to another vaccine[3]. All boosters have been approved under the current emergency use authorization, and only one booster dose is currently approved. The "mix-and-match" booster approach is unique; typically vaccine booster shots are of the same type as the initial vaccine doses or series.

Vaccines & Variants

As of mid-October, just under 6.5 million vaccine doses have been administered statewide in Wisconsin. 3.7 million of those doses were the Pfizer vaccine, 2.5 million were the Moderna vaccine, and 269,000 were the Johnson & Johnson vaccine. Rates of vaccination in the state have dropped from a peak in the spring, and now around 4,500 daily doses are given. These rates include people who have begun to receive booster vaccines. Overall, 54.7% of Wisconsin residents have completed the vaccine series for COVID-19; this percentage includes children, some of whom may not yet be eligible for the vaccine[4]. In August 2021, the Department of Administration (DOA) began collecting the vaccination status of State of Wisconsin employees. On September 13, 2021, DOA reported that nearly 70% of state employees reported having received at least one dose of a COVID-19 vaccine[5].

Vaccination continues to be a key strategy for limiting the opportunity for further virus mutations, leading to new variants that could become resistant to the vaccines available. While the current wave of COVID-19 appears to be moderating, the Delta variant remains the dominant strain detected in Wisconsin. According to Wisconsin State Laboratory of Hygiene tracking data, the Delta variant is now nearly the exclusive strain found in genetically sequenced samples within the state. See Chart 1 below from the Wisconsin State Laboratory of Hygiene's genomic dashboard.

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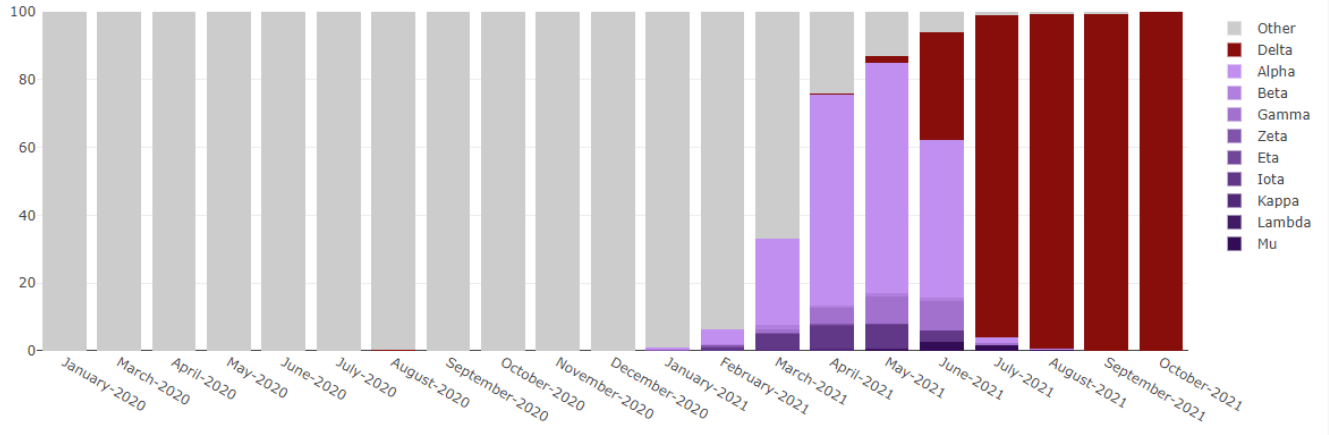
[2] *Ibid.*

[3] Food and Drug Administration. *Coronavirus (COVID-19) Update: FDA Takes Additional Actions on the Use of a Booster Dose for COVID-19 Vaccines.* https://www.fda.gov/news-events/press-announcements/coronavirus-covid-19-update-fda-takes-additional-actions-use-booster-dose-covid-19-vaccines

[4] Wisconsin Department of Health Services. *COVID-19: Vaccine Data*. https://www.dhs.wisconsin.gov/covid-19/vaccine-data.htm. Accessed October 19, 2021.

[5] Wisconsin Department of Administration. *Wisconsin State Employees Report Nearly 70 Percent Vaccination Rate*. https://content.govdelivery.com/accounts/WIGOV/bulletins/2f11b26. Accessed October 19, 2021.

Chart 1. Wisconsin SARS-CoV-2 (hCoV-19) Genomic Dashboard, Proportion of Variants, Updated 2021-10-19



Reference: https://dataportal.slh.wisc.edu/

Other variants continue to emerge worldwide, but none currently have overtaken Delta in terms of transmissibility.

