State Employees Health Plan Task Force

Finding Cost Savings and Efficiencies

September 9, 2015

Final

Prepared by Aon
Consulting | Health & Benefits

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Introduction

- Welcome
- Epilogue Language in FY2016 Budget (Section 73)
- Purpose: finding cost savings and efficiencies
- Areas of Inquiry: plan design, rate setting process, rates across plans, premiums based on income, cost share of premiums; increased participation in wellness programs, surcharges based on wellness activities, deductibles, high cost claims, case management, third party administrators, prescription benefits manager, centers of excellence, employee health centers, consolidation of plans, covered groups and eligibility of members, coordination of benefits, double state share, disease management and wellness outcome measures, and alternate coverage (market place, exchange and insured), and the Cadillac Tax (excise tax)
- The Office of Management and Budget shall staff the committee and shall engage a consultant to conduct an operational review from an actuarial and benefits perspective
  - Aon Hewitt Health and Benefits Consulting
- Target Completion Date for delivery: December 1, 2015

Procedural Issues: General Planning for Task Force Meetings

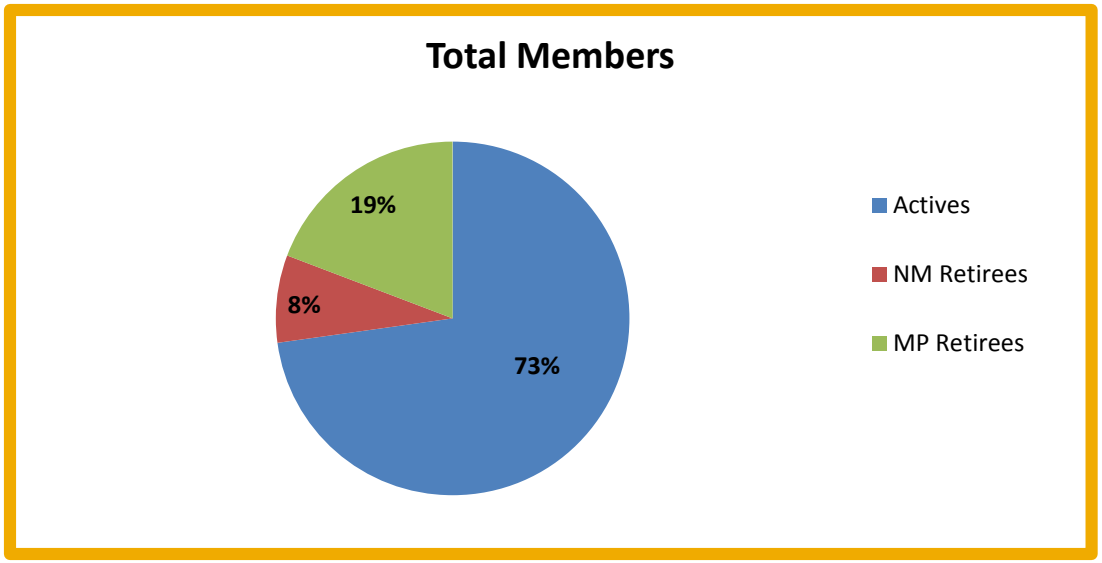
- General Planning for Task Force meetings
  - Process
  - Aon role in meeting
  - Task Force Members roles and responsibilities
  - Public disclosure
    - Meetings open to public
    - Suggestions mailbox – healthplan.taskforce@state.de.us
    - Public testimony/workshops scheduled over next two weeks – see handout
    - All meeting materials and schedules posted at www.ben.omb.delaware.gov/hptf

Agenda

- Agenda for September Kick-off meeting:
  - Understanding existing plan designs and current state
  - Sizing the problem
  - Addressing the issues

Plan Overview

- The Group Health Insurance Program (“GHIP”) is available to:
  - Active Employees,
  - Non Medicare (NM) Retirees
  - Medicare Primary (MP) Retirees
- The above groups represent 67,000 contracts and just over 122,000 covered lives



Based on GHIP financial reporting through FY15
Includes NonState group membership – 7300 contracts/17100 members

Plan Overview – Understanding the GHIP Health Plans

- Health Plan Options Available to GHIP members
  - 6 active/non Medicare plans (same plans available to both groups)
  - 1 Medicare supplement plan (supplements coverage and services not covered by traditional Medicare)
  - All plans include prescription drug coverage administered by Express Scripts

	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%	
Highmark & Aetna HMO	93.5%/6.5%	93.5%/6.5%	
Highmark & Aetna Consumer Directed	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%**

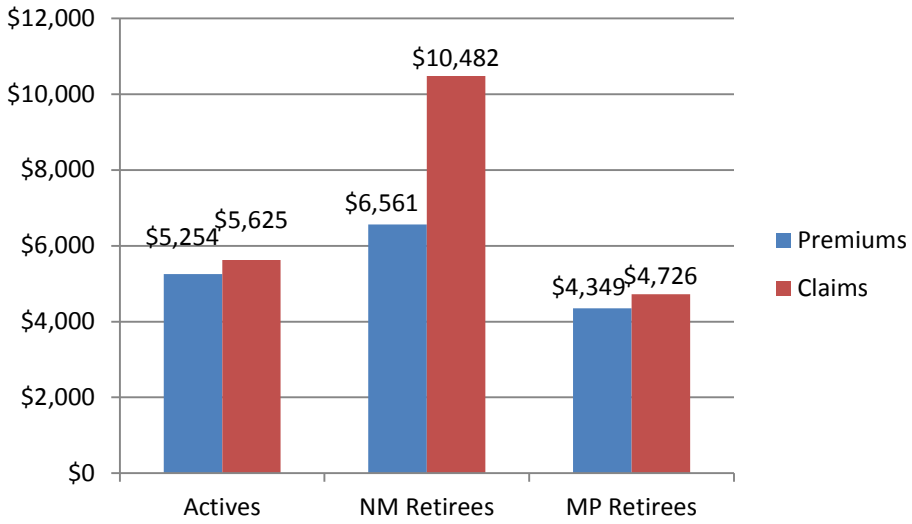
*Retirees with full state share who retired before July 1, 2012

