State Employees Health Plan Task Force

Finding Cost Savings and Efficiencies

October 22, 2015 and November 5, 2015

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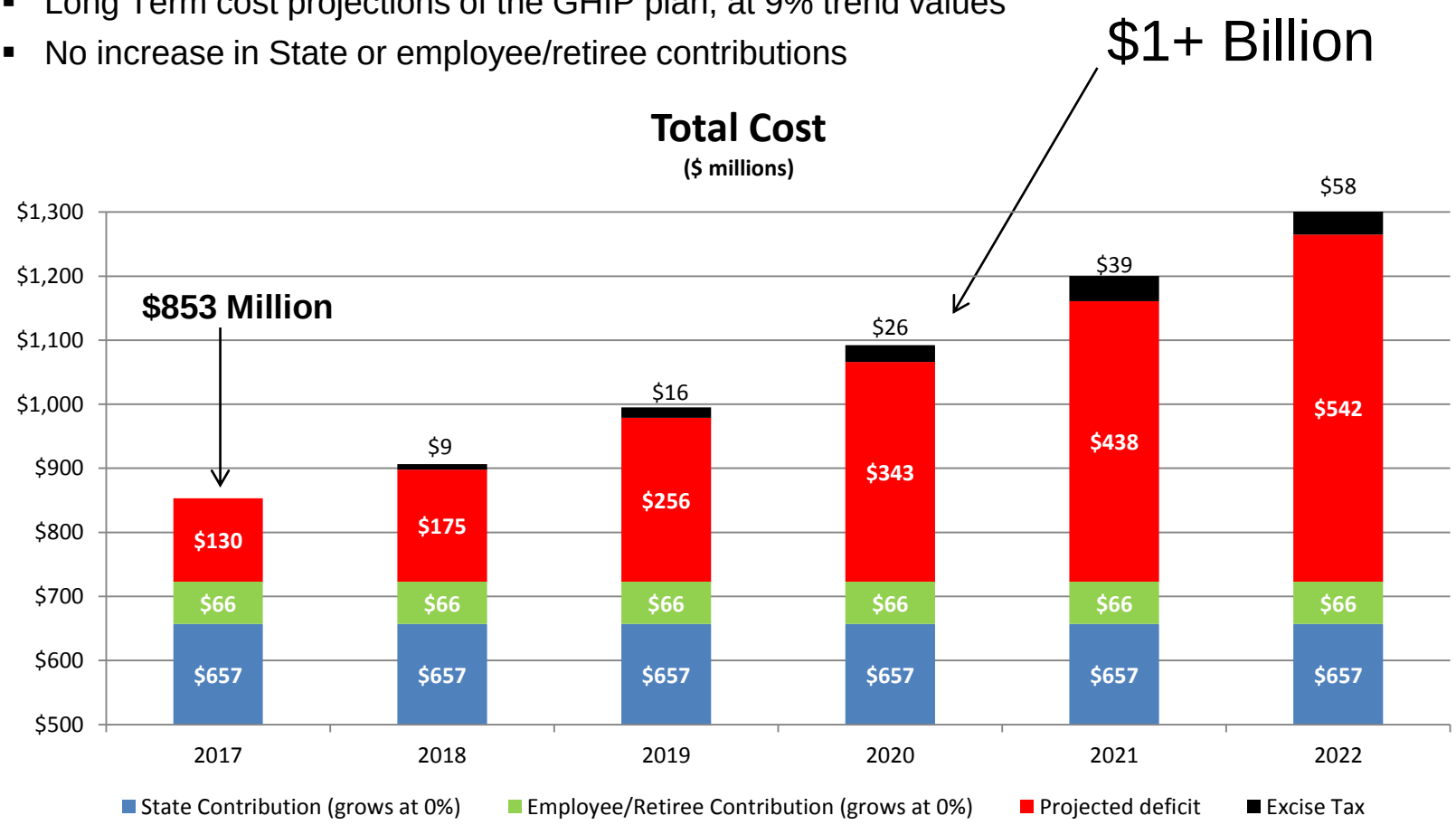
Consulting | Health & Benefits

