State Employee Benefits Committee
Group Health Program FY16 Planning
February 20, 2015

Objectives for Today's Discussion

- **Review of Grandfathered Status**
- **Group Health Fund Budget Projections for FY15 and FY16 through FY15Q2**
- **FY16 Health Care Rates**
- **Medical and Prescription Cost Saving Opportunities**
  - Prescription
    - Copay Modeling
    - Plan Changes
  - Benefit Plan Design Changes
    - Outpatient Surgery – PPO plan
    - Lab and Radiology point of service
  - Medical Plan Design Change Modeling

Grandfathered Status Overview

- **Purpose** is to preserve existing coverage, and **Advantage** is plan does not have to comply with certain coverage mandates
- Grandfathered status is determined for each plan option (e.g., PPO, HMO), so it is measured separately for each option
- Any change (including the cumulative effect of incremental changes) must be measured relative to the plan in effect on March 23, 2010
- Every single change must be reviewed because a change that affects even one benefit may be sufficient to trigger loss of grandfathered status for the entire plan option
- Grandfathered status is lost upon effective date of changes that cause the loss of that status

Grandfathered Status
What Triggers Loss?

- Elimination of all or substantially all benefits to diagnose or treat a particular condition
- Any increase in percentage cost-sharing requirement (i.e., coinsurance)
- Increase in deductible or out-of-pocket maximum by an amount that exceeds medical inflation + 15 percentage points
- Increase in copays by an amount that exceeds medical inflation + 15 percentage points (or, if greater, $5 + medical inflation)
- Decrease in employer's contribution rate by more than 5 percentage points (measured for each tier of coverage)
- Imposition of annual limits on the dollar value of benefits below certain amounts

Grandfathered Status
Current Status of Delaware Plans

Grandfathered Plans:

- Aetna HMO Plan
- Highmark Delaware: First State Basic Plan
- Highmark Delaware: Preferred Provider Organization
- Highmark Delaware: Blue Care HMO
- Highmark Delaware Port POS

Non-Grandfathered Plans:

- Aetna CDH Gold Plan with HRA
- Highmark Delaware: CDH Gold

Loss of Grandfathered Status

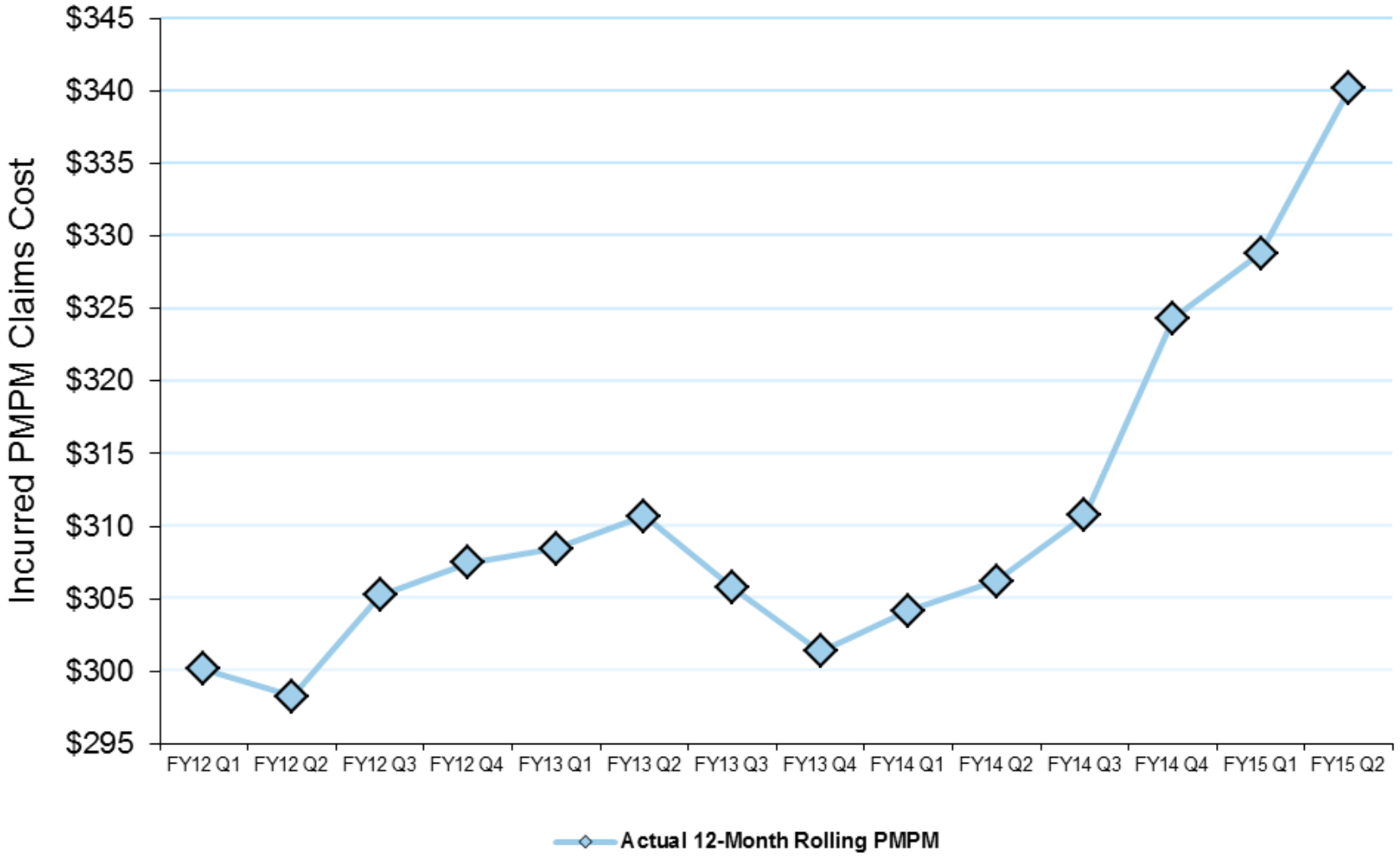
- As mentioned earlier, Non-Grandfathereds plans have to comply with certain coverage mandates. Two significant coverage mandates are limits on member cost-share (out-of-pocket maximums) and coverage of preventive services at 100%