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

Plan Overview – Understanding the GHIP Health Plan Premiums

- GHIP is self-insured for health and prescription benefits
  - Health plan premiums paid to GHIP are used to pay:
    - Actual claims incurred by GHIP members
      - Approximately 95% of total contributions are used to pay claims
    - Administrative fees to Highmark, Aetna and Express Scripts
    - Premiums are the same for actives/Non Medicare retirees
    - Per capita claims for active members are significantly less than Non Medicare Retiree members

Per Capita Claims vs. Per Capita Premiums*



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***Based on GHIP financial reporting through FY15**

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Plan Overview - Understanding Industry Standards and the GHIP Active/non Medicare Health Plan Designs

- Actuarial Value is a health care industry term used to represent the percentage of total average costs for covered benefits that a plan will cover
- Actuarial Value is not tied to a predetermined plan design
- Four primary levels keyed to actuarial values:
  - 60% (bronze)
  - 70% (silver)
  - 80% (gold)
  - 90% (platinum)

GHIP Active and Non Medicare Plans Compared to Sample Platinum & Gold Level Plan Designs

	Sample Gold Plan**	Highmark First State Basic Plan	Highmark & Aetna CDHP (with HRA)	Sample Platinum Plan**	Highmark PPO*	Highmark & Aetna HMO
Actuarial Value (Segal for GHIP)	80%	**86.1%**	**87.0%**	90%	**90.4%**	**90.6%**
Deductible (Single/Family)	$900/$1,800	$500/$1,000	$1,500/$3,000 +1,250/2,500 HRA	None	$0/$0	$0/$0
Out-of-Pocket Maximum (Single/Family) *Medical Only*	$4,500/ $9,000	$2,000/$4,000	$4,500/$9,000	$4,500/ $9,000	$4,500/$9,000	$4,500/$9,000
In-Network Coinsurance	25%	10% Coinsurance	10% Coinsurance	10%	0%	0%
Primary Care	$30	10% Coinsurance	10% Coinsurance	$20	$20	$15
Specialist	$50	10% Coinsurance	10% Coinsurance	$40	$30	$25
Inpatient Facility	25% coinsurance	Deductible & coinsurance	Deductible & coinsurance	10% coinsurance	$100/day up to 2 copays	$100/day up to 2 copays
Emergency Room	$300	Deductible & coinsurance	Deductible & coinsurance	$200	$150	$150
Out-of-Network Coinsurance	40%	30%	30%	30%	20%	N/A
Prescription Drug Benefit						
30-day Retail	$10/$40/$80	$8/$28/$50	$8/$28/$50	$5/$20/$50	$8/$28/$50	$8/$28/$50
90-day Retail & Mail	$25/$100/$200	$16/$56/$100	$16/$56/$100	$10/$50/$125	$16/$56/$100	$16/$56/$100
Out-of-Pocket Maximum (Single/Family)	$2,100/$4,200	$2,100/$4,200	$2,100/$4,200	$2,100/$4,200	$2,100/$4,200	$2,100/$4,200

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*Actuarial Value based on in-network benefits only, out- of network feature increases value slightly
**Sample plan designs with split out of pocket maximums, medical and drug, and not specific to Delaware marketplace

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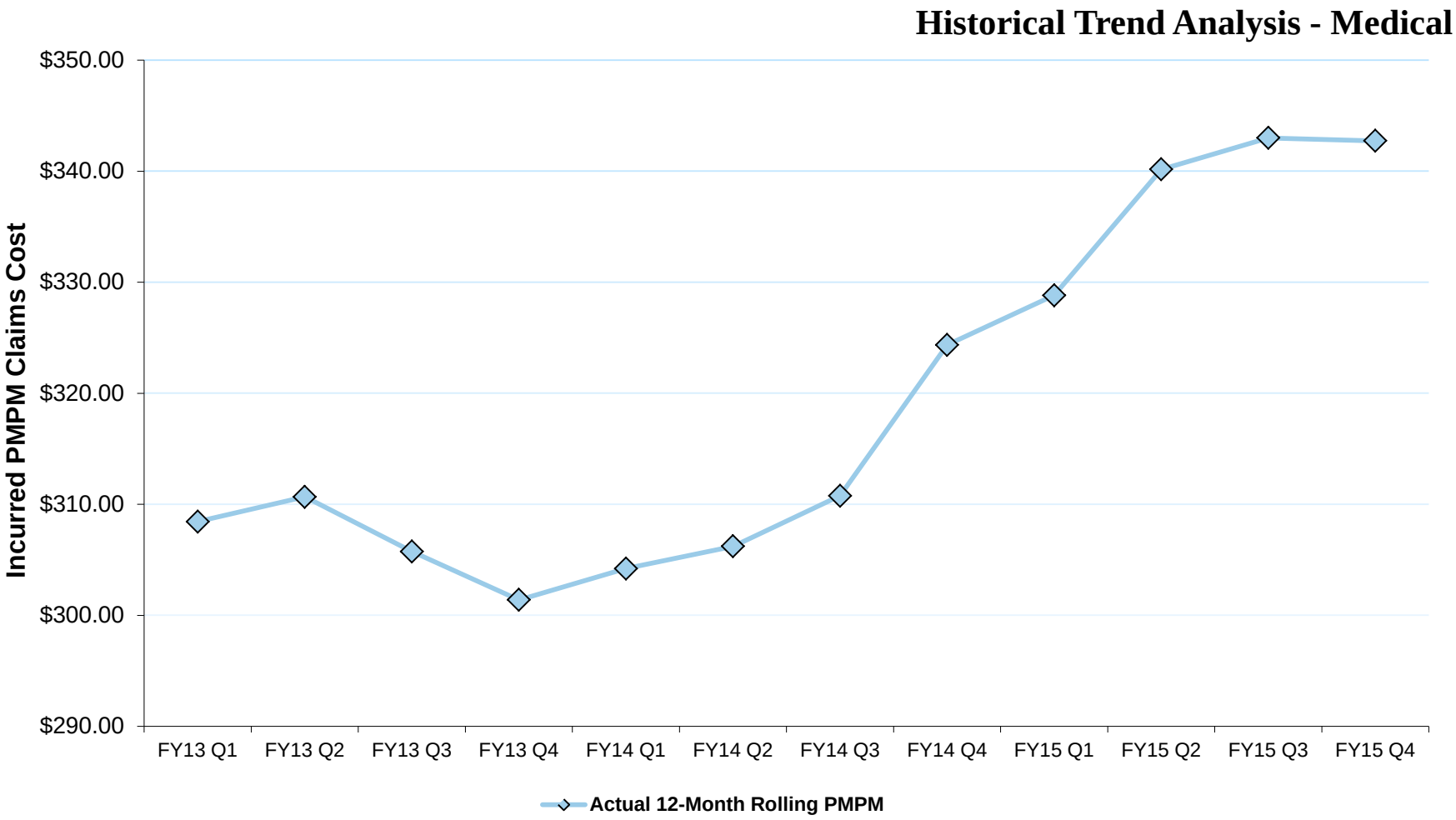
Historical Overview of GHIP Costs