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



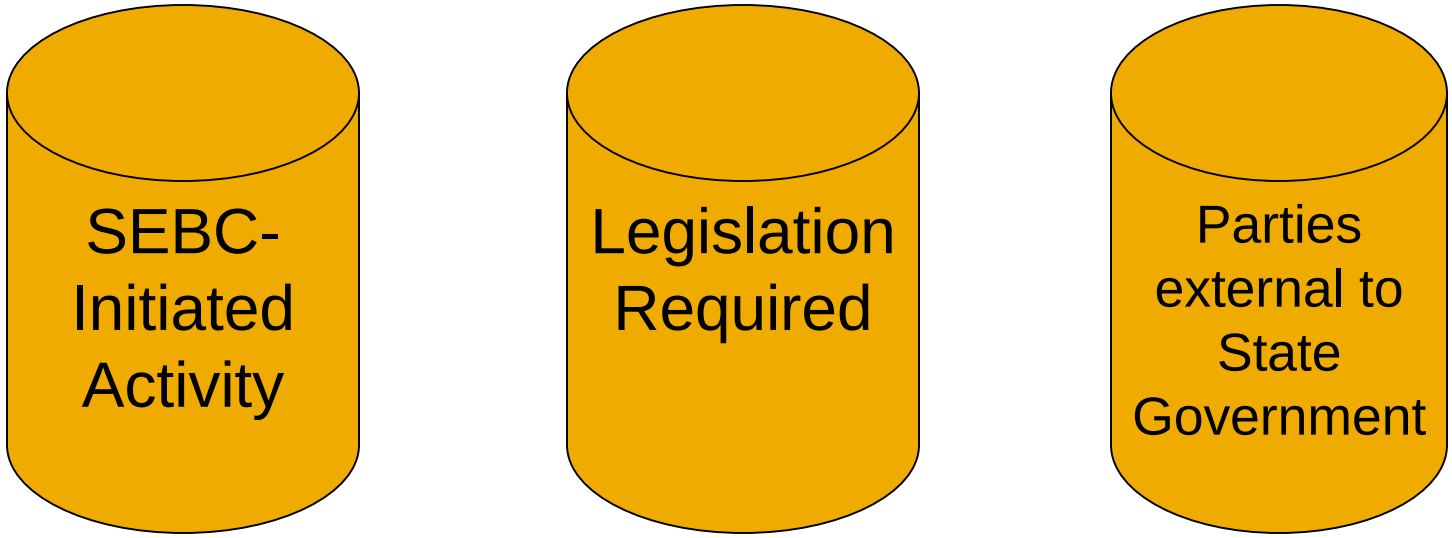
Data from various Segal documents, long term projections at 9% trend.

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 dimension covered on October 22, remaining dimensions following.
  - Excise tax is mitigated with Plan Design Changes (or changes that reduce plan cost)
  - 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



Active Employee Plan: Design and Contributions

Financial Detail for FY 2017: Active Employee Plan

- Focus of discussion October 22 is on the Active and Non Medicare Retiree plan
- 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%
  - CDH and FSB: 86 to 87%
  - 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 retirees 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., up to $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

Enhance Population Health / Health Plan Management: Active Employee Plans

Enhance Population Health: Health Plan Management

- The State of Delaware's health risk scores (both employees and members) increased 20% between 2013 and 2014 indicating an increasingly higher than average illness burden in the State of Delaware population
  - The Statewide Benefits population has a higher prevalence of every chronic condition compared to the entire state average
- Plan design and out of pocket costs can be a barrier to members seeking necessary health services for chronic conditions
- Reimbursement for services and programs doesn't lead to member compliance and better health outcomes/lower costs
- Higher costs of service doesn't mean better quality and/or results
- Program success has repeatedly been shown as a function of member accountability and members having "skin in the game"
- Members need supporting tools and resources to assist them with research and decision making
- Programs can be implemented on a standalone basis or in combination with other programs
- Programs selected target areas of highest current cost and potential for highest future cost savings
- All programs need to be communicated and understood by members during and after program implementation
- Member participation is driven in large part by financial steerage incentives
- Program management and implementation may have additional administrative fees

Innovation among Public Employers: Population Health/Health Plan Management

- **State of Connecticut,** introduced Health Enhancement Program in 2012:
  - Requires members to manage their health and complete certain key activities
    - Opt-outs pay higher monthly premiums
    - Opt-ins receive reduction or elimination of copays for medication to manage chronic conditions and/or visits to treat chronic conditions
  - Early results:
    - High program participation: 98% enrolled in year 1 and 99% completed requirements
    - Increase in primary care visits, decrease in specialist visits and ER visits
    - Improvements in preventive screening rates
    - Medical trend from **13% in FY 2011 to 3.8% in 2012** after one year of new program
- **California Public Employees' Retirement System (CALPERS)** implemented reference pricing for hip and knee replacements. First year results: CALPERS saved close to $3 million/enrollees $300,000
  - A threshold of $30,000 for hospital payments to designated hospitals where enrollees could get care at or below that price.
  - Enrollees opting for care at a non designated hospital were responsible for both the typical cost sharing and all allowed amounts in excess of $30,000 threshold were not subject to the out-of-pocket maximum
- The program extended to outpatient colonoscopies, cataract surgeries, and arthroscopies in 2013