	Highmark PPO	Highmark First State Basic	HMOs	CDH Plans	Port POS
Current:					
Medical					
Deductible	**None**	**$500/$1,000**	**None**	**$1,500/$3,000**	**None**
Coinsurance Expense Limit	**None**	**$1,500/$3,000**	**None**	**$3,000/$6,000**	**$500/$1,500**
Prescription Drug					
Out-of-Pocket Maximum	**None**	**None**	**None**	**None**	**None**
Effective Total Out-of-Pocket Maximum	**None**	**$2,000/$4,000**	**None**	**$4,500/$9,000**	**$500/$1,500**
FY16 ACA Compliant:					
Medical					
Out-of-Pocket Maximum	**$4,500/$9,000**	**$2,000/$4,000**	**$4,500/$9,000**	**$4,500/$9,000**	**$500/$1,500**
Prescription Drug					
Out-of-Pocket Maximum	**$2,100/$4,200**	**$2,100/$4,200**	**$2,100/$4,200**	**$2,100/$4,200**	**$2,100/$4,200**
Effective Total Out-of-Pocket Maximum	**$6,600/$13,200**	**$4,100/$8,200**	**$6,600/$13,200**	**$6,600/$13,200**	**$2,600/$5,700**
Impact of implementing OOP Maximums					
Medical	**$53,800**	**$0**	**$106,200**	**$0**	**$6,200**
Prescription Drug	**$61,400**	**$600**	**$37,300**	**$2,200**	**$600**
Impact of covering preventive at 100%					
Medical	**$1,452,600**	**$0**	**$787,300**	**$0**	**$4,300**
Prescription Drug	**$776,000**	**$7,300**	**$471,300**	**$27,300**	**$6,900**
Total Impact for Loss of Grandfathered Status[2]	**$2,343,800**	**$7,900**	**$1,402,100**	**$29,500**	**$18,000**

[2]Total for All Plans: $3,801,300

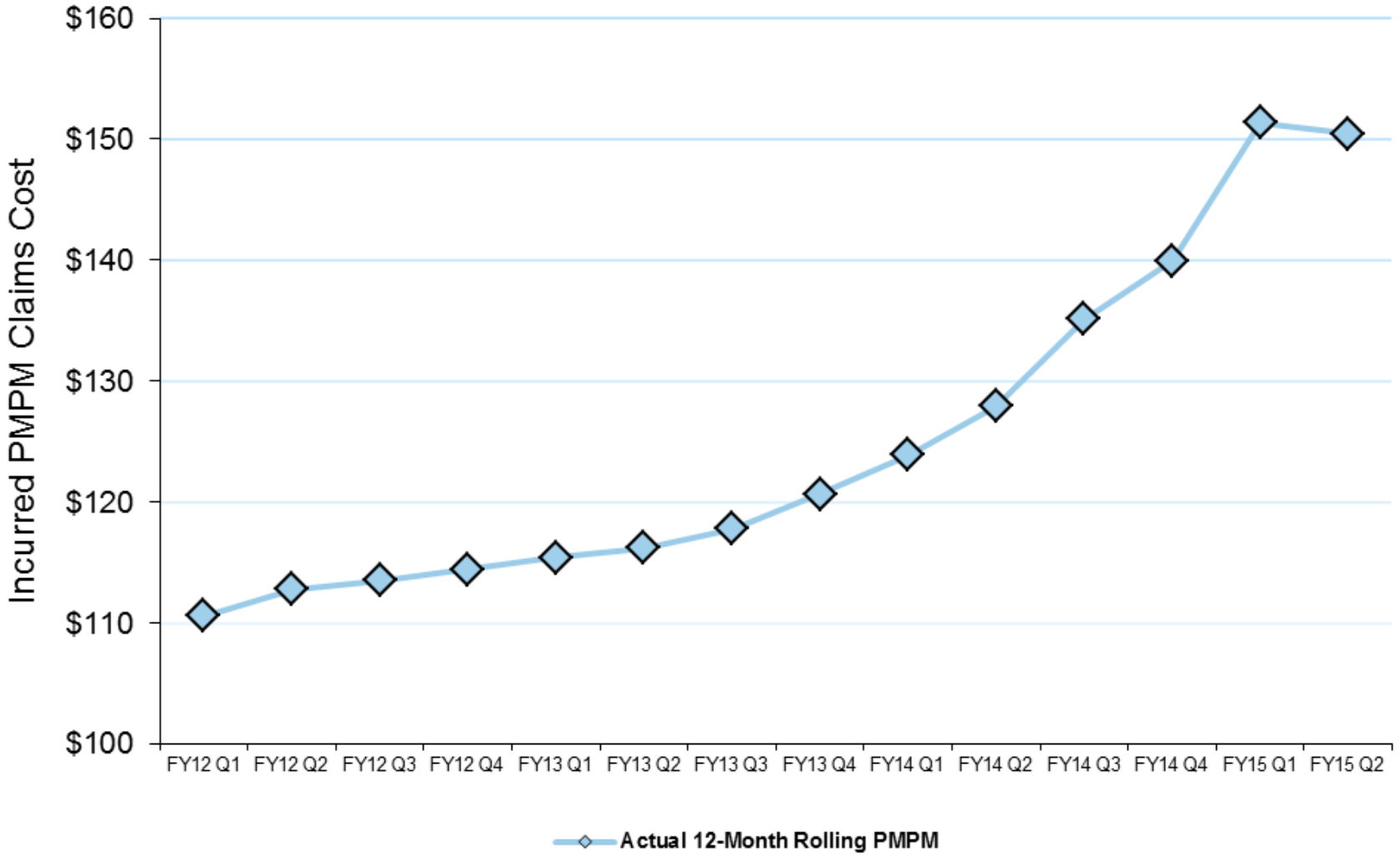
Group Health Fund Budget Projections for FY15 and FY16 through FY15Q2

Historical Trend Analysis - Medical



*12-Month Rolling PMPM represents the average Per Member Per Month claims cost for the latest 12 months at that point in time.