- The State Employee Benefits Committee regularly review GHIP costs and interested parties convened in 2011 resulting in House Bill 81 to address Health and Pension reform
- GHIP health benefit premium increases represented the largest addition to State general fund budget in FY16
- State pays 91.4% of total health premium on average
- Challenge of managing health premium increases needed to fund rising costs accelerated in FY14
  - Per member costs had remained at relatively stable levels in FY12 and FY13
  - Based on last three years of actual GHIP costs, projected trend is 7.1% annually
  - Using most recent two years of actual GHIP costs, projected trend rises to over 10% annually
  - If costs continue to increase at rate experienced in most recent year, GHIP costs will exceed $1 billion by FY2020

High Level Cost Increase Overview

- Sources of cost increases are driven by both medical and prescription components.
  - Number of services and medications = Higher utilization
  - Severity of the diagnosis/treatment protocol
- On the medical side:
  - Outpatient surgery
  - Inpatient hospital admissions
- On the prescription side:
  - High price inflation for brand and specialty drugs,
  - A slowdown in blockbuster drugs losing patent protection,
  - Generic dispensing rates leveling off, and
  - The robust pipeline of specialty drugs including the new Hepatitis C treatments.
- In depth analysis of trend drivers will be presented at the September 24th meeting

GHIP Medical Costs Per Member Per Month



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GHIP claim data -Chart prepared by Segal

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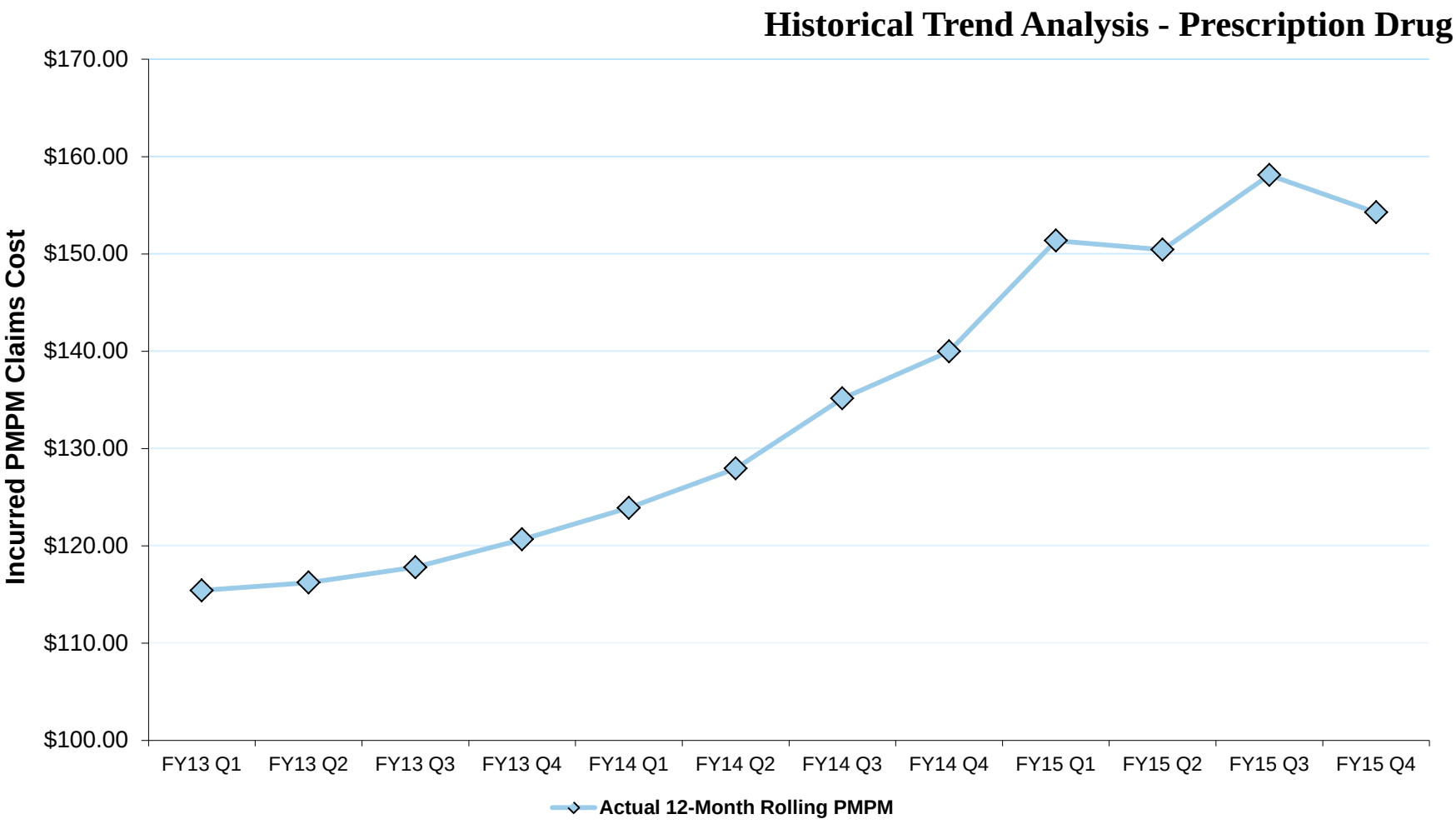
GHIP Prescription Drug Costs Per Member Per Month



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GHIP claim data - Chart prepared by Segal