Innovation among Public Employers: Population Health/Health Plan Management

- **State of Kentucky**
  - Comprehensive wellness program through Vitality and Anthem
    - Enrollees need to complete LivingWell program components – a health assessment or a biometric screening prior May 1st of each year in order to receive a higher level of benefits: (coinsurance of 15% versus 30% in the non LivingWell plans.
    - Offers a diabetes prevention program including no copayments for preventive drugs
    - Offers onsite health care through H2U with Nurse Practitioners at various locations
    - Provides health coaching for all members including smoking cessation and weight management programs
    - Allows for accumulation of points earned in the completion of activities as well as to earn savings for healthy food at Walmart
  - Year over year results: medical and rx claims down 9.2%; medical down 10.7% and rx down 3.9%

Value Based Design

- Target highest cost/risk chronic conditions and provide financial incentives/cost share reduction for members with asthma, congestive heart failure, COPD, coronary artery disease, depression, diabetes, high cholesterol, hypertension
- Financial incentives and/or reduction of cost share may apply to the following services:
  - Pharmacy and supplies
  - Diagnostic testing
  - Office visits to primary care/specialists
  - Additional preventive visits for dental cleaning and vision screening (as applicable)
- In order to quality for the program, active participation is required including:
  - Completion of a health assessment including biometric screening
  - Agreement to work with a health coach and participate in monthly or quarterly check ins that demonstrate health outcomes are improving or stabilized: e.g., A1C values, BMI, normal blood pressure range, etc.
  - Program opt in and participation for at least 90 days before eligible for benefits
- Value of Impact:
  - Varies based on targeted conditions and compliance rates
- Implementation and impact in 2017
  - Doable for July 1, 2017
  - Health assessment and biometric data is extremely helpful in identification of program participants
  - Need process for integration of data between Highmark/Aetna with ESI to ensure right members are receiving the discounts and access

Reference Based Pricing

- Implement reference based pricing for outpatient diagnostic testing: MRIs, endoscopies, CT scans and /or elective surgeries: hip replacements, knee arthroscopies, knee replacements
- How it works:
  - A payment threshold based on median payments made to free standing and hospital affiliated facilities in the state
  - Provider reimbursement capped to payment threshold and member responsibility for amounts in excess of the threshold
  - Amounts in excess of the threshold not applicable to the deductible or out of pocket maximum typically (in-network or out of network)
- Implementation
  - Need access to information which easily identifies facilities that are at or under the threshold for each test/procedure
  - Health Coaches available at both Highmark and Aetna, who can assist in the process
- Value of Impact:
  - Cost benefit analysis in process
  - Variable based on the services selected
- Implementation and Impact in FY 2017
  - Lead time is 6 months to ensure the fee schedule is built, communication and rules established for exceptions
  - Possible to be implemented in FY 2017, may not be fully ready as of July 1. Can be implemented non-coincident with plan year beginning.

Tiered Networks: Laboratory Services

- Implement a change in copays for outpatient laboratory services not rendered thought a national free-standing laboratory -- tiered network pricing for outpatient laboratory services
  - Charges for lab services vary widely
  - Lab services provided through national providers are significantly less costly than other lab facilities, e.g., inpatient hospital
- How it works:
  - Members with non-preventive lab testing completed through a national laboratory facility will continue to have current copay schedule
  - Members having non-preventive lab testing done outside of the national laboratory facility will be have charges subject to the deductible and out of pocket maximum
- Implementation
  - Members are accountable for ensuring providers send labs to Quest and LabCorp rather than hospital based labs
- Value of Impact:
  - Cost benefit analysis in progress
- Implementation and Impact in FY 2017
  - Lead time is 6 months to ensure member communication is completed
  - Possible to be implemented in FY 2017, may not be fully ready as of July 1. Can be implemented non-coincident with plan year beginning.

