State Employees Health Plan Task Force

Finding Cost Savings and Efficiencies

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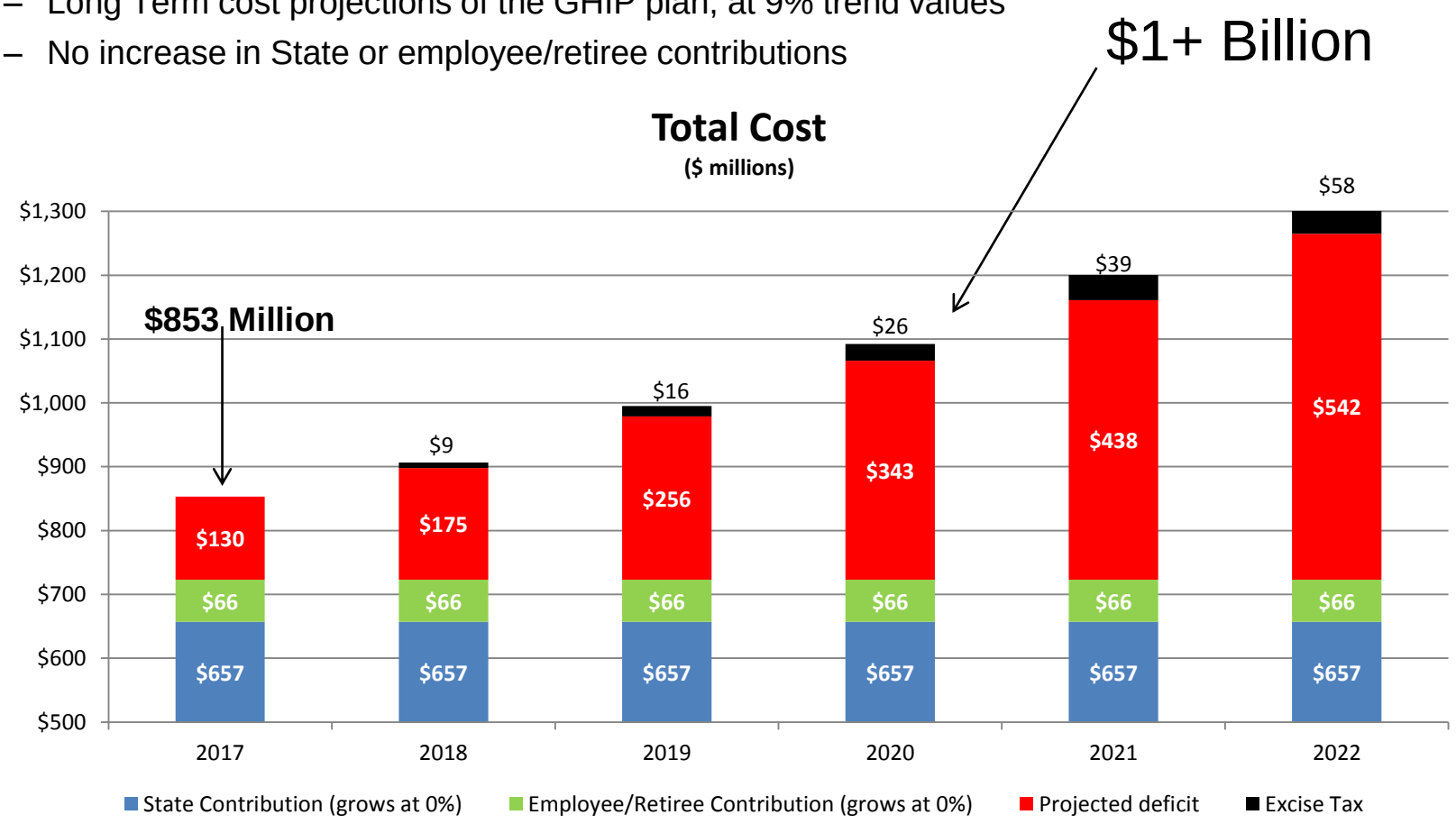
Consulting | Health & Benefits

