Group Health Program FY17 Planning
March 18, 2016

Agenda

- FY17 Group Health Projections
- Claim Liability and Reserve Funding
- FY17 Rate Illustration
- Medical Plan Design Options to promote consumerism/behavior change
  - Urgent Care/Emergency Room
  - HiTech Radiology
- Pharmacy Benefit Plan Design Options
  - Over-the-Counter Drug Coverage
  - Medicare B versus D Coverage
- Review other short term cost reductions options in process
- Recommendations

FY17 Group Health Operating Budget Projections

FY2017 Projected Expenditures (includes ACA fees, estimated rebates, adjustments for EGWP subsidies/reinsurance and Prescription contract savings)	($852.7M)	through FY15 Q4
	-$30.9M	Prescription Savings
	-$28.4M	Impact of Improved Claim Experience
	($793.4M)	through FY16 Q1
	-$37.2M	Impact of Improved Claim Experience
	($756.2M)	through FY16 Q2
FY2017 Revenue Projections (based on the rates effective September 1, 2015 for active and non-Medicare retirees/January 1, 2016 for Medicare retirees)		$736.8M
FY2017 Projected Group Health Fund Deficit		($19.4M)

FY17 Group Health Claim Liability

FY2017 Recommended Claim Liability Target	**$48M**
FY2016 Year End Projected Claim Liability Funded (as of February)	**$22.7M**
FY17 Claim Liability Deficit	**($26.3M)**

FY16 Group Health Fund Reserve Deficit

FY2016 Recommended Target	**$79M**
FY2016 Year End Projected Balance	**$0M**
FY2017 Reserve Deficit	**($79M)**

FY17 Group Health Funding Allocation

FY2017 Governor's Recommended Budget of $33.3M General Funds equals $56.6M All Funds to be allocated as follows:

- FY2017 Operating Funding - $19.4M
- FY2017 Claim Liability Funding - $26.3M
- FY2017 Reserve Funding - $10.9M

FY2017 Group Health Premiums - Actives and Non-Medicare Retirees Based on $56.6M All Funds State Share Increase

	Total Monthly Rate	Funded State Share Rate	Employee/Pensioner Share Effective July 1, 2016	Rate Increase Over FY16
First State Basic Plan				
Employee	$695.36	$667.52	$27.84	$1.98
Employee & Spouse	$1,438.68	$1,381.16	$57.52	$4.10
Employee & Child(ren)	$1,057.02	$1,014.76	$42.26	$3.00
Family	$1,798.42	$1,726.50	$71.92	$5.14
CDH Gold				
Employee	$719.68	$683.70	$35.98	$2.58
Employee & Spouse	$1,492.22	$1,417.64	$74.58	$5.32
Employee & Child(ren)	$1,099.56	$1,044.60	$54.96	$3.92
Family	$1,895.74	$1,800.96	$94.78	$6.76
Aetna HMO				
Employee	$725.94	$678.78	$47.16	$3.36
Employee & Spouse	$1,530.58	$1,431.08	$99.50	$7.10
Employee & Child(ren)	$1,110.52	$1,038.34	$72.18	$5.14
Family	$1,909.82	$1,785.70	$124.12	$8.86
BlueCARE® HMO				
Employee	$726.52	$679.34	$47.18	$3.36
Employee & Spouse	$1,535.42	$1,435.62	$99.80	$7.12
Employee & Child(ren)	$1,111.64	$1,039.38	$72.26	$5.16
Family	$1,915.68	$1,791.16	$124.52	$8.88
Comprehensive PPO Plan				
Employee	$793.86	$688.68	$105.18	$7.50
Employee & Spouse	$1,647.34	$1,429.08	$218.26	$15.58
Employee & Child(ren)	$1,223.46	$1,061.38	$162.08	$11.56
Family	$2,059.40	$1,786.54	$272.86	$19.48

FY2017 Group Health Premiums – Medicare Retirees Based on $56.6M All Funds State Share Increase

	Total Monthly Rate	Funded State Share Rate	Pensioner Share Effective January 1, 2017	Rate Increase Over CY16
Special Medicfill Rates for Retirees retired before July 1, 2012				
Subscriber with RX	$459.38	$459.38	$0	$0
Subscriber – no RX	$260.44	$260.44	$0	$0
Special Medicfill Rates for Retirees retired on or after July 1, 2012				
Subscriber with RX	$459.38	$436.42	$22.96	$1.64
Subscriber – no RX	$260.44	$247.44	$13.00	$0.92

Plan Design Change Options – Promoting Consumerism High Tech Radiology Site of Service

Purpose: Encourage members to utilize freestanding facilities.