Facility Site Selection Review: High Tech Radiology

- Program is designed to move place of service from higher cost facilities to lower cost facilities when possible for high tech radiology
- How it Works:
  - Selection of facility occurs during the authorization process already in place with NIA
  - Provider does not select a facility during the authorization process
  - NIA works directly with member to select facility and schedule appointment
  - Clinical reasons for selection of higher cost facility considered
  - Physician is notified of confirmed facility
- Implementation
  - Various options for model are available.
- Value Impact
  - Assessment in progress
- Implementation and impact in FY 2017
  - Highmark deals with NIA on set up
  - Possible to be implemented in FY 2017, may not be fully ready as of July 1. Can be implemented non-coincident with plan year beginning.

Physical Medicine Management

- Outcomes and efficacies of physical therapy and related physical medicine treatments vary considerably and are not always provided in accordance with widely accepted standards of treatment
  - PT/OT/ST services accounted for 2 percentage points increase in the overall 3% increase in outpatient utilization trend
- How it works: 8 initial visits are approved each calendar year.
  - If the member's care is anticipated to exceed eight (8) visits in a calendar year, additional treatment requires preauthorization through a third party (Healthways.)
  - Before the ninth (9th) visit, care authorization is sought by submitting information about the patient's history, condition, response to prior treatment and treatment plan; services provided without an authorization are denied
- Implementation
  - Accountability on provider to seek authorization
- Value Impact
  - Specific impact being assessed
- Implementation and value impact in FY 2017:
  - More than adequate lead time for July 1, 2017
  - Impacts new cases started after July 1st

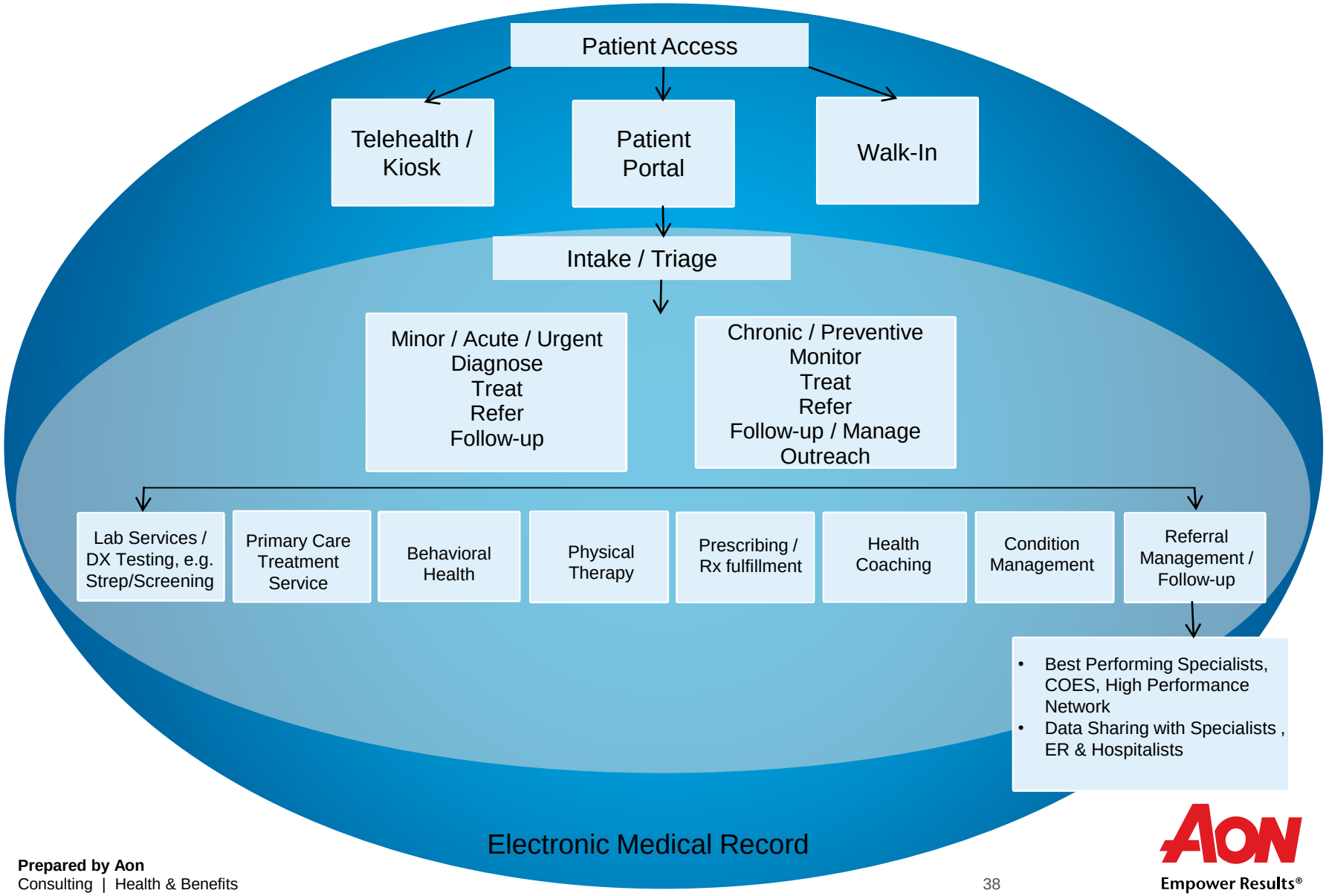
Onsite Services : Primary Care, Therapy, EAP