Historical Trend Analysis – Prescription Drug



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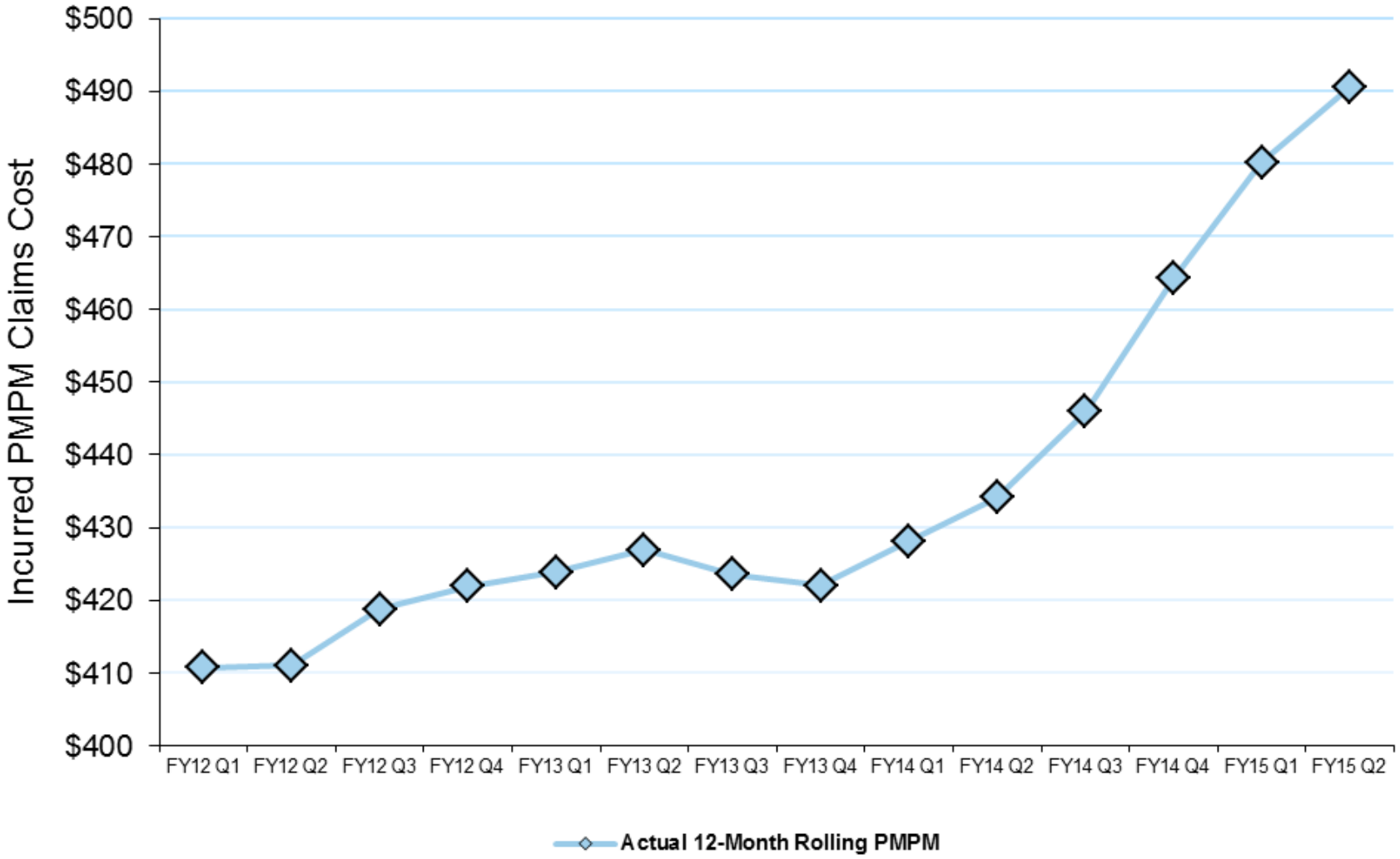
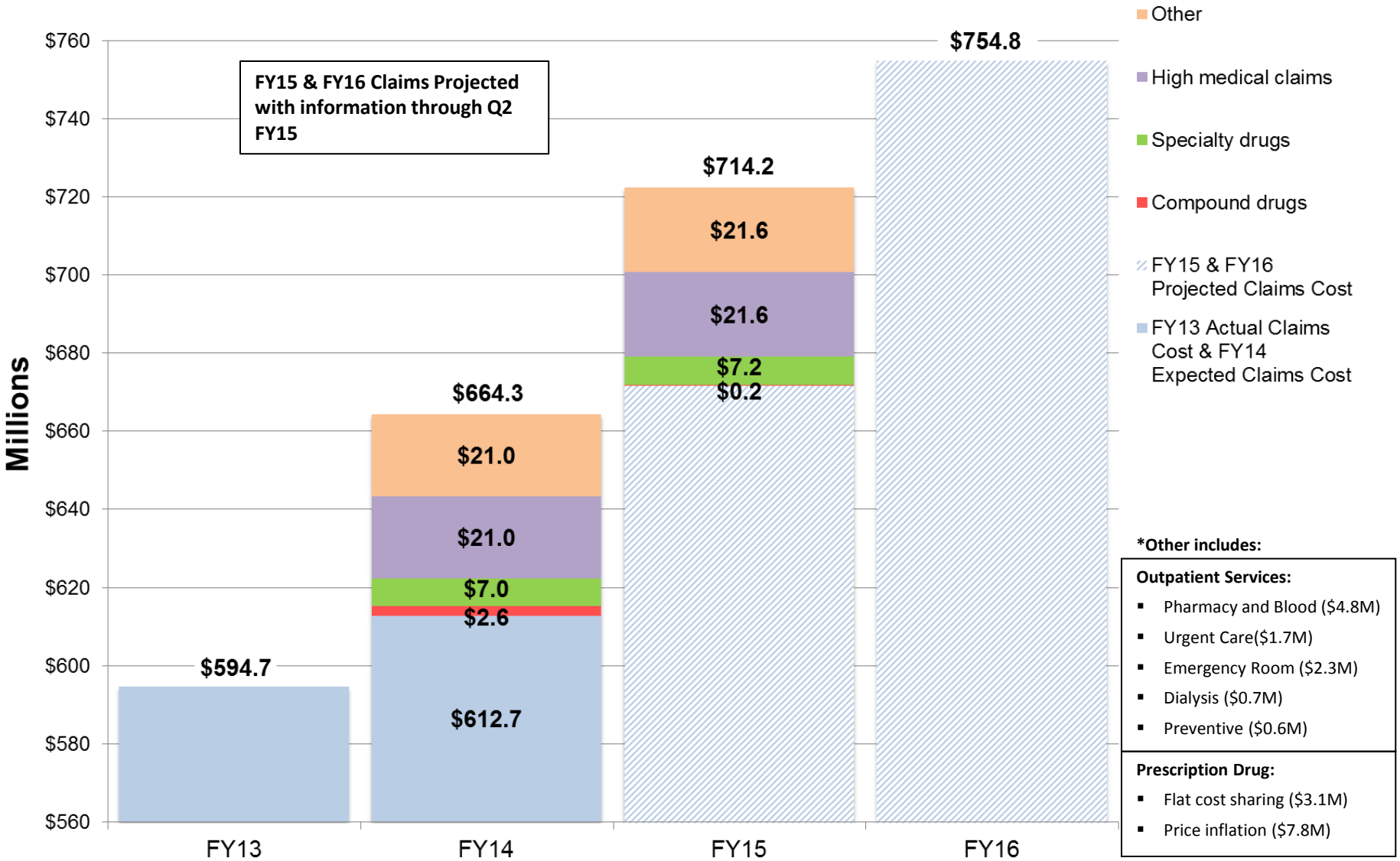
Historical Trend Analysis – Medical & Drug