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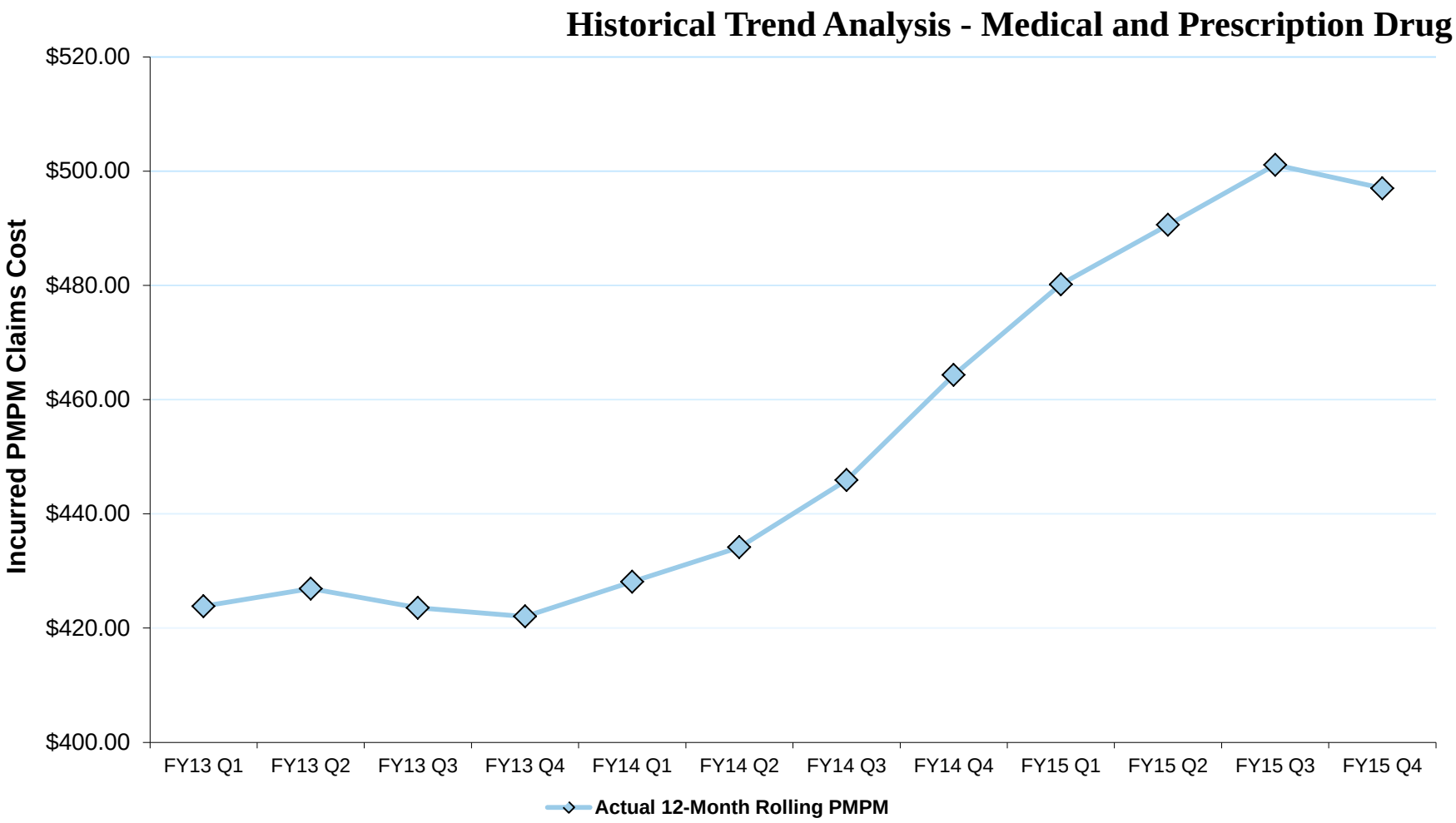
GHIP Medical and Prescription Drug Costs Per Member Per Month



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GHIP claim data- Chart prepared by Segal

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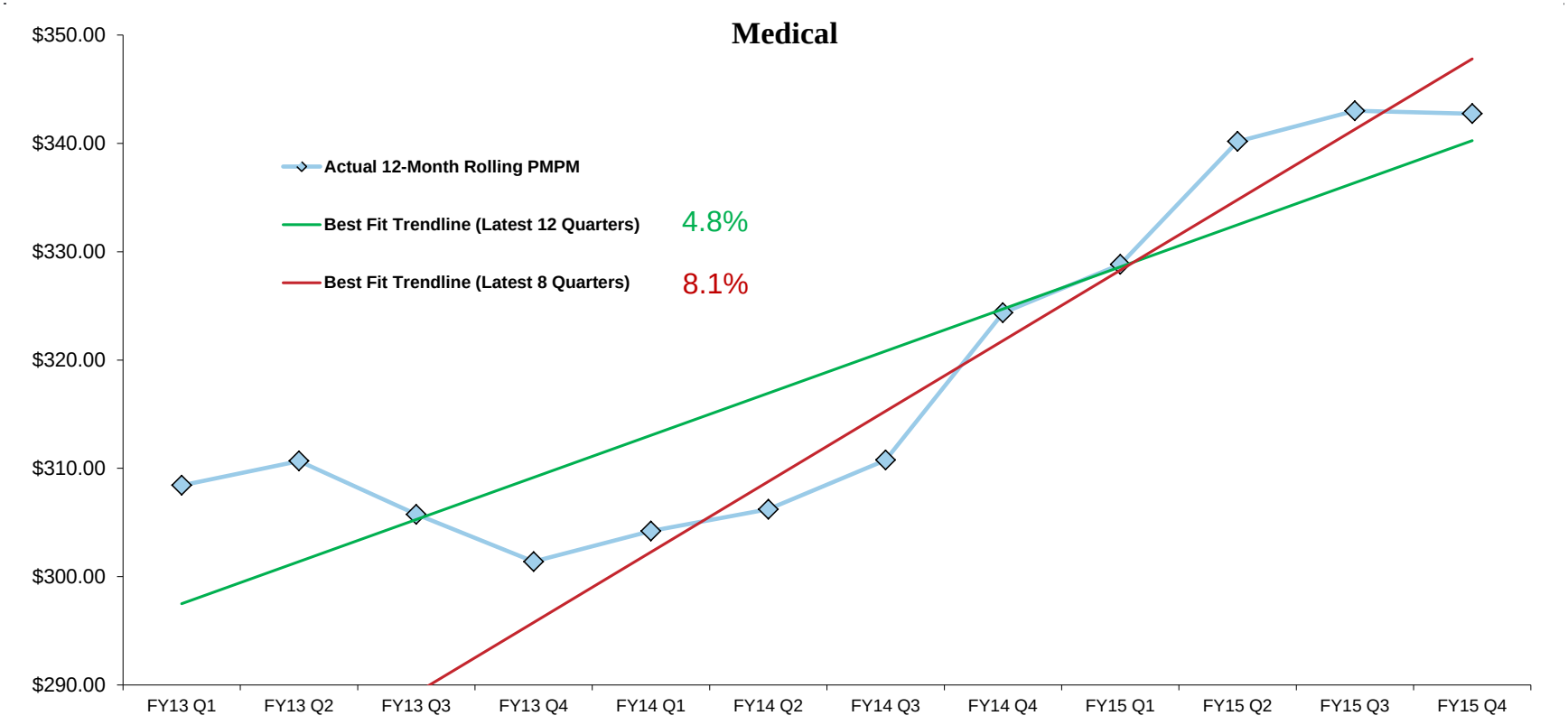
GHIP Medical Costs Per Member Per Month "Best Fit" Trend