Triple Aim Impacts: Health

ETF continues to monitor member deaths using life insurance claim information provided by Securian, the Board's life insurance vendor. As reported in the last update memo, death rates have slowed. Below are the counts of deaths reported to the life insurance plan as of October 21, 2021, broken down by the decedent's classification and sex. Note, this is likely an undercount of the total deaths of the Board's members, since not all are enrolled in the life insurance program.

Table 1. Life Insurance Program Reported Deaths as of 10/21/21, by Classification

Classification	Number of Deaths
Active	18
Retiree	282
Spouse/Dependent	14
Total	**314**

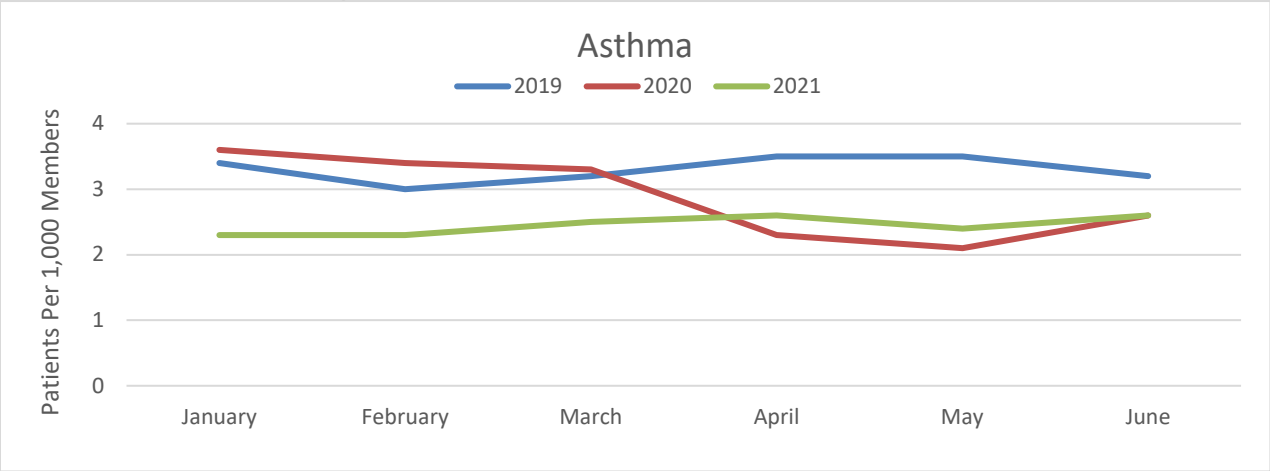
Table 2. Life Insurance Program Reported Deaths as of 10/21/21, by Sex

Sex	Number of Deaths
Male	193
Female	121
Total	**314**

In May 2021, ETF reported to the Board on utilization rates related to chronic condition care. At that time, ETF highlighted asthma care as an area of concern; people with asthma still had a marked difference in their utilization rates even when people with other chronic conditions appeared to have returned to regular care. As shown in Chart

2, data from ETF's data warehouse, Data, Analytics, and Insights (DAISI) provided by IBM Watson Health, shows that utilization by members with asthma still has not rebounded to pre-COVID levels.

Chart 2. Asthma Rates Reported as Patient's Per 1,000 Members



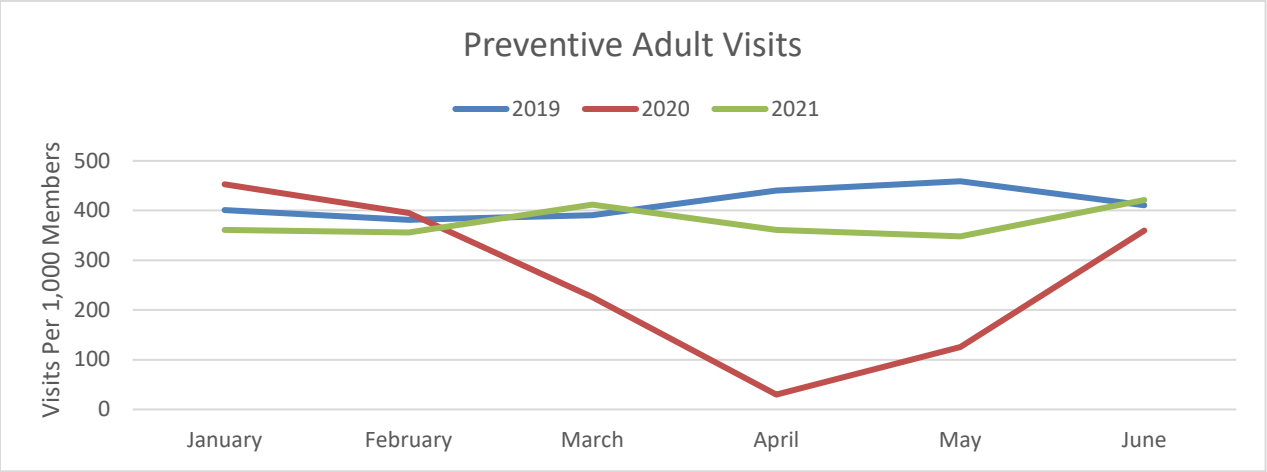
Based on medical claims incurred January 2021 – June 2021, compared to medical claims incurred January 2020 – June 2020 and January 2019 – June 2019. The reported data includes payments made through September 2021.