Empower Results®

Sizing the Problem

- Long Term cost projections of the GHIP plan, at 9% trend values
- No increase in State or employee/retiree contributions



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

Four Dimensions of Potential Changes to Review

- Discussed on October 8, presentations to illustrate potential opportunities for cost savings and efficiencies to the GHIP in four dimensions:
  - Redesign Plans / Plan Design
  - Review Premium Cost-Sharing Structure
  - Enhance Population Health / Health Plan Management
  - Options for Retirees
- Presentation of several “top” ideas in each of these dimensions
  - To be used as information or “stepping stones” for evaluation
  - Each idea will have a brief explanation of construction, example, potential value, and implementation/impact potential in FY 2017
- First two dimensions October 22, second two dimensions following.
  - Excise tax is mitigated with Plan Design Changes
  - Excise tax is not mitigated with Premium Cost-Sharing Changes
- Changes from different dimensions can be considered for integrated implementation
  - For example, some Plan Design and Premium cost-sharing options can be implemented together, others are mutually exclusive

Options to Review - Execution

- Possible action items to be discussed by the Task Force can be “bucketed” into three responsible parties for moving the item forward

Financial Detail for FY 2017

- Focus of discussion today is on the Active and Non Medicare Retiree plan
- Medicare Primary Retiree Options to be discussed during retiree-specific dimension in meeting on November 5th
- Details of the projected plan cost of $853M in 2017 are:
  - $590.2 Active, $120.5M Non Medicare Retiree, which totals to $710.7M
  - $142.0M Medicare Primary Retiree
- 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)

Importance of Actuarial Value in Discussion of Plan Design Changes

- The current plans have actuarial values of:
  - PPO and HMO: 90 to 91% (platinum)
  - CDH and FSB: 86 to 87% (golde)
  - State Share is approximately 80% Actuarial Value
  - For purposes of discussing GHIP plan design changes, reducing the overall actuarial value of the plans, excluding Medicare Primary has an estimated value/savings as follows:
    - 5% = $35.5M
    - 10% = $71.0M
    - 15% = $106.6M

Options to Review - Redesign plans/ Plan Design

- Plan Design 1 - Two Option CDH plans – Only plans offered
  - High and Low Option
    - High Option current HRA-style CHDP (87% actuarial value (AV))
    - Low Option is HSA-style CDHP (80% actuarial value)
- Plan Design 2 - Two Option “gated” plan design -- Only plans offered
  - High and Low Option – recommend CDH Plans
  - High Option only available if key health management / biometric tasks performed (the “gate”)
- Plan Design 3 - Managed Care Plans – open-ended HMOs – Only plans offered
  - HMO platform, like current HMO, various cost-sharing to achieve differing AV
  - PCP required to focus on care coordination and pay for value
- Plan Design 4 - Trend Mitigation of current plans –
  - HMO, PPO = 90% AV; CDHP, FSB = 87% AV
  - Increase the cost-sharing to adjust actuarial value
- Plan Design 5 - Active Exchange (private) – group basis
  - Use private exchange with group programs, offer silver (70% AV), gold (80% AV), platinum (90% AV) plan
  - Portfolio of plans is determined by plan sponsor, from offering of available plans constructed by the Active Exchange

Options to Review - Redesign Plans / Plan Design - 1

- Two Option CDH plans – Sample plan designs in Delaware context
  - High Option: Current CDHP – $1,500 / $3,000 deductible, with $1,250 / $2,500 Health Reimbursement Account funding, $ 90%/10% coinsurance (87% AV)
  - Low Option: new Low Option CDHP – $2,000/$4,000 deductible with $1,000 / $2,000 Health Savings Account (HSA) Funding by State, 80/20% coinsurance (80% AV). HSA-compliant HDHP, implies compliant drug benefit (prescription drugs subject to the deductible, with compliant Out-of-Pocket Maximum)
  - Member to pay the difference between the low and the high option
- HSA Compliant HDHP plans have several requirements (2015 values)
  - Minimum Deductibles: $1,300/$2,600, increase slightly every year
  - Maximum Out of Pocket values: $6,450/$12,900 (different than ACA limits)
  - Prescription drugs subject to **integrated** deductibles and OOP values
    - Full cost of drugs must be paid out of pocket in deductible phase
- HSA funding limits
  - $3,350/$6,650 in general
  - “catch up” contributions if over 55 of $1000 per person
  - HSA can be employer or employee funding
- Why It Works: CDHP supported with transparency tools that allow participants to become consumers of health care