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GHIP claim data - Chart prepared by Segal

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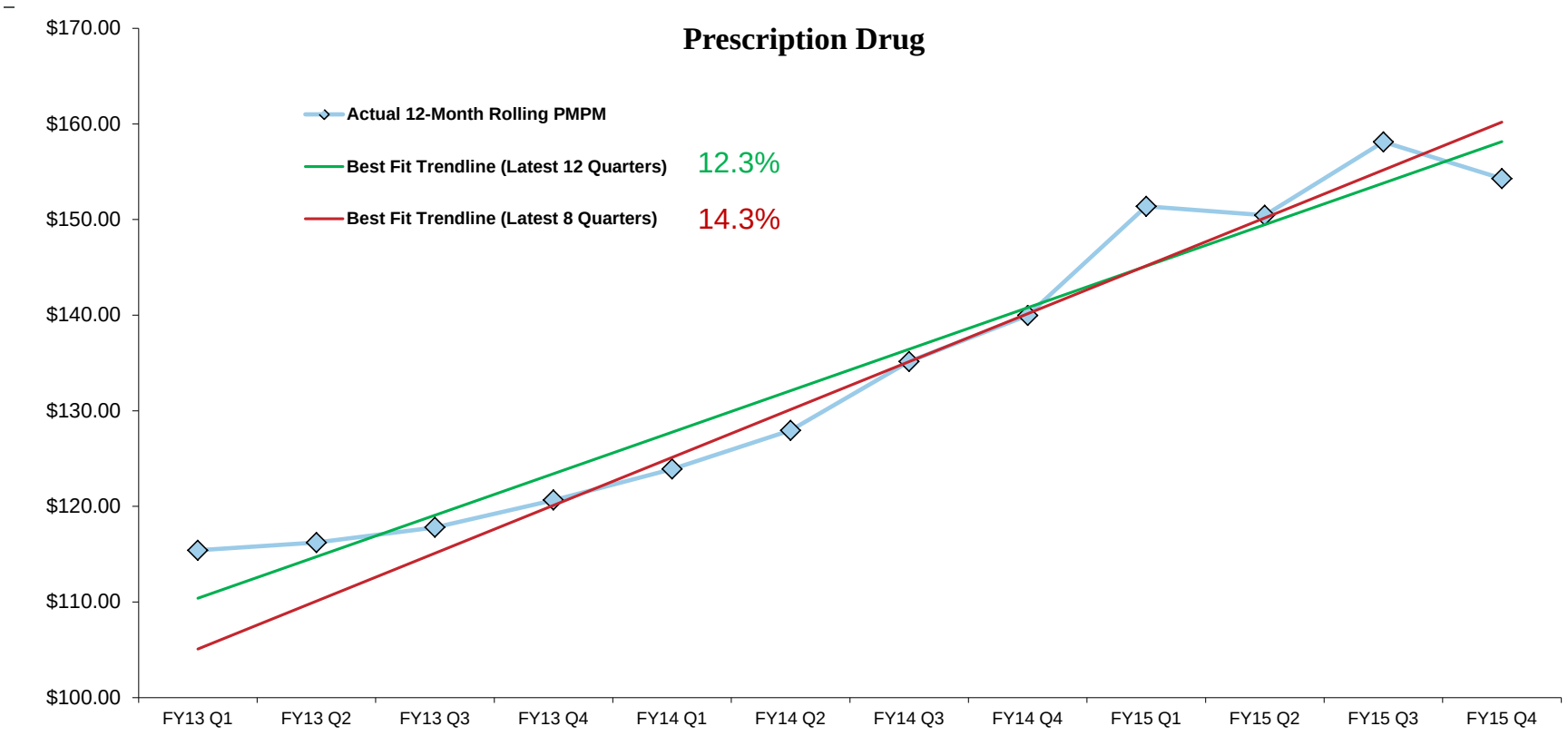
GHIP Prescription Drug Costs Per Member Per Month "Best Fit" Trend



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GHIP claim data -Chart prepared by Segal