*12-Month Rolling PMPM represents the average Per Member Per Month claims cost for the latest 12 months at that point in time.

Actual and Projected Increase in Incurred Claims FY13 to FY16



***Other includes:**

Outpatient Services:

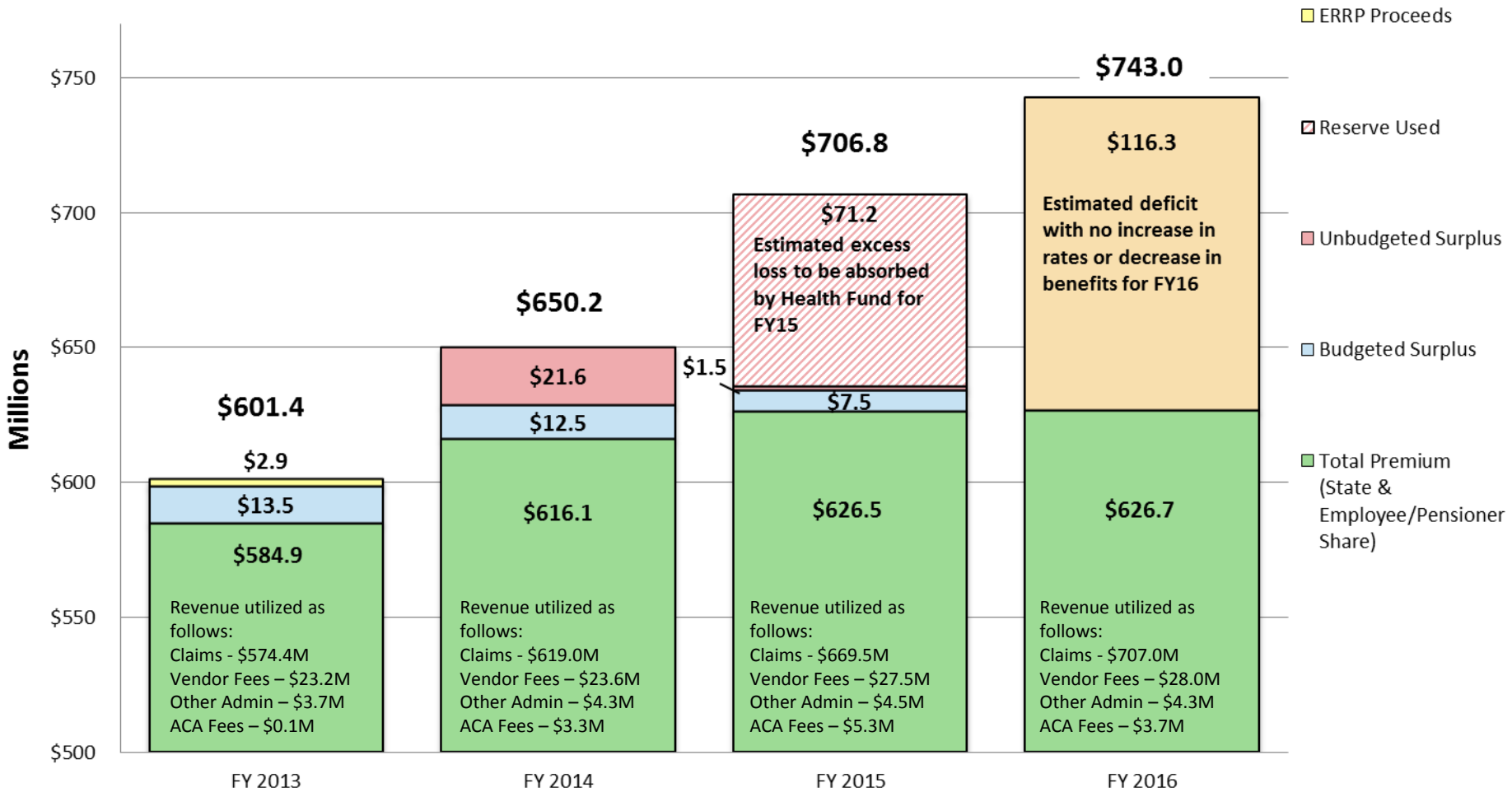
- Pharmacy and Blood ($4.8M)
- Urgent Care($1.7M)
- Emergency Room ($2.3M)
- Dialysis ($0.7M)
- Preventive ($0.6M)