Options to Review - Redesign Plans / Plan Design - 1

- Value of Impact determined by Premium Sharing Arrangement
  - 5% plan cost decrease to be achieved, need Low Option plan to have contribution of 5%
  - 10% plan cost decrease to be achieved, need Low Option plan to have contribution of 10%
- A 10% savings example: a two plan offering with monthly rates of $800 (low option – 80% actuarial value) and $870 a month (high option – 87% actuarial value)
  - State Share of 70% actuarial value would imply a State Share of $700 per month
  - Employee contributions would be $100 per month (low option), and $170 per month (high option)
  - Equates to $71.0M for FY 2017
- Implementation and Impact in FY 2017:
  - Possible to implement by July 2016 with enabling legislation early in 2016
  - PBM will need to be able to support the HSA-compliant plan

Options to Review - Redesign Plans / Plan Design - 2

- Two Option “gated” plan design
  - High and Low Option
  - High Option only available if key health management / biometric tasks performed (the “gate”)
- Two Option CDH plans
  - High and Low Option
  - High Option: lower deductible, 10-15% coinsurance
  - Low Option: greater deductible, 20-30% coinsurance
  - Marginally greater contribution (premium share) rate for High Option plan
- Why It Works: Gates identify and risk-mitigate trend pressure
- Gate(s) to receive access to High Option
  - Biometric screening or detailed Health Assessment
  - Participation in risk management program or wellness program depending on outcome of assessments
  - Specific, personalized goals to get and stay healthy
  - Could dovetail onto plan design 1 – a next phase

Options to Review - Redesign Plans / Plan Design - 2

- Two Option CDH plans – Sample plan designs in Delaware context
  - High Option: Current CDHP – $1,500 / $3,000 Deductible with $1,250 / $2,500 HRA funding by State, 90%/10% coinsurance (87% AV)
  - Low Option: new Low Option CDHP – $2,000/$4,000 deductible with $1,000 / $2,000 Health Savings Account (HSA) Funding by State, 80/20% coinsurance (80% AV). HSA-compliant HDHP, implies compliant drug benefit (prescription drugs subject to the deductible, with compliant Out-of-Pocket Maximum)
- Gate(s) to receive access to High Option
  - Biometric screening and/or detailed Health Assessment
  - Participation in risk management program or wellness program depending on outcome of assessments with specific, personalized goals to get and stay healthy
  - Significantly more intensive risk management techniques in High Option plan
- Value of Impact: 5% to 15% depending on contribution structure, level of care management intensity ($35.5M to $106.6M)
- Implementation and Impact in FY 2017:
  - Requires enabling legislation
  - Identification and implementation of more intensive risk management techniques for Delaware-specific population may take more than 3-6 months
  - Implementation lead time makes a FY 2017 effective date challenging

Options to Review - Redesign Plans / Plan Design - 3

- Managed Care Plans – open-ended HMOs. Specifications:
  - HMO platform, like current HMO, with various cost-sharing changes to achieve differing AVs between the plans
  - PCP is required and very focused on care management and pay for value (P4V)
  - Modest Out-of-Network benefit, consistent with the CMS definition of open-ended HMO (typically formulated to assure 90+% in-network utilization)
- High & Low Option - Sample plan designs in Delaware context
  - High Option: Current GHIP offering with 90% AV, add modest Out-of-Network benefit
  - Low Option: 80-85% AV offering, modest Out-of-Network benefit
  - Sample Plan Design for Low Option Plan at 85% AV:
    - $500 deductible
    - $200 copay per day on hospital stay – with maximum
    - Greater Physician and Emergency Room copays
- Why it Works: significant P4V and “managed care effect” should risk-mitigate trend pressure – expect considerable participation by participants as well