- Many employers have found that contracting directly with health care providers or a third party to provide onsite health services is effective in controlling costs, increasing access to primary and preventive care services and creating more highly engaged and productive employees
- The University of Delaware offers a comprehensive Patient Center Medical Home to its employees and dependents as well as to the general public. University employees are not required to use the center and there are no financial incentives to do so.
  - Additional services offered include physical and occupational therapy and mental health treatment. Other program elements include:
    - Integrated approach to health care-physical and emotional well being supported by staffing resources and electronic medical records,
    - Tele health capabilities for expert and mental health consults and satellite locations
    - Mobile services offered in one location and more contemplated for the future
    - Care coordination including follow-up/home outreach
    - Nutrition counseling and diabetes education
    - Counseling for stress, substance abuse and other mental health issues
    - Concierge services– assisting with use of tools, resources, appointment making, advocacy
- There is an opportunity to explore promotion and expansion of the service offerings at the University of Delaware with the State of Delaware's health plan

Onsite Services : Primary Care, Therapy, EAP

- Implementation
  - Current staffing at University of Delaware center can handle additional capacity; additional staff can be added if necessary
  - Opportunities to pilot program with select groups within the State
  - Mobile unit will be available
- Impact Value
  - To be determined based on cost differential, use and steerage incentive (if applicable)
- Implementation and Value Impact in 2017
  - University of Delaware participates with current health carriers and is an established PCMH
  - Lead time for marketing campaign
  - Can be implemented within plan design/contribution parameters

Optimal Onsite Health Care Delivery Model Framework



Tobacco Surcharge -Tobacco-Free Reward

- Incent employees, Non Medicare Retirees and family members to quit tobacco use and rewards healthy behavior in providing lower health insurance premium rates for non-tobacco users.
- Background Information on Smoking Cessation Programs
  - The State of Delaware has supported smoking cessation for its covered members since 2012 including adoption of a tobacco-free workplace 1/1/13 and a $0 co-pay for tobacco cessation prescription medications as of 7/1/13.
  - In spite of these efforts smoking rates among members are largely unreduced
- How it works:
  - Use of tobacco among any member over age 18 within the past 6 months results in a premium surcharge. Tobacco use is defined as the use of any tobacco product, including cigarettes, cigars, chewing tobacco, snuff, e-cigarettes and pipe tobacco.
  - Members self report smoking status
- Implementation
  - Would begin in 2016 for a July 1st effective date
- Value Impact
  - Immediate savings due to increased contributions from surcharge
  - Longer term savings as a result of health improvements and reduced absenteeism

Centers of Excellence

- Highmark and Aetna have identified certain facilities as centers of distinction based on quality/outcomes and cost for elective hip, knee and spine surgery.
- How it Works:
  - Members would be required to use centers of distinction for these surgeries in order to receive reimbursement
  - Members could be provided financial incentives to use centers of distinction
- Value Impact
  - Estimated projected savings as great as $1.4M (or 0.28% overall savings) for hip and knee surgeries
  - Estimated projected savings as great as $346K (or 0.07% overall savings) for spine surgeries
- Implementation for FY 2017 is possible

Rewarding Wellness Participation

- Providing incentives to perform certain activities doesn't guarantee optimal participation or health behaviors/health outcomes
- How it works: A surcharge can be imposed for those that aren't participating in certain activities and/or health status
  - Surcharge could be greater than previous incentives, (marketplace up to $100 per month) for failure to take the health assessment and/or biometric screening
  - Surcharge can also be stratified based on current health status
- Value Impact based on surcharge and specific requirements
- Implementation for FY 2017 is possible