Prescription Drug:

- Flat cost sharing ($3.1M)
- Price inflation ($7.8M)

Costs above do not reflect offsets for rebates or EGWP subsidies. Vendor fees, ACA fees, and other administrative costs not included. Amounts for Specialty Drugs, High Medical Claims, and Other for FY15 represent the amounts for FY14 plus 3.0% trend; Actual trend for these categories may be much higher. Compound Drug management program implemented in September 2014 resulting in a significant reduction in Compound Drug expenses for FY15 and beyond.

State of Delaware
Group Health Revenue



- Grand totals include claims, offset by rebates and EGWP subsidies, vendor fees, other admin, and ACA fees.
- FY15 revenue and expenditures are estimates based upon premiums in place through 6/30/15 and actual claims experience through 12/31/14 and projected through 6/30/15 using a trend factor of 3.0%.
- FY16 revenue estimates as shown assume no change in current FY15 premiums. FY16 claims are estimated using a trend factor of 5.5%, based on current plan design and do not reflect potential savings achieved through plan design modifications.

FY15 Group Health Fund Projections

	February 2015
FY 2015 Projected Expenditures	($706.8M)
FY 2015 Projected Revenue	$626.5M
FY 2015 Projected Loss (06/30/2015)	($80.3M)

As of FY15 Year End :
Surplus = $0
Reserve = $0

FY16 Group Health Fund Projections

	February 2015
FY 2016 Expenditure Projections (includes ACA fees, estimated rebates, adjustments for EGWP subsidies and reinsurance reimbursements, and the cost of losing grandfather status)	($743.0M*)
FY2016 Revenue Projections (based on current FY2015 Rates)	$626.7M
Total Deficit Prior to General Fund Allocation	($116.3)
Additional Revenue based on FY2016 General Fund allocation of $26.1M	$56.2M
Remaining Deficit for FY16	($60.1M)

*Reflects trend increase (5.5%)

FY16 Health Care Rates
Based on $26.1M General Fund Allocation

FY16 Plan Rates assuming $26.1M General Fund Increase

		Total Monthly Rate	Funded State Share Rate	Employee/Pensioner Rate	$ Increase in Employee/Pensioner Rate
First State Basic Plan					
Employee	540	$602.80	$578.66	$24.14	$2.14
Employee & Spouse	96	$1,247.20	$1,197.32	$49.88	$4.42
Employee & Child(ren)	121	$916.34	$879.68	$36.66	$3.26
Family	126	$1,559.04	$1,496.70	$62.34	$5.52
CDH Gold					
Employee	808	$623.88	$592.70	$31.18	$2.76
Employee & Spouse	231	$1,293.60	$1,228.94	$64.66	$5.72
Employee & Child(ren)	325	$953.22	$905.56	$47.66	$4.22
Family	319	$1,643.42	$1,561.24	$82.18	$7.28
Aetna HMO					
Employee	1,249	$629.32	$588.42	$40.90	$3.62
Employee & Spouse	423	$1,326.86	$1,240.60	$86.26	$7.64
Employee & Child(ren)	679	$962.72	$900.14	$62.58	$5.54
Family	802	$1,655.64	$1,548.02	$107.62	$9.54
BlueCARE® HMO					
Employee	5,240	$629.84	$588.90	$40.94	$3.64
Employee & Spouse	2,022	$1,331.06	$1,244.54	$86.52	$7.66
Employee & Child(ren)	3,335	$963.68	$901.04	$62.64	$5.54
Family	3,864	$1,660.70	$1,552.74	$107.96	$9.56
Comprehensive PPO Plan					
Employee	9,271	$688.20	$597.02	$91.18	$8.08
Employee & Spouse	3,976	$1,428.06	$1,238.86	$189.20	$16.74
Employee & Child(ren)	4,438	$1,060.62	$920.10	$140.52	$12.44
Family	5,556	$1,785.30	$1,548.76	$236.54	$20.94
Port POS Plan					
Employee	141	$521.66	$521.66	$0.00	$0.00
Employee & Spouse	37	$1,292.18	$1,292.18	$0.00	$0.00
Employee & Child(ren)	43	$785.06	$785.06	$0.00	$0.00
Family	47	$1,305.04	$1,305.04	$0.00	$0.00
Medicfill Rates with EGWP Offset Effective Jan 2016 for pensioners retired prior to July 1, 2012					
Subscriber	20,077	$398.24	$398.24	$0.00	$0.00
Subscriber no Rx	639	$225.78	$225.78	$0.00	$0.00
Medicfill Rates with EGWP Offset Effective Jan 2016 for pensioners retired after July 1, 2012					
Subscriber	879	$398.24	$378.32	$19.92	$1.78
Subscriber no Rx	24	$225.78	$214.50	$11.28	$0.99