Options to Review - Redesign Plans / Plan Design - 3

- Value of Impact determined by Premium Sharing Arrangement
  - As mentioned previously, State Share is currently approximately 80% actuarial value
  - 5% to 15% depending on contribution structure, level of care management intensity (35.5M to 106.6M)
- A 10% savings example: a two plan offering with monthly rates of $800 (low option – 80% actuarial value) and $900 a month (high option – 90% actuarial value)
  - State Share of 70% actuarial value would imply a State Share of $700 per month
  - Employee contributions would be $100 per month (low option), and $200 per month (high option)
  - Equates to $71.0M
- Implementation and Impact in FY 2017:
  - Appears to require enabling legislation
  - Identification and implementation P4V primary care physicians may take more than 3-6 months
  - Unlikely there is enough runway to implement with impact in FY 2017 – Plan designs and structure possible, provider execution and risk-taking primary concern
  - Capability and readiness of providers for P4V is outside the influence of SEBC or legislators

Options to Review - Redesign Plans / Plan Design - 4

- Trend Mitigation of current plans (HMO,PPO = 90% AV; CDHP, FSB = 87% AV)
  - Continue all current benefit plans
  - Change plan designs by increasing the cost-sharing – notably change/add deductible or other significant cost-sharing additions.
- Currently PPO and HMO have no deductible on medical or drugs, and mostly copay-style cost sharing with an Out-of-Pocket Maximum mandated by ACA
- CDHP and FSB have the following:
  - CDHP has a “gap” of $250 between $1,250 and $1,500 (single) -- twice these for coverage tiers with dependents
  - FSB has a $500 deductible (single) – twice this for coverage tiers with dependents
- Easiest to contemplate and most meaningful change is implementation of deductible on plans
- All plans assumed to change in a similar fashion
- Value of Impact:
  - 5% plan cost decrease to be achieved ($35.5 M)
  - Increase/implementation of approximately +$500 deductible
- Implementation and Impact in FY 2017:
  - Could be implemented with approval of SEBC
  - Would have immediate financial impact in FY 2017

Options to Review - Redesign Plans / Plan Design - 5

- Active Exchange: 2-4 vendors offer identical benefits designs set by the Exchange Vendor to participants, with a fixed dollar subsidy per coverage tier
  - Applicable to active employees and family members
  - Can be insured or self-insured, depending on the exchange vendor
  - Typically offer Silver (70% AV), Gold (80% AV) and Platinum (90% AV) as directed by the Exchange vendor – *Exchange Vendor has total control of plan design*
  - Not unlike what is offered today with CDHP and HMO options with Highmark & Aetna
  - Private exchange vendors will establish plan design and network coverage with Highmark, Aetna and possibly other carriers
  - Bronze, Silver, and sometimes Gold Plans are CDHP, otherwise traditional PPO or HMO/EPO plan designs
- Why It Works: Direct competition between Insurers creates incentives for them to reduce costs, provide most efficient plan inner-workings; administrative exchange platform provides shopping tools and transparency, and administrative infrastructure; plan sponsor relieved of plan design change burden year over year
- Observations on Delaware Marketplace and current GHIP
  - Delaware Marketplace dominated by two insurers – Highmark and Aetna
  - Current GHIP has capacity to duplicate administrative infrastructure and shopping tools