Retiree Options

Financial Detail for FY 2017

- Focus of discussion today is on the Non Medicare Retiree plan and Medicare Retiree plan
- Details of the projected plan cost of $853M in FY 2017 include:
  - $120.5M Non Medicare Retiree,
  - $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
- The current plans have actuarial values of:
  - PPO and HMO: 90 to 91%
  - CDH and FSB: 86 to 87%
  - Medicare Plan has actuarial value of 100% for medical, while having the same drug plan as the NM retirees (83% AV)
  - Note that Medicare A&B provide about 85% of that actuarial value for medical, and the GHIP pays second to Medicare medical
  - More difficult to measure the allocation of actuarial value for Medicare of the prescription drug plan – the drug plan does not pay second to Medicare, but receives direct Medicare payments (known as EGWP)
- For Non Medicare Retiree, they receive the same rate as the actives, and have a loss ratio (expenses / premium) of 160% for FY 2015

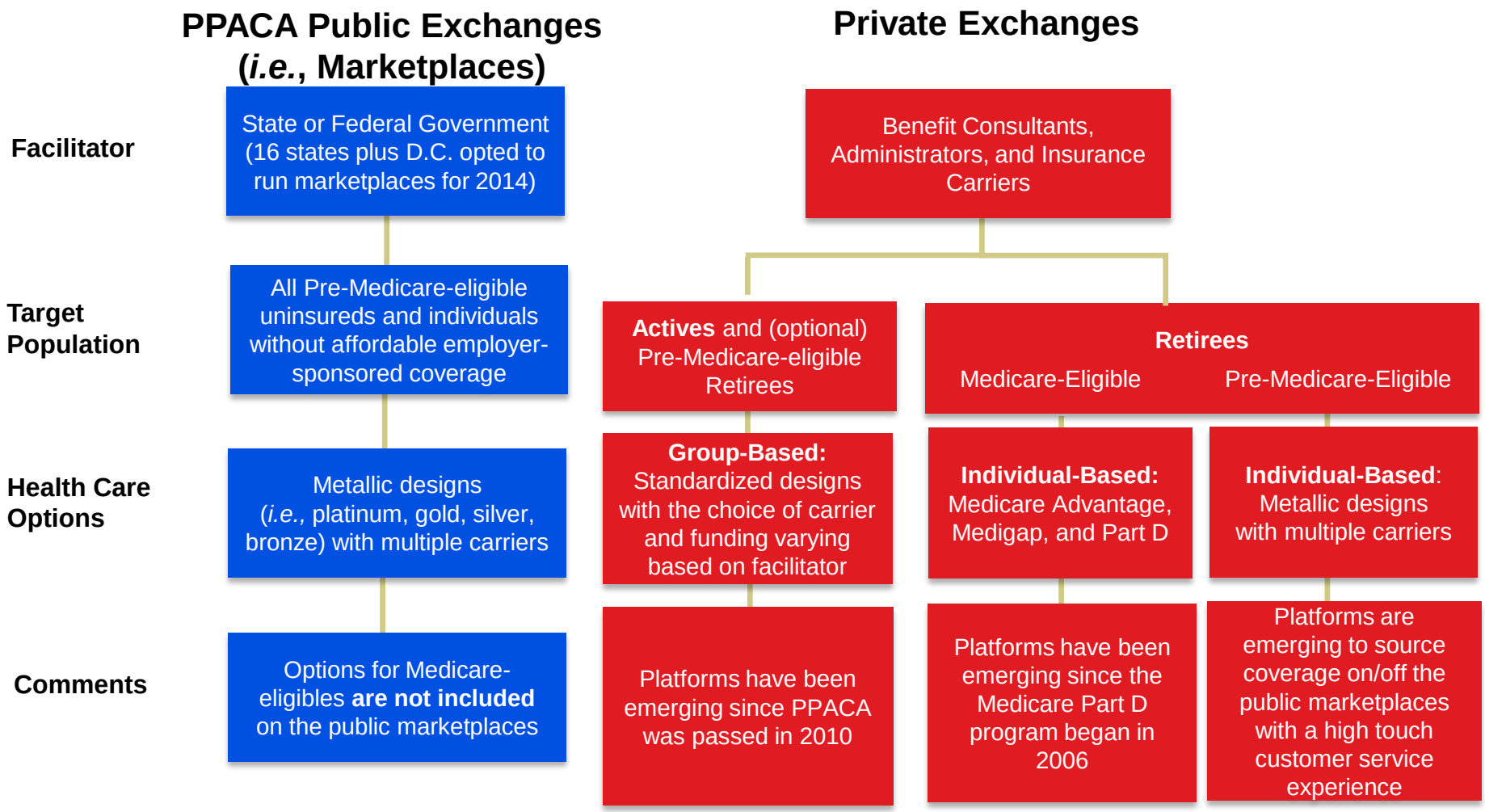
Options to Review - Retirees

- Plan Design Changes - Separated Non Medicare Retiree plan
  - Self-supporting premium rates
  - Participant contributions based on self-supporting premium rates
  - Can follow active plan design, or use same ideas
  - HSA-compliant plans should have considerable value to Non Medicare retirees
- Non Medicare Retiree Exchange
  - Retiree exchanges are focused on Individual-market purchasing
  - Can permanently eliminate Excise Tax on Non Medicare Retirees
- Medicare Retiree Exchange
  - Retiree exchanges are focused on Individual-market purchasing
  - Mature, efficient marketplace for Medicare products
- Medicare Advantage Plan – National in nature, PPO plan design
  - EGWP concept for Medical Plan
  - Can result in 5-25% savings, in addition to plan design savings
- Plan Design Changes – Medicare Primary Medical Plan
  - Current Actuarial Value is 100% medical
  - Suggest 85% to 90% AV plan, noting Medicare A&B provide about 85%
  - Could be similar to high option offered to Non Medicare Retirees, or two options

Options to Review – Non Medicare Retiree HSA plans

- Two Option CDH plans – Sample plan designs in Delaware context – same as active discussion – at least one HSA compliant plan
- Value of Impact determined by Premium Sharing Arrangement
  - Self-supporting rates likely to be +40% to +60% greater than combined rates
  - Expect some "mitigation" of rate increase for corresponding self-supporting active rates (6 times more actives than Non Medicare retirees)
- Expanding the "10% savings example": a two plan offering (low option – 80% actuarial value) and (high option – 87% actuarial value)
  - Actual Non Medicare retiree rates likely to be $1280 versus $800 and $1400 versus $870 (at 160%)