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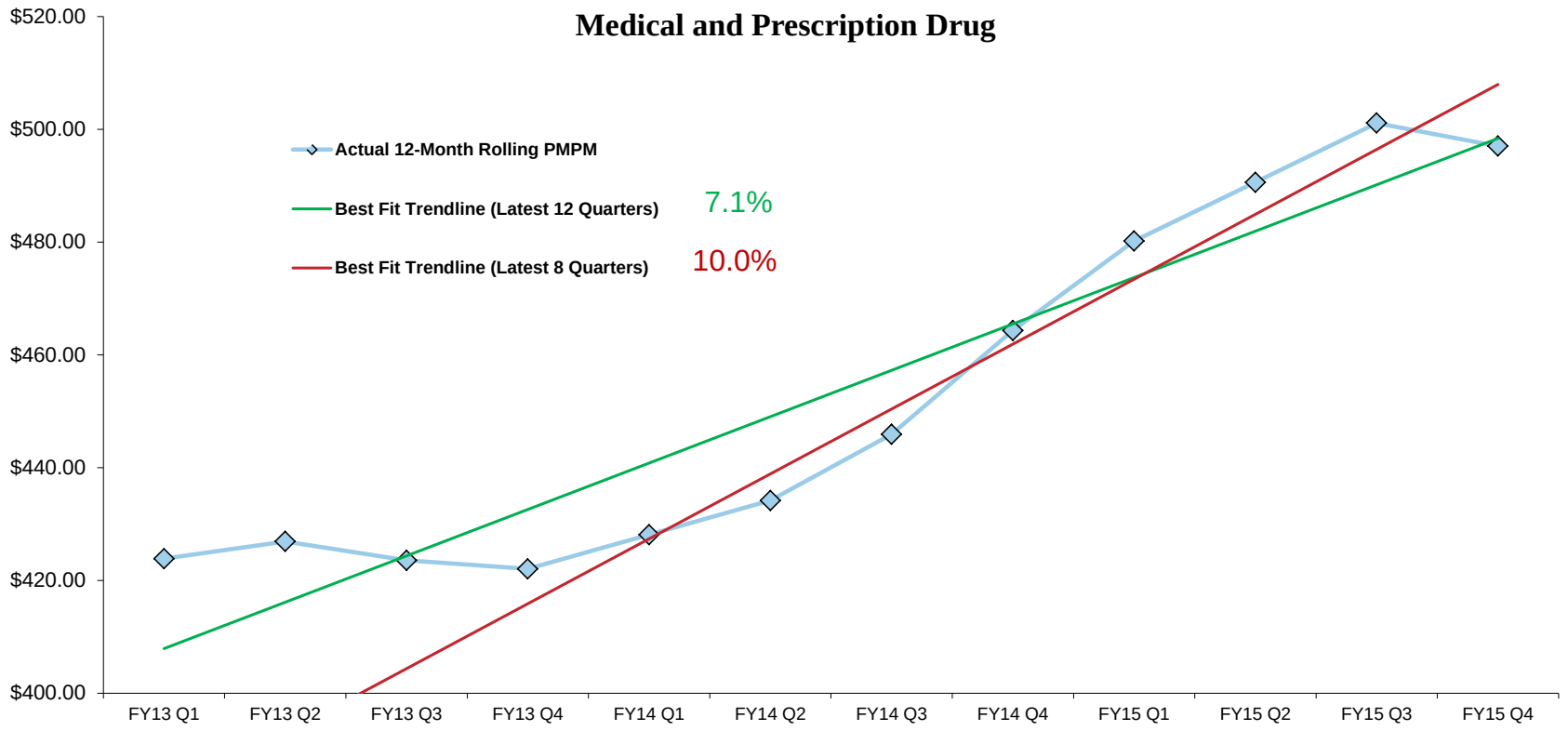
GHIP Medical and Prescription Drug Costs Per Member Per Month "Best Fit" Trend



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GHIP claim data -Chart prepared by Segal

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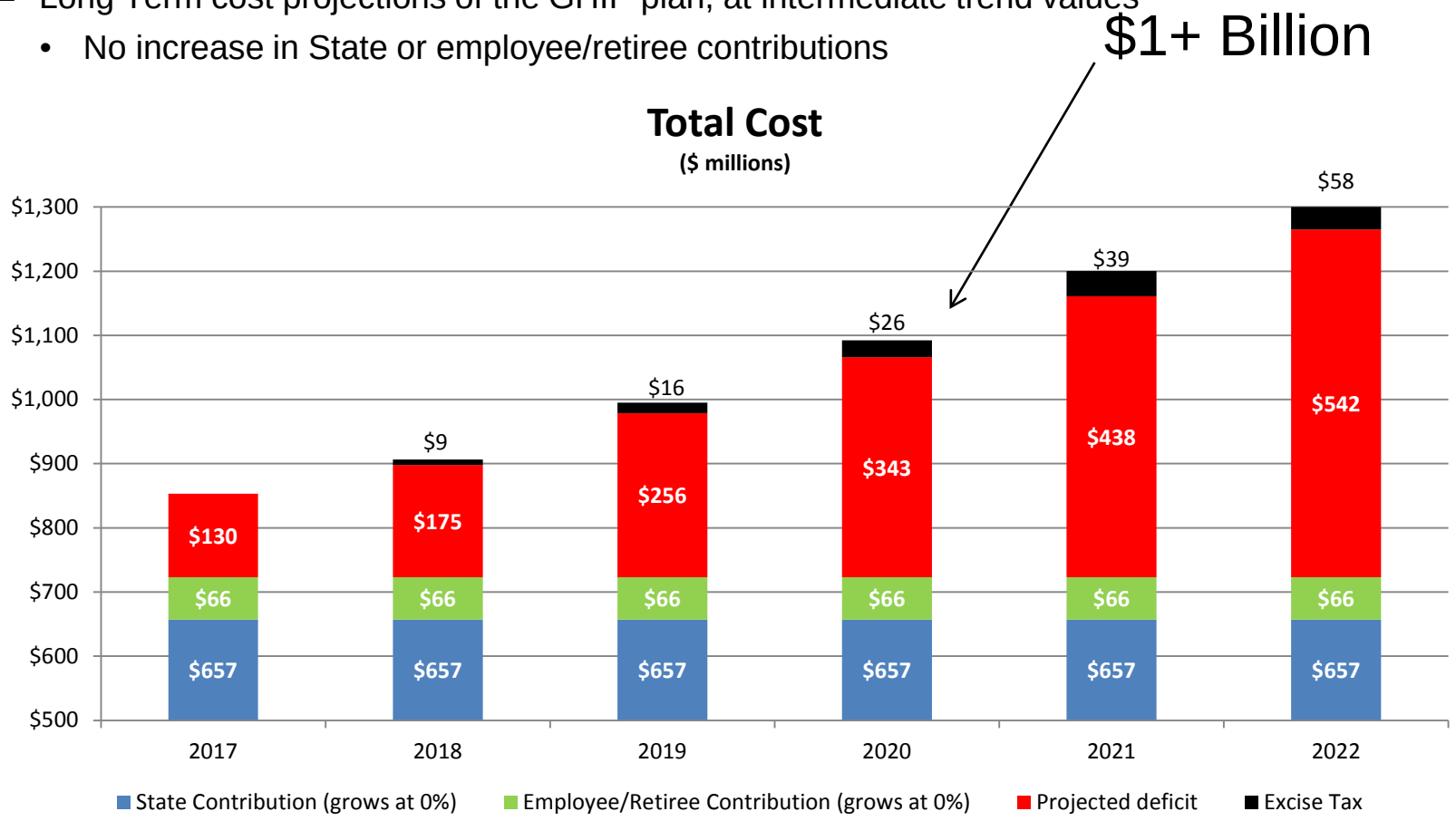
Medical and Prescription Drug Trend – overview of current market