Options to Review - Redesign Plans / Plan Design - 5

- Value of Impact determined by Premium Sharing Arrangement, that is level of State Share subsidy provided to the participants
  - Likely a requirement to offer a Silver plan, hence:
    - 10% plan cost decrease to be achieved, offer Silver for free, others at full incremental cost
    - 15% plan cost decrease to be achieved, offer Silver at contribution of 5%, others at full incremental cost
  - A 10% savings example: silver plan with rate of $700 per month (70% actuarial value, gold plan with rate of $800 (80% actuarial value) and $900 a month (high option – 90% actuarial value)
    - State Share of 70% actuarial value would imply a State Share of $700 per month
    - Employee contributions would be $0 for Silver, $100 per month (Gold), and $200 per month (Platinum)
    - 10% savings equates to $71M
- Significant amount of planning support required – option not viable for FY 2017:
  - Appears to require enabling legislation
  - Would require procurement of Exchange vendor, then setup of Exchange specifics
  - Length of Implementation lead time makes a FY 2017 effective date impractical

Plan Design 5 - Sample Exchange Plan Designs

	Sample Silver Plan**	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)	70%	80%	**86.10%**	**87.00%**	90%	**90.40%**	**90.60%**
Deductible (Single/Family)	$3000/$6000	$750/$1,500	$500/$1,000	$1,500/$3,000 +1,250/2,500 HRA	None	$0/$0	$0/$0
Out-of-Pocket Maximum (Single/Family)	$5,000/ $10,000	$3,000/ $6,000	$2,000/$4,000	$4,500/$9,000	$4,500/ $9,000	$4,500/$9,000	$4,500/$9,000
In-Network Coinsurance	25%	20%	10% Coinsurance	10% Coinsurance	10%	0%	0%
Primary Care	$30	$35	10% Coinsurance	10% Coinsurance	2000%	$20	$15
Specialist	$50	$50	10% Coinsurance	10% Coinsurance	4000%	$30	$25
Inpatient Facility	25% coinsurance	20% coinsurance	Deductible & coinsurance	Deductible & coinsurance	10% coinsurance	$100/day up to 2 copays	$100/day up to 2 copays
Emergency Room	$150	$250	Deductible & coinsurance	Deductible & coinsurance	$150	$150	$150
Out-of-Network Coinsurance	No benefit	No benefit	30%	30%	30%	20%	No benefit
Prescription Drug Benefit							
30-day Retail	$15/25%	$8/$35/$50	$8/$28/$50	$8/$28/$50	$5/$20/$50	$8/$28/$50	$8/$28/$50
90-day Retail & Mail	$30/25%	$16/$700/$100	$16/$56/$100	$16/$56/$100	$10/$50/$125	$16/$56/$100	$16/$56/$100
Out-of-Pocket Maximum (Single/Family)	Integrated	integrated	$2,100/$4,200	$2,100/$4,200	$2,100/$4,200	$2,100/$4,200	$2,100/$4,200

*Actuarial Value based on in-network benefits only, out- of network feature increases value slightly
**Sample plan designs – Silver and Gold from 2015 Delaware Marketplace, Platinum design crafted by Aon

Options to Review – Premium / Cost-Sharing Structure

- Increase contribution percentages –
  - Currently 4% for FSB, 5% for CDHP, 6.5% for HMOs, and 13.25% for Comp PPO
  - If current designs are maintained, these contribution structures could be consistently changed
  - Alternatively, for new plan designs, Institute Buy-Up structure
    - Prior to HB 81 in 2012, the GHIP was a buy-up structure linked to FSB
    - Institute a percentage of lowest cost option, e.g., 10% for FSB with a buy-up to richer benefits
- Implement salary-based contributions
- Subsidize dependents different than employees
- Eliminate “Double State Share”
- Implement surcharges
  - Tobacco
  - Wellness Assessment / Health Screenings / Health Risk Assessment
  - Working Spouse