ETF reached out to health plans, who all indicated that they were continuing with outreach for asthma to encourage patients to continue care. Additional research and analysis will be performed to identify causation and evaluate the impact of lower utilization of care by members with asthma (e.g., admissions, emergency room visits, medication compliance, etc.).

Triple Aim Impacts: Quality

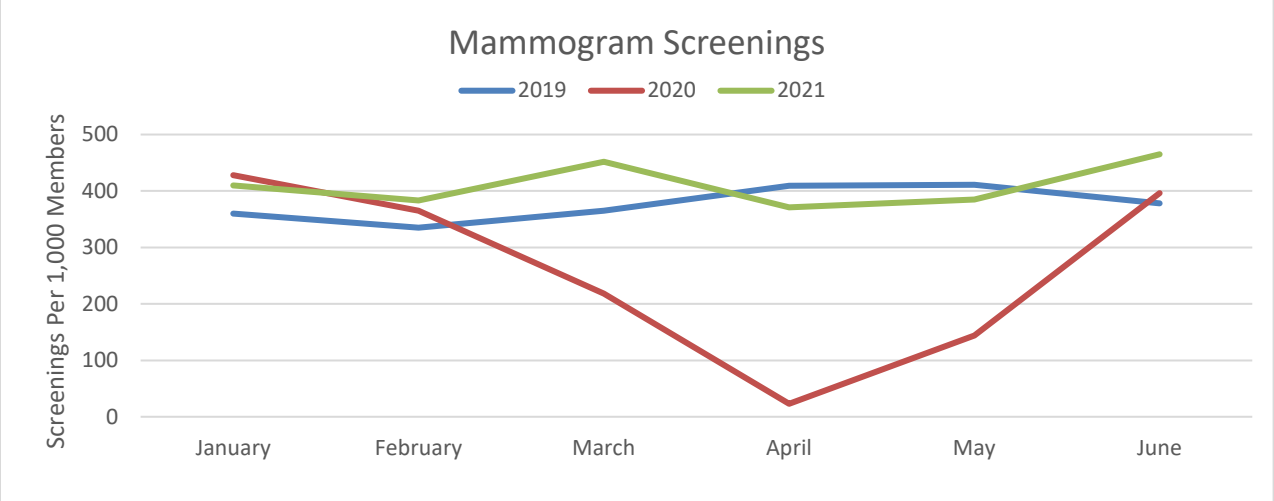
ETF continues to monitor how COVID-19 impacts member health engagement and utilization of services. Charts 3 through 5 show adult preventive visits and screenings have normalized to near pre-COVID-19 rates. The data below is based on claims incurred from January 2021 to June 2021, compared to the same period in 2019 and 2020.