- Medical costs are beginning to increase from historically low levels.
- Pharmacy costs have increased significantly and Aon now expects low double digit trends through 2017.
- Pharmacy cost trends may vary significantly by plan sponsor depending on their particular issues such as compound drug spend, generic/brand shift and utilization and management of specialty drugs.
- Aon expectation of national trend is 5.5% for medical, and 10.5% for prescription drugs, for the foreseeable future. This weights to approximately 7% (6.8% at 75/25).
- This is consistent with externally reported survey information, for example:
  - For 2015, PricewaterhouseCoopers' Health Research Institute (HRI) projects a medical cost trend of 6.8%. Taking into account likely adjustments to benefit design such as higher deductibles, HRI anticipates a net growth rate of 4.8%.

Sizing the Problem

– Long Term cost projections of the GHIP plan, at intermediate trend values
  - No increase in State or employee/retiree contributions



Data from various Segal documents, long term projections at 9% trend.

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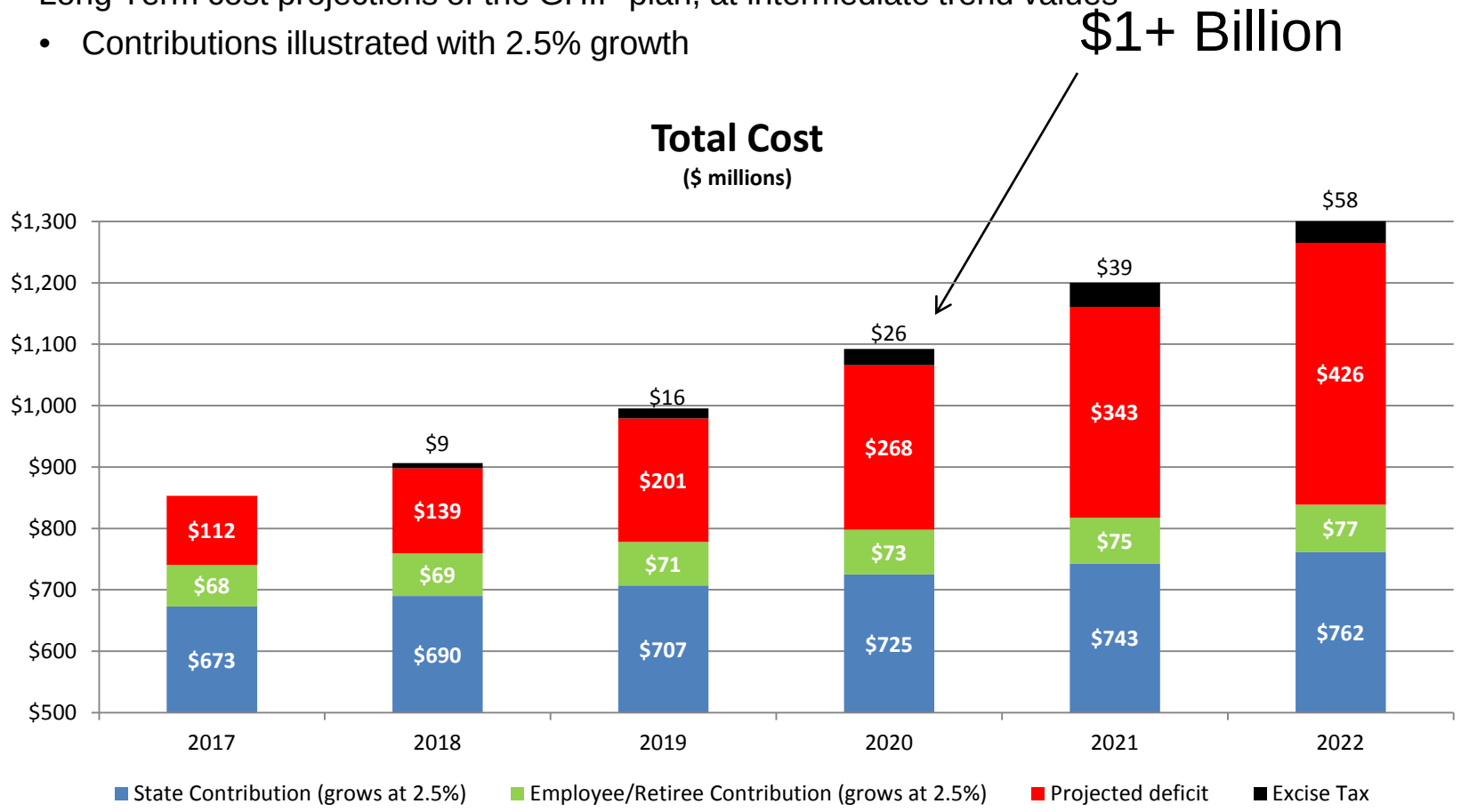
Cost Increases Cannot Be Absorbed Through Premiums Alone

– Long Term cost projections of the GHIP plan, at intermediate trend values
  - Contributions illustrated with 2.5% growth



Data from various Segal documents, long term projections at 9% trend.