  - State Share likely to be $1100 at "70%", resulting in contributions of $180 per month (low option) and $300 per month (high option) – compared to $100 and $170 in "combined" example
- Implementation and Impact in FY 2017
  - Possible to implement in 2017 with enabling legislation
  - PBM will need to be able to support the HSA-compliant plan
  - HSA funding by the State will need to be reviewing for Excise Tax risk in 2018 and later
  - May want to move Non Medicare Retiree Plan to Calendar year, to synchronize to Excise Tax calculation

General Overview of Exchanges: Public vs. Private/Active vs. Retiree



Options to Review – Non Medicare Retiree Exchange

- Retiree Exchange mechanics facilitate purchasing Individual-Market products with a plan sponsor subsidy (State Share), administration, infrastructure, purchasing tools and concierge service
- State Share would be converted to a stand-alone Retiree Reimbursement Account (RRA), which is primarily used to pay insurance premiums, but can be used for cost sharing such as deductibles and copays
- Attractive features of Non Medicare Retiree Exchange:
  - If RRA is below Excise Tax threshold, Excise Tax is permanently eliminated
  - If Retirees have income less than 400% of Federal Poverty Limit, they will qualify for federal assistance, which may be more attractive than RRA (note: for Non Medicare Retirees, using both RRA and Federal assistance is not allowed)
  - Wide variety of plan designs to choose from on Individual Market, many are HSA compatible
- Implementation and Impact in FY 2017
  - Significant amount of planning support required – option not viable for FY 2017
  - Requires enabling legislation
  - Would require procurement of Exchange vendor, then setup of Exchange specifics
  - May be viable for a January 1, 2018 implementation, works best on Calendar Year

Options to Review – Non Medicare Retiree Exchange

- 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
- Special Excise Tax observations – Non Medicare Retirees
  - Excise Tax thresholds are only 10-20% greater for Non Medicare Retirees than actives, while costs are 40-60% greater
  - Individual-market plans are not subject to Excise Tax, as it is imposed on Employer Plans
  - Instead, the State Share becomes the “plan” to compare to the Excise Tax threshold
  - Keeping the State Share below the Excise Tax threshold permanently mitigates Excise Tax on this group
- Observations on Delaware Marketplace and current GHIP
  - Delaware Individual Marketplace dominated by two insurers – Highmark and Aetna
  - Retirees would be able to duplicate vendor options currently in place in individual marketplace
  - Many Individual Market plans are HSA compliant
  - Savings driven by amount of Retiree Reimbursement Account