Chart 3. Preventive Visits Per 1,000 Adult Members



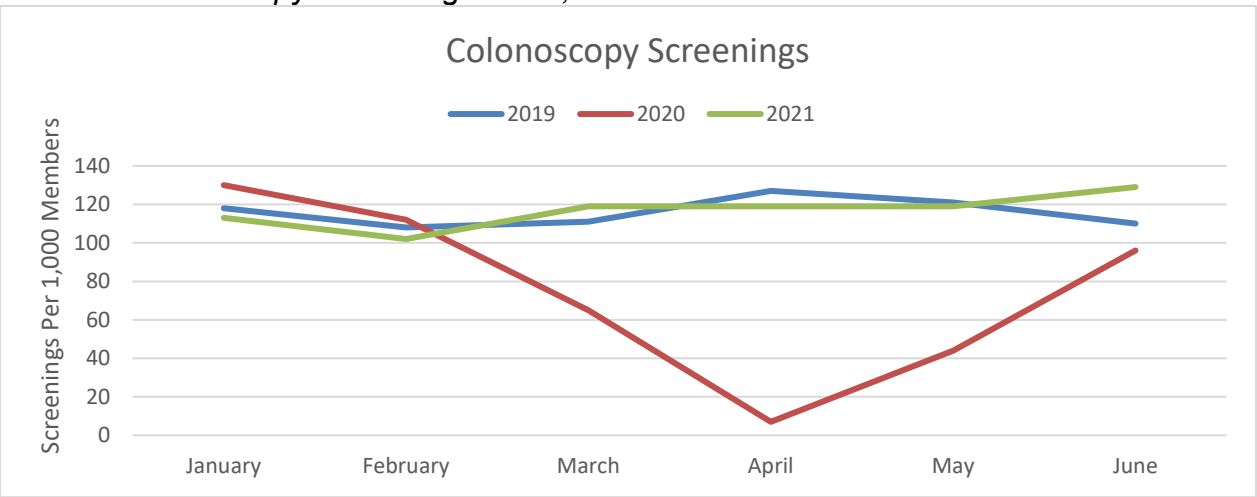
Based on medical claims incurred January 2021 – June 2021, compared to medical claims incurred January 2020 – June 2020 and January 2019 – June 2019. The reported data includes payments made through September 2021.

Chart 4. Mammogram Screenings Per 1,000 Members



Based on medical claims incurred January 2021 – June 2021, compared to medical claims incurred January 2020 – June 2020 and January 2019 – June 2019. The reported data includes payments made through September 2021.

Chart 5. Colonoscopy Screenings Per 1,000 Members



Based on medical claims incurred January 2021 – June 2021, compared to medical claims incurred January 2020 – June 2020 and January 2019 – June 2019. The reported data includes payments made through September 2021.

Triple Aim Impacts: Cost

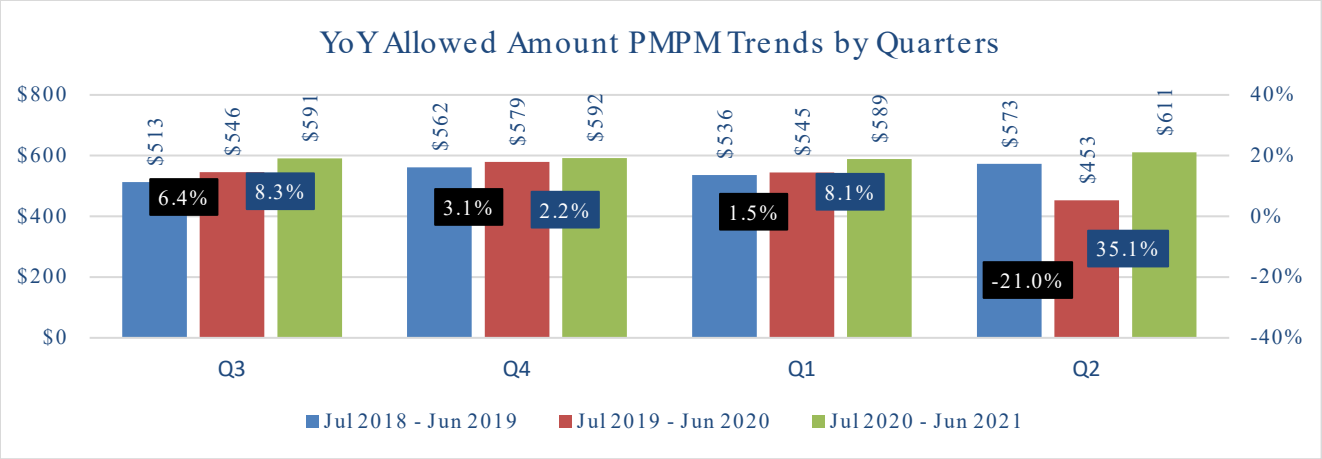
The Board's dental program continues to see a substantial number of people returning to care and associated increased costs. As of October 18, 2021, dental claims received this year were slightly above 2019 amounts. See Table 3 below for details on claims submitted for the same time period over the last three years.