Premium / Cost-Sharing Structure – Increase Contribution Percentages

- Increase Target contribution percentage - currently 4% for FSB, 5% for CDHP, 6.5% for HMOs, and 13.25% for Comp PPO
  - Many external plan design options contemplate a “buy-up” of richer costs (buy-up means at least full actuarial value of difference is charged in contribution structure)
  - Current percentages formulated to simulate a buy-up, but also reflective of actual plan cost
  - Average actuarial value of GHIP is about 90%, with participant contribution rate of about 10% of cost. Simplistically, State Share is about 80% actuarial value
  - **Would need enabling legislation**
- Increasing the target contribution rate implies decreasing the State Share Actuarial Value
  - >5% savings implies an average / target State Share actuarial value of 75%
  - >10% Savings implies an average / target State actuarial value of 70%
  - A 10% savings example:
    - FSB at 14%, CDH at 15%, HMO at 16.5%, PPO at 23.25%
    - Maintains relative cost differences between plans, absolute dollars increase
    - 10% savings equates to $71M

Premium / Cost-Sharing Structure – Salary-Based Contributions

- Implement Salary-based Contributions for Active Employees
  - Possible to be done for retirees premised on pension amount
  - Retirees not as typical as actives
- Suggested Implementation:
  - Create stratification “buckets” of salary bands
  - Implement a different contribution structure (dollar amount or percentage) per salary band
  - Can be phased in over time for change management purposes.
  - Can be implemented in virtually any multiple-option environment
  - **Would need enabling legislation**
- Why it works
  - Can result in contributions being a stable percentage of pay, resulting in “fair” contributions
- Sample Contributions Schedule on following page, leveraging existing contribution rates
  - Results in contribution rate average of about 17% , compared to about 10% today
  - Assumes no significant migration between plans

Salary-Based Contribution – Sample Schedule

- Implement Salary-based Contributions for Active Employees - Sample Schedule
- Shown Percentages are percentages of premium rates paid through payroll deduction
  - Assumes same percentage for each dependent tier of premium

	Sample Contribution Schedule				Demographics		
Salary Strata	FSB	CDHP	HMO	PPO	Participant Count	Participant Avg Sal	Combined contributions as % of pay
1. < $30,000	4.0%	5.0%	6.5%	13.3%	4,169	$25,324	5.8%
2. $30,000-$39,999	6.5%	7.5%	9.0%	15.7%	7,076	$34,935	5.6%
3. $40,000-$49,999	9.0%	10.0%	11.5%	18.2%	5,688	$44,849	5.5%
4. $50,000-$59,999	11.5%	12.5%	14.0%	20.7%	4,371	$54,486	5.8%
5. $60,000-$69,999	14.0%	15.0%	16.5%	23.3%	3,207	$64,827	6.0%
6. $70,000-$79,999	16.5%	17.5%	19.0%	25.7%	2,485	$74,777	5.8%
7. $80,000-$89,999	19.0%	20.0%	21.5%	28.3%	1,600	$84,334	5.8%
8. $90,000-$99,999	21.5%	22.5%	24.0%	30.8%	552	$94,126	5.8%
9. >=$100,000	24.0%	25.0%	26.5%	33.3%	1,161	$121,922	5.1%
Grand Total	**8.6%**	**10.9%**	**12.5%**	**21.0%**	30,309	$51,740	**5.7%**

This table results in approximately 70% more contributions than the current schedule, for the 30,000+ participants shown above. Based on the 30,000 Participants shown above, $36M savings / greater contributions.

Premium / Cost-Sharing Structure – Dependent Subsidies

- Subsidizing dependents different than employees
  - Currently the GHIP operates on a four tier structure
  - Each tier maintains the same contribution percentage including those covering dependents
  - Option to create scenarios with higher percentage contribution for tiers covering spouses and/or dependents
- Suggested Implementation:
  - Create target percentage amount to subsidize,
  - Can be phased in over time for change management purposes
  - Can be implemented in virtually any multiple-option environment
  - **Would need enabling legislation**
- Why it works
  - Emerging practice of reducing the additional plan sponsor funding of covering dependents, which doesn't exist in other compensation-based systems such as pay or retirement income
- Sample Contributions Schedule on following page, leveraging existing contribution rates