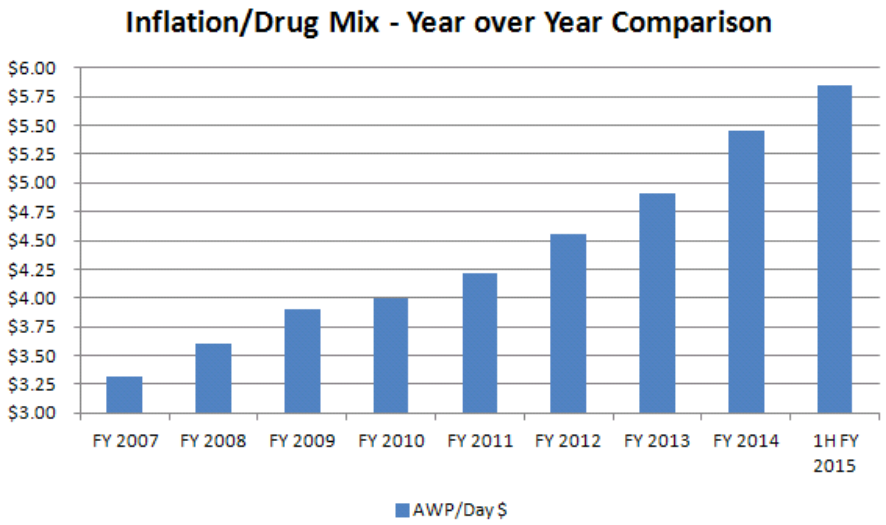
Enrollment as of 12/31/14

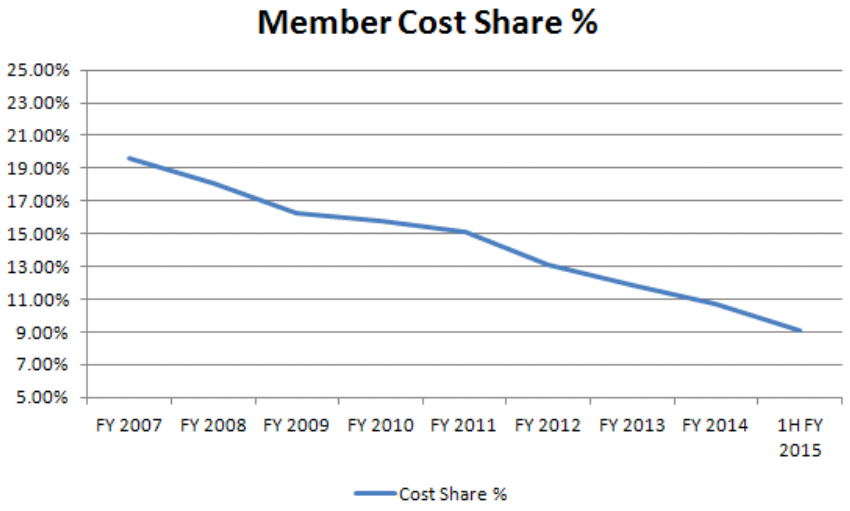
Medical and Prescription Cost Saving Opportunities

- Prescription
  - Copay Overview and Modeling
  - Plan Changes
- Benefit Plan Design Changes
  - Outpatient Surgery copays
  - Lab and Radiology point of service copays
- Medical Plan Design Change Modeling

Prescription Copay Overview

- The State of Delaware has experienced a decrease in the member cost share year over year since FY08 which is common for plans with flat dollar copays as manufacturers increase the Average Wholesale Price (AWP) of drugs