Areas to Address the Deficit – Finding Cost Savings and Efficiencies

- Plan design
- Rate setting process
- Rates across plans
- Premiums based on income
- Cost share of premiums
- Increased participation in wellness programs
- Surcharges based on wellness activities
- Deductibles
- High cost claims
- Case management
- Third party administrators
- Prescription benefits manager

Areas to Address the Deficit – Finding Cost Savings and Efficiencies

- Centers of excellence
- Employee health centers
- Consolidation of plans
- Employee health centers
- Consolidation of plans
- Covered groups and eligibility of members
- Coordination of benefits
- Double state share
- Disease management and wellness outcome measures
- Alternate coverage (market place, exchange and insured), and
- The Cadillac Tax/Excise tax

Path Forward

- Output: Need blueprint for solving the next several years' projected deficit

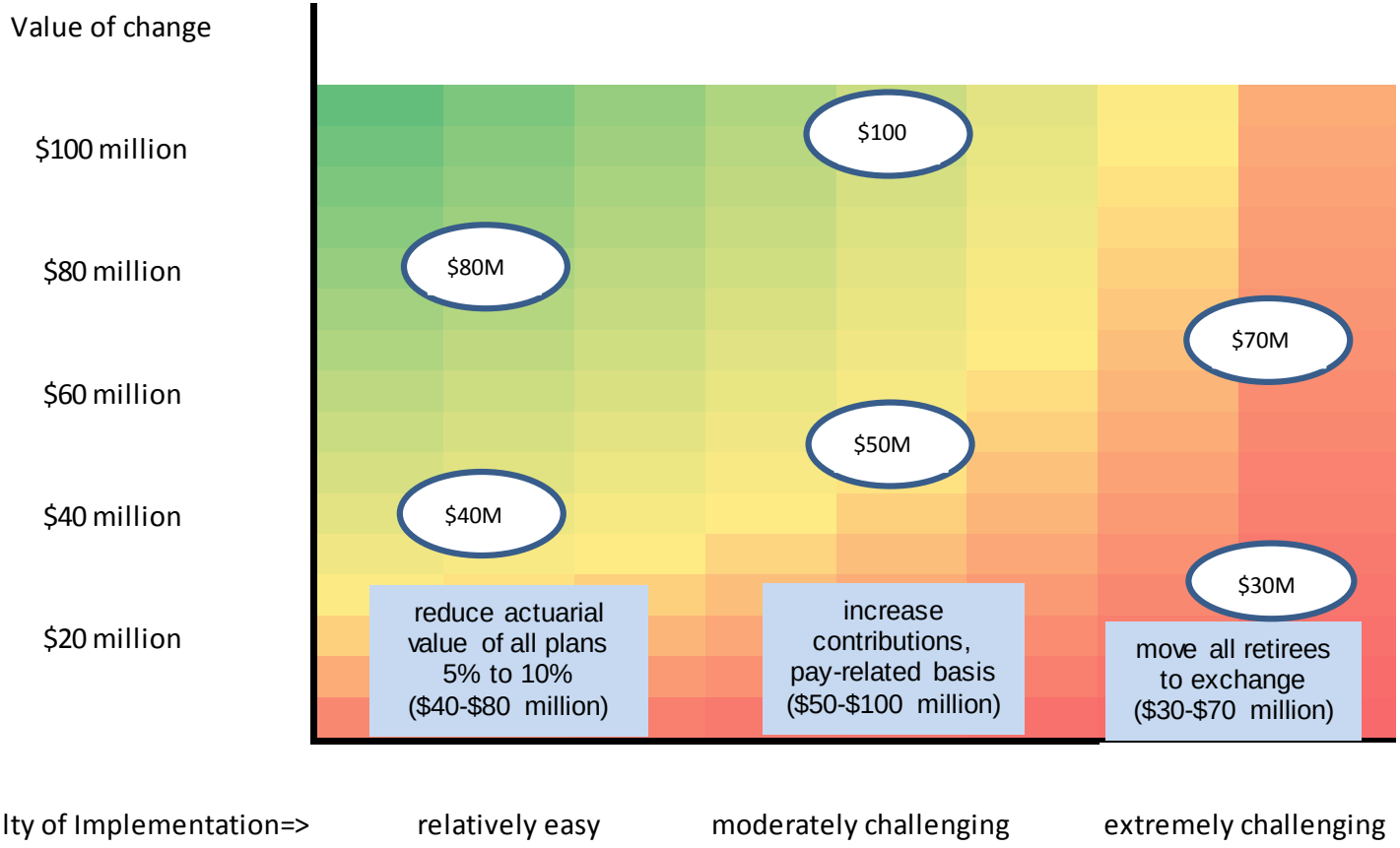
- Note: Task Force charter is to submit the recommendations to the Governor and General Assembly no later than December 1, 2015.

Next Steps

- Determine if dollar amount should be target
- Determine time period to achieve savings
  - Some immediacy necessary for FY 2017 given current high trend
  - Need to manage trend beyond FY 2017
- Determine scope of populations to assess changes for medical and prescription drug benefits only
  - Actives
  - Non Medicare retirees
  - Medicare Primary retirees
- Determine options to find cost savings and efficiencies

- Reminder:
  - SEBC approval
  - Some legislation may be required

Solving the Deficit– two dimensional staging of options



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Next Steps

Technical Appendix – Excise Tax

- In 2018, the Excise Tax on High Cost Employer-Sponsored Health Coverage, a provision of the Patient Protection and Affordable Care Act (ACA), will go into effect:
  - ACA adds the following to the Internal Revenue Code: SEC. 4980I. Excise Tax on High Cost Employer Sponsored Health Coverage
  - Applies to all employer-sponsored plans, including governmental plans
  - Includes active coverage, and all retiree coverage
  - The Excise Tax will impose a 40 percent tax on the aggregate cost of employer-provided group health coverage that exceeds certain thresholds.
  - The aggregate cost of coverage includes employer contributions to medical coverage, health reimbursement accounts (HRAs), health savings accounts, and employee salary-reduction contributions under cafeteria plans. The tax applies to both fully insured and self-funded plans
- Currently no regulatory guidance on how this provision will be implemented
  - Many potential mitigation options available to plan sponsors
  - Mitigation options require regulatory guidance to fully assess potential impact

Technical Appendix – Excise Tax, cont.

- Projections in this presentation take conservative route
  - All benefit options tested individually, and actives, Non Medicare Retirees and Medicare Primary Retirees tested separately
  - Potential to blend certain retiree costs together would substantially mitigate the excise tax cost for retiree plans
  - Intermediate CPI assumption used (2.5%)

Excise Tax 2018 Thresholds	Active employees and Medicare Primary retirees	Qualified retirees and those in hazardous-duty employment
Individual coverage	$10,200	$11,850
All other coverage tiers	$27,500	$30,950