Premium / Cost-Sharing Structure – Dependent Subsidies

- Subsidizing dependents differently than employees - Sample Schedule

Scenario for FY 2016 Rates

	Rate	Current % State Share	Employee	Revised % State Share	Revised Employee	Change
FSB						
Employee	$645.74	$619.88	$25.86	$619.88	$25.86	$0.00
Employee & Spouse	$1,336.02	$1,282.60	$53.42	$1,213.53	$122.49	$69.07
Employee & Child(ren)	$981.60	$942.34	$39.26	$908.72	$72.88	$33.62
Family	$1,670.08	$1,603.30	$66.78	$1,500.83	$169.25	$102.47
CDH						
Employee	$668.32	$634.92	$33.40	$634.92	$33.40	$0.00
Employee & Spouse	$1,385.74	$1,316.48	$69.26	$1,244.74	$141.00	$71.74
Employee & Child(ren)	$1,021.10	$970.06	$51.04	$934.79	$86.31	$35.27
Family	$1,760.46	$1,672.44	$88.02	$1,563.24	$197.22	$109.20
HMO						
Employee	$674.68	$630.86	$43.82	$630.86	$43.82	$0.00
Employee & Spouse	$1,425.86	$1,333.18	$92.68	$1,258.10	$167.76	$75.08
Employee & Child(ren)	$1,032.32	$965.22	$67.10	$929.49	$102.83	$35.73
Family	$1,778.98	$1,663.34	$115.64	$1,552.95	$226.03	$110.39
PPO						
Employee	$737.22	$639.54	$97.68	$639.54	$97.68	$0.00
Employee & Spouse	$1,529.78	$1,327.10	$202.68	$1,247.84	$281.94	$79.26
Employee & Child(ren)	$1,136.16	$985.64	$150.52	$945.73	$190.43	$39.91
Family	$1,912.44	$1,659.06	$253.38	$1,541.53	$370.91	$117.53

- Revised % State Share reflects a 10% decrease in State Share, e.g., 95% decreases to 85%, for dependent costs
- Savings on these 37,000 active participants equates to $22.7M, or about 40% more contributions.

Premium / Cost-Sharing Structure – Double State Share

- Double State Share (DSS) exists when a husband and wife were married, both worked for the State (or were retired from the State), and were enrolled in the GHIP prior to January 1, 2012
  - HB 81 implemented a modest contribution requirement of $25 for each contract chosen by the DSS eligible employee or pensioner effective July 1, 2012 (previously there was no contribution if one contract was chosen)
  - State pays the difference between the $25 employee contribution and the actual total employee contribution for the plan and tier chosen
- Eliminating DSS does not change the amount of funds into the GHIP, but reduces the cost that the State contributes to the GHIP for the DSS eligible employees
- Recent estimate of State funding for this feature is approximately $3.5M General Funds
- Implementation:
  - DSS would be eliminated and grandfathered Double State Share eligible employees and pensioners would pay the full amount for the group health plan and tier in which they were enrolled.
  - **Would need enabling legislation**

Premium / Cost-Sharing Structure - Surcharges

- Implement Surcharges
  - Tobacco
  - Wellness Assessment / Health Screenings / Health Risk Assessment
  - Working Spouse
- Tobacco Surcharge
  - How it works: certification of being tobacco free (employee), may require testing
  - If not tobacco free, then a surcharge is added to the contribution rate
  - Typically a fixed dollar amount per pay period, e.g. $100 per month
- Wellness Assessment / Health Screenings / Health Risk Assessment
  - Similar to past few years where there was an incentive to participate
  - Surcharge is a “reverse” process, execute or pay greater contributions
  - Surcharge could be greater than previous incentives, up to $100 per month
    - Could be stratified depending on health status
    - Deeper dive necessary for details
- Working Spouse
  - Current program requires working spouses to take “their” coverage if “affordable”
    - 50% or less of employee-only coverage
  - Could be refined if desired

Next Meeting

- Discuss additional two areas for potential cost savings and efficiencies:
  - Enhance Population Health / Health Plan Management
  - Special Opportunities for Retirees