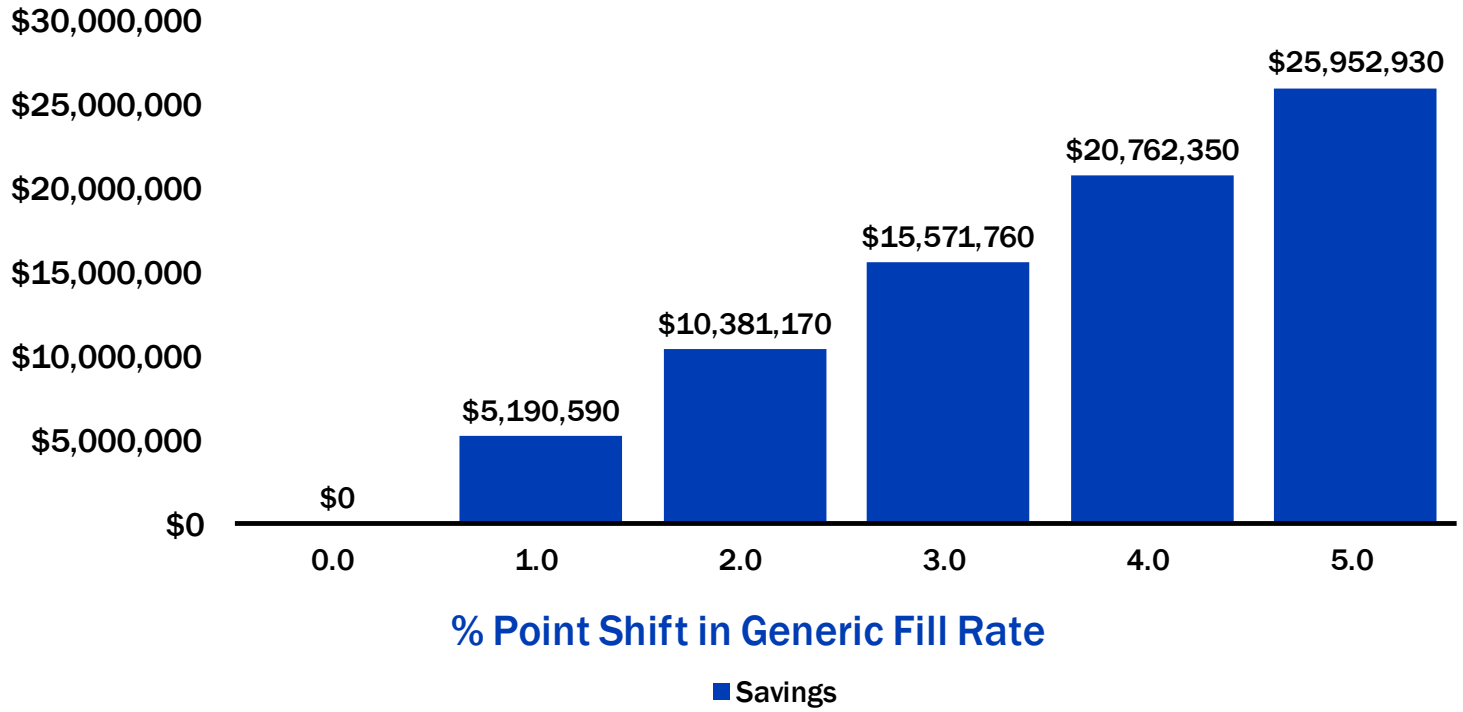
Prescription Copay Overview

- The State had an estimated annualized drug spend of $245 million in first half of FY2015, with members paying 9.1% of these costs and the plan paying the remainder.
- Express Script's Government Advisory Panel (Government Peer) averaged 15.2% member cost share for the first half FY2015.
- Using the estimated annualized drug spend for the first half of FY2015 as a baseline, the chart below shows the additional costs that the State has incurred from the reduction of cost share percentage year over year.

	Cost Share %	Additional Costs to the State as of 2015
1H FY 2015	9.1%	$0
FY 2014	10.7%	$3.9M
FY 2013	11.9%	$6.9M
FY 2012	13.1%	$9.8M
FY 2011	15.1%	$14.7M
FY 2010	15.8%	$16.4M
FY 2009	16.3%	$17.7M
FY 2008	18.1%	$22.1M
FY 2007	19.6%	$25.8M

Additional Prescription Drug Savings Opportunity – Increase in Generic Dispensing

- Changing the copays is an opportunity to incentivize the use of generic prescriptions which becomes additional savings to the plan.
- As of the first half of FY2015, for every point increase in GDR the plan could save approximately 2.3% of total plan cost or $5.2M.



Prescription Drug Plan Copay Option

- Options for Copay Design:
  - Option 1 –
    - Increase 30 day copays for all tiers – generic, formulary and non-formulary
    - Increase 90 day copays at two times 30 day copay levels
  - Option 2 –
    - Increase 30 day copays for all tiers – generic, formulary and nonformulary
    - Increase 90 day copays at two and a half times 30 day copay levels

Last copay increase July 1, 2005

Prescription Drug Plan Copay Option 1

	Current	Savings Option
RETAIL 30 DAY		
Generic	$8.50	$10.00
Formulary	$20.00	$25.00
Non-Formulary	$45.00	$50.00
RETAIL & MAIL (31-90 DAYS SUPPLY)		
Generic	$17.00	$20.00
Formulary	$40.00	$50.00
Non-Formulary	$90.00	$100.00
Total Estimated Cost Share %	9.1%	**11.1%**
Total Estimated Savings		**$ 2.6M**

Last copay increase July 1, 2005

Prescription Drug Plan Copay Option 2

	Current	Savings Option
RETAIL 30 DAY		
Generic	$8.50	$10.00
Formulary	$20.00	$25.00
Non-Formulary	$45.00	$50.00
RETAIL & MAIL (31-90 DAYS SUPPLY)		
Generic	$17.00	$25.00
Formulary	$40.00	$62.50
Non-Formulary	$90.00	$125.00
Total Estimated Cost Share %	9.1%	**12.6%**
Total Estimated Savings		**$ 4.7M**

Last copay increase July 1, 2005

Erectile Dysfunction Drug Coverage

- Current coverage = 6 pills for 30 days
- Utilization = 3,413 members
- Total annual cost to plan= $2.7M
- Options for Change:
  - Option 1: Decrease quantity limit of impotence drugs
    - From 6 to 4 each 30 days
    - Estimated savings = $0.9M
  - Option 2: Eliminate Coverage Entirely
    - Savings = $2.7M

Outpatient Surgery Copay Change

- Current Outpatient Surgery Copay Tiers under HMO plans
  - Specialist Doctor's Office - $20
  - Outpatient Surgery - $30
  - Hospital – $75
- Recommend increasing copays for HMO and adopting tiered structure in Comprehensive PPO plan as follows:
  - Specialist Doctor's Office - $20 HMO/ $25 PPO*
  - Outpatient Surgery - $50 HMO and PPO
  - Hospital – $100 HMO and PPO

  *Current Specialist Doctor's Office copay
- Reason:
  - Encourages lower cost place of service options to be utilized
  - Savings – only due to copay increases = $0.5M
  - Additional savings should be realized if changes occur from higher cost place of service to lower cost place of service

Lab and Radiology Copay Change

- Current costs for lab services at hospitals versus freestanding lab sites is 189% higher
- Current costs for radiology services at hospitals versus freestanding radiology sites is over 67% higher
- Recommend increasing copays for lab and radiology provided by hospital systems as outlined on following slides for active and non-Medicare members effective July 1, 2015
- Recommendation will be forthcoming on March 6th for similar change to State payment of lab and radiology provided at hospital systems for Medicare members effective January 1, 2016

PPO Lab and Radiology Changes

COMP PPO	Current	Proposed
Radiology - Hospital (Regular)	$15 Copay	**$75 Copay**
Radiology - Freestanding (Regular)	$15 Copay	$15 Copay
Radiology - Hospital (Hi-Tech)	$15 Copay	**$100 Copay**
Radiology - Freestanding (Hi-Tech)	$15 Copay	**$25 Copay**
Radiology - OON	80% after deductible	**60%** after deductible
Lab - Hospital	$5 Copay	**$30 Copay**
Lab - Freestanding	$5 Copay	$5 Copay
Lab - OON	80% after deductible	**60%** after deductible