Table 3. Dental Claims through Week 42, 2019, 2020, 2021

	YTD 2021	***YTD 2020***	***YTD 2019***
Claims in Actual $	$46,775,584	$37,628,549	$45,646,876
Number of Claims	336,427	271,235	334,747

Chart 6 shows the GHIP total allowed amount per member per month (PMPM) for all services by quarter for the last three 12-month periods. The chart shows the marked disruption in services in the second 12-month period and then a return to normalcy in the most recent period.

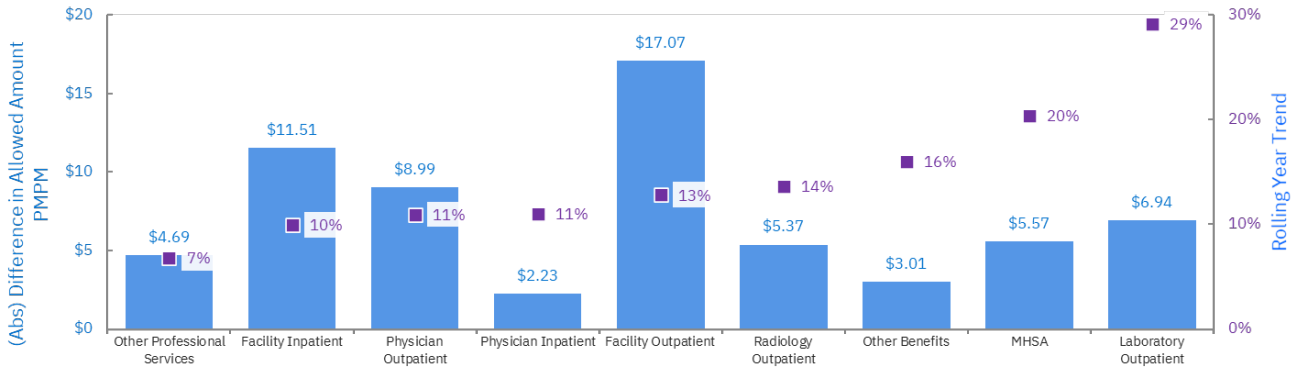
Chart 6. Changes for All Care – Total Allowed Amount



Based on medical claims incurred July 2020 - June 2021, compared to medical claims incurred July 2018 - June 2019 and July 2019 - June 2020. The reported data includes payments made through September 2021.

Chart 7 reflects the Year over Year (YoY) difference in total allowed amount by service category for the most recent 12-month period. All service categories except "Other Professional Services" experienced double-digit trends. The largest increase is for laboratory outpatient category which primarily represents the cost of COVID-19 testing. The mental health and substance abuse (MHSA) cost trend is very high, indicative of continued increased demand for services due to COVID-19. The total allowed amount double-digit trend during the past year is equal to the typical single-digit YoY trend over two years, pointing to a return to normalcy.

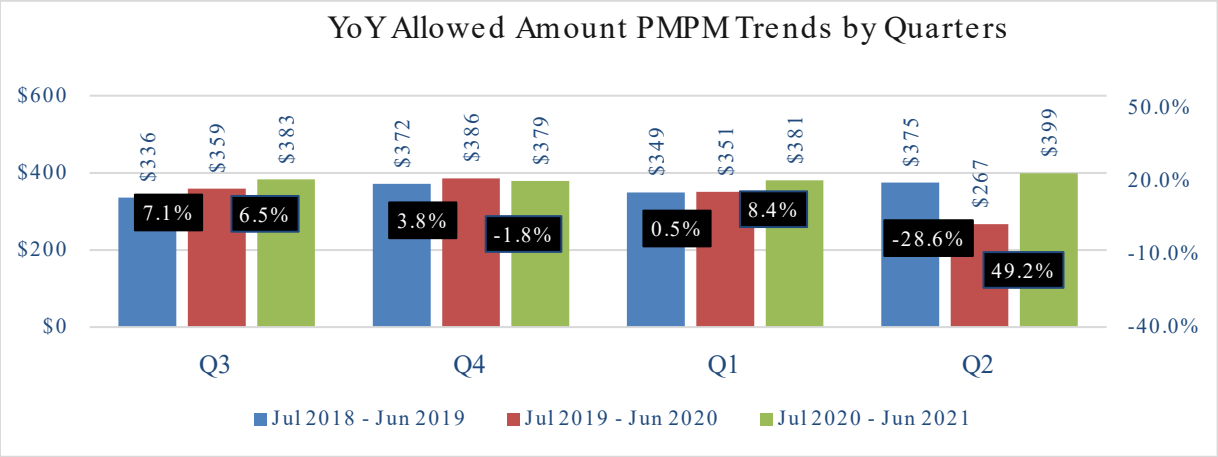
Chart 7. Changes in All Care by Service Category



Based on medical claims incurred July 2020 - June 2021, compared to medical claims incurred July 2019 - June 2020. The reported data includes payments made through September 2021.