Options to Review – Medicare Retiree Exchange

- Retiree Exchange mechanics facilitate purchasing Individual-Market products with a plan sponsor subsidy (State Share), administration, infrastructure, purchasing tools and concierge service
- State Share would be converted to a stand-alone Retiree Reimbursement Account (RRA), which is primarily used to pay insurance premiums, but can be used for cost sharing such as deductibles and copays
- Attractive features of Medicare Retiree Exchange:
  - Wide variety of plan designs to choose from on Individual Market
  - Attractive low-cost Medicare Advantage plans (as low as $0 per month)
  - Improvement to Standard Medicare Part D plan (required by Affordable Care Act) results in similar drug plan (to current design) in 2020
  - Ability to replicate current medical design with Medicare Supplement Plan F
- Implementation and Impact in FY 2017
  - Significant amount of planning support required – option not viable for FY 2017
  - Requires enabling legislation
  - Would require procurement of Exchange vendor, then setup of Exchange specifics
  - May be viable for a January 1, 2018 implementation, works best on Calendar Year (Medicare Primary retirees have Calendar Year plan currently)
  - No real excise tax issues for Medicare Primary retirees

Options to Review – Medicare Retiree Exchange

- 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; attractive Medicare Advantage plans; plan sponsor relieved of plan design change burden year over year
- Medicare Advantage Observations – Medicare Primary Retirees
  - Affordable Care Act revamped (again) payment systems to Medicare Advantage Plans
  - Extra revenue for high quality plans, driving quality in the marketplace
  - Zero premium plans still abundant nationally, and including Delaware
  - More than 30% of Medicare Participants in Medicare Advantage, and on average the premiums for Medicare Advantage plans are lower in 2015 than they were in 2010 prior to the passages of the ACA
- Observations on Delaware Marketplace and current GHIP
  - Delaware GHIP does not offer choice to Medicare Primary retirees, but does offer significant benefits at zero to little (5%) premium share to those with 20 or more years of service at retirement
  - Savings driven by amount of Retiree Reimbursement Account
    - May be able to duplicate current retiree experience at lower cost
    - More savings available if cost-shift consistent with Non Medicare Retirees is implemented

Options to Review – National Medicare Advantage Plan

- National “PPO” Plan - typically offered as “passive” PPO
  - PPO requirement for Medicare purposes
  - “Passive PPO” allows access to all Medicare providers at same benefit level, no “steerage” to specific providers
  - Medicare Advantage framework should allow desired plan design, with advantageous cost to GHIP
    - Medicare Advantage plan must have AV at least as great as original Medicare (for medical), and Medicare Part D standard Plan (for prescription drugs)
    - Mandatory out of pocket maximum on medical similar to GHIP for NM retirees, “True Out of Pocket Maximum” for prescription drugs
- Value of Impact: 5% to 15% expected with no plan changes, plan changes and contribution changes would increase savings
- Implementation and Impact in FY 2017
  - Could be implemented for January 1, 2018, may not need enabling legislation
- Observations on Delaware Marketplace and current GHIP
  - Presence of “zero premium” plans, and multiple vendors, in Delaware a good “leading indicator” for a successful Medicare Advantage strategy
  - Highmark BCBS does not offer an individual market Medicare Advantage plan at this time, a significant disadvantage for offering a group Medicare Advantage plan

Options to Review - Redesign Plans – Medicare Primary Retirees

- Medicare Primary retirees receive medical benefit through a Medicare Supplement plan, from Highmark, that covers 100% of the cost that Medicare A&B does not cover
  - Effectively provides an actuarial value of 100%
  - Significantly greater than any of the 4 benefit options of the Non Medicare retirees
- In Redesigning Medicare Primary plan, need to recognize
  - Underlying benefit design of Medicare A&B (this plan pays secondary)
  - Medicare “integration” method, leading to cost-share experienced by Retirees
- Suggest targeting a plan design, similar to PPO for Non Medicare Retirees, with actuarial value of approximately 90%
  - Should result in significant cost reduction in medical premium rate
  - Prescription drug component would remain unchanged
- Value of Impact: solely on the Medical component, which is approximately 50% of the overall Medicare Primary premium rate. Moving to 90% Actuarial Value from 100% could be worth as much as $50M per year (on a total of $142M)
- Implementation and Impact in FY 2017
  - Could be implemented for January 1, 2018, may not need enabling legislation