HMOs Lab and Radiology Changes

HMOs	Current	Proposed
Radiology - Hospital (Regular)	$15 Copay	**$75 Copay**
Radiology - Freestanding (Regular)	$15 Copay	$15 Copay
Radiology - Hospital (Hi-Tech)	$25 Copay	**$100 Copay**
Radiology - Freestanding (Hi-Tech)	$25 Copay	$25 Copay
Radiology - OON	N/A	N/A
Lab - Hospital	$5 Copay	**$30 Copay**
Lab - Freestanding	$5 Copay	$5 Copay
Lab - OON	N/A	N/A

Lab and Radiology Copay Change

- Resulting savings for copay changes =
  - Lab = $1.0M
  - Radiology - $4.2M

- Additional savings for shift in utilization:
  - For each 5% movement from hospital based services to freestanding clinics = $0.2M

***Savings reflected are due to change for active employees and non-Medicare retirees only**

Medical Plan Design Changes

- Each benefit plan contains various changes to deductibles and copays for different services as follows:

Medical Plan Changes – First State Basic Plan

FIRST STATE BASIC				
			Dollar Savings	
All Plan Changes			($573,200)	
	Current Benefit	Proposed Benefit		
Deductible	$500/$1,000	$1,000/$2,000		
Overall Plan Coinsurance	90%/10%	90%/10%		
Out-of-Pocket Maximum	$2,000/$4,000	$2,250/$4,500		
Primary Care Physician Visit Coinsurance	90%	90%		
Specialist Visit Coinsurance	90%	90%		
Inpatient Room & Board Coinsurance	90%	90%		
Emergency Room Visit Coinsurance	90%	90%		
Lab Tests Coinsurance	90%	90%		
X-Rays Coinsurance	90%	90%		
Advanced Imaging Coinsurance	90%	90%		

Medical Plan Changes – Consumer Directed Gold Plans

CDH plans				
			Dollar Savings	
All Plan Changes			($874,600)	
	Current Benefit	Proposed Benefit		
Deductible	$1,500/$3,000	$2,000/$4,000		
Overall Plan Coinsurance	90%/10%	90%/10%		
Out-of-Pocket Maximum	$4,500/$9,000	$4,500/$9,000		
Primary Care Physician Visit Coinsurance	90%	90%		
Specialist Visit Coinsurance	90%	90%		
Inpatient Room & Board Coinsurance	90%	90%		
Emergency Room Visit Coinsurance	90%	90%		
Lab Tests Coinsurance	90%	90%		
X-Rays Coinsurance	90%	90%		
Advanced Imaging Coinsurance	90%	90%		

Medical Plan Changes – HMO plans

HMOs				
			Dollar Savings	
All Plan Changes			($21,497,300)	
	Current Benefit	New Benefit		
Deductible	$0	$500/$1,000	($14,946,000)	
Overall Plan Coinsurance	N/A	N/A		
Out-of-Pocket Maximum	None	$4,500	$106,200	
Primary Care Physician Visit Copay	$10	$20	($3,029,300)	
Specialist Visit Copay	$20	$30	($470,000)	
Inpatient Room & Board Copay	$100 per day, $200 Max	$150 per day, $450 Max	($997,800)	
Outpatient Surgery[1]	$30 / $75	$50 / $100	($72,300)	
Lab Tests Copay[2]	$5 / $5	$5 / $30	($381,000)	
X-Rays Copay[2]	$15 / $15	$15 / $75	($1,707,100)	
Advanced Imaging Copay[2]	$25 / $25	$25 / $100		

[1]Ambulatory Surgicenter / Outpatient Hospital

[2]Freestanding Facility / Hospital

Medical Plan Changes – PPO plan

Comprehensive PPO				
			Dollar Savings	
All Plan Changes			($32,043,600)	
	Current Benefit	New Benefit		
Deductible	$0	$500/$1,000	($24,803,200)	
Overall Plan Coinsurance	100%	100%		
Out-of-Pocket Maximum	None	$4,500	$53,800	
Primary Care Physician Visit Copay	$15	$20	($1,353,000)	
Specialist Visit Copay	$25	$30	($700,000)	
Inpatient Room & Board Copay	$100 per day, $200 Max	$150 per day, $450 Max	($1,701,800)	
Outpatient Surgery[1]	100%	$50 / $100	($400,000)	
Lab Tests Copay[2]	$5 / $5	$5 / $30	($614,400)	
X-Rays Copay[2]	$15 / $15	$15 / $75	($2,524,700)	
Advanced Imaging Copay[2]	$15 / $15	$25 / $100		

[1]Ambulatory Surgicenter / Outpatient Hospital

[2]Freestanding Facility / Hospital

Medical Plan Changes – Medicfill plan

Savings[1]		($1,117,700)	($2,226,800)
	Current Benefit	Option 1	Option 2
Deductible	$0	$0	$0
Overall Plan Coinsurance	100%	95%	90%
Out-of-Pocket Maximum	None	$4,500	$4,500

[1]Savings estimate for Fiscal Year 2016. Plan Changes would not become effective until January 1, 2016.

Savings Options to Balance Budget

Balance Needed:	**$ 60.1M**
Implement One or More Medical/Prescription Plan Changes –	
Prescription Copay Changes:	
Option 1:	**$ 2.6M**
Option 2:	**$ 4.7M**
Impotence Drug Quantity Level Change:	
Option 1:	**$ 0.9M**
Option 2:	**$ 2.7M**
Outpatient Surgery Copay change:	**$ 0.5M**
Lab and Radiology Copay change:	**$ 5.2M**
Other Medical Copay Changes –	
Doctors and Hospital	**$ 8.3M**
Medical Plan Deductibles	**$41.2M**
Medicfill Plan Changes:	
Option 1:	**$1.1M**
Option 2:	**$2.2M**
Total:	**$59.8M to $64.8M**

FY16 Group Health Planning – Next Steps
March Meetings – March 6 and March 20

- Choose Options to Close Gap
- Balance FY16 Health Fund Budget
- Approve FY16 Health Plan Rates
- Approve FY16 DelaWELL Strategy