Chart 8 shows the allowed amount PMPM cost trend for delayable care had a larger increase in Quarter 2 for delayable care (-28.6%/49.2%) for the most recent 12-month period compared to all care (-21.0%/35.1%) shown in Chart 6 above. The current YoY trend overall is up 13.1% for delayable care which shows a move towards normalcy but at a slightly slower rate than for all care.

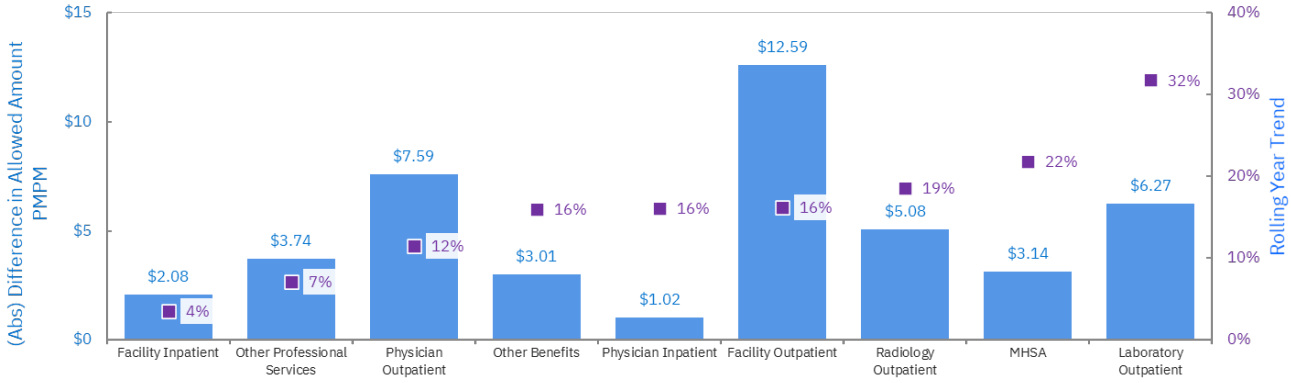
Chart 8. Changes for Delayable Care – Total Allowed Amount



Based on medical claims incurred July 2020 - June 2021, compared to medical claims incurred July 2018 - June 2019 and July 2019 - June 2020. The reported data includes payments made through September 2021.

Chart 9 shows delayable care trends for multiple service categories. Delayable care has higher trends than all care for multiple categories, showing a more rapid rebound from sharper decline during COVID-19. Both physician and facility outpatient categories are slightly higher for delayable care (12%/16%) compared to all care (11%/13%), indicating a faster rebound in services typically rendered in these settings (e.g., preventive screenings). The 4% facility inpatient trend for delayable care is much lower than the 10% for all care, suggesting that less urgent and severe services requiring admissions have not yet returned to pre-COVID-19 levels.

Chart 9. Changes in Delayable Care by Service Category



Based on medical claims incurred July 2020 - June 2021, compared to medical claims incurred July 2019 - June 2020. The reported data includes payments made through September 2021.

To identify the ongoing or past presence of COVID-19 in GHIP, 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 sites).

Table 4 shows the total allowed amount spent on COVID-19 testing from January 2020 through June 2021 was about $17.3 million.

Table 4. COVID-19 Testing Experience and Costs

COVID-19 Test	Members	Average Cost Per Member	Total Allowed Amount
Diagnostic Test	81,896	$199	$16,261,795
Antibody Test	15,806	$69	$1,083,998

Based on medical claims incurred January 2020 - June 2021, payments made through September 2021.

Table 5 shows the total allowed amount spent on members with COVID-19 from January 2020 through June 2021 was about $45.7 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
9,868	$4,626	$45,653,607

Based on medical claims incurred January 2020 - June 2021, payments made through September 2021.

Next Steps

While the current Delta COVID-19 wave may be attenuating, it appears that COVID-19 will persist within our population to some extent for the foreseeable future. ETF will continue to monitor the impacts of the COVID-19 pandemic and will report to the Board on impacts if any substantial changes arise.

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