- Lower copay for high tech imaging at freestanding facility to $0 for a year evaluation period effective July 1, 2016
- Provide scheduling assistance through Highmark and Aetna

Highmark

- Upon approval of High Tech Imaging test to provider through NIA, NIA will contact member if not scheduled at freestanding clinic to provide information on copays at different facility and option to schedule at different site of service
- Cost for service is $33,000 (annual program fees) per year

Aetna

- Custom network can be established to steer provider to schedule High Tech Imaging at freestanding clinic due to $0 copay to member
- Does not prevent provider from scheduling at hospital based facility
- Will also look into back end notification to member of lower cost option

For both options, communications will be key – both from State and from Highmark/Aetna

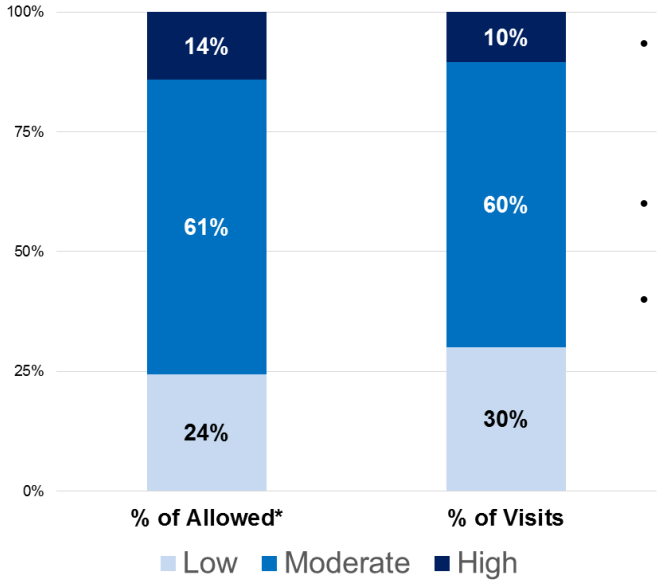
Plan Design Change Options – Promoting Consumerism
High Tech Radiology Site of Service

- High Tech Radiology Copay Tiering
  - To encourage members to utilize freestanding facilities, lower copay for high tech imaging at freestanding facility to $0 for a year evaluation period effective July 1, 2016
    - Cost for reduction of copay to $0 is estimated at $200K if no change in behavior or movement from hospital based facilities to freestanding facilities. This does not include the $33K annual program fees.
    - Movement of approximately 300 visits would cover reduction in urgent care copay – ($233,000 copay reduction/$800 difference in price)
    - Number of high tech imaging tests in FY15 was 12,213 with 7,167 done at a hospital outpatient setting.
    - Movement above 300 visits will result in an average savings of $800 per high tech test.
  - Monitor utilization for 1 year. If movement does not cover costs of copay reduction and result in additional savings, resume high tech copay for freestanding facilities effective January 1, 2018

Plan Design Change Options – Promoting Consumerism Urgent Care vs Emergency Room Site of Service Non-Medicare Population Only

Site of Service	Incurred FY 2014				Incurred FY 2015				Change	
	Visits	Visits per 1000	Allowed Amount	Allowed Amount per Visit	Visits	Visits per 1000	Allowed Amount	Allowed Amount per Visit	Vists	Allowed
Urgent Care	32,730	333	$4.18M	$128	38,020	382	$4.82M	$127	16.2%	15.3%
ER (No Admission)	23,114	235	$39.59M	$1,713	24,052	242	$44.02M	$1,830	4.1%	11.2%
ER (Admission)	2,750	28	$7.92M	$2,882 ($26,425 with Admit)	2,777	28	$7.22M	$2,601 ($27,507 with Admit)	1.0%	-8.9%
Total	58,594	*	$51.70M	*	64,849	*	$56.06M	*	10.7%	8.4%

ER Severity Levels[1]



Summary Findings

- Use and cost of both urgent care[2] and emergency room services without admissions increased in FY2015, resulting in the following:
  - $649K increase in urgent care costs
  - $4.4 million increase for emergency room visits without an admission
- Some of the common clinical conditions treated in an the urgent care setting could cost over 9 times as much to treat in the emergency room
- One third of the Emergency Room visits incurred in FY 2015 had primary diagnosis signifying potential non emergence. Some of these primary diagnosis included:
  - 7804 Dizziness & giddiness (284 visits resulting in $641K costs)
  - 7242 Lumbago (lower back pain) (261 visits resulting in $349K costs)
  - 7820 Disturbance skin sensation (119 visits resulting in $326K costs)
  - 56400 Constipation NOS (190 visits resulting in 322K costs)

Top Urgent Care Clinical Conditions FY 2015		
Clinical Conditions	Allowed Amount / Visit	
	Urgent Care	ER
Infections - Ear, Nose and Throat Ex Otitis Media	$119	$1,103
Infections - Respiratory, NEC	$124	$1,351
Infec/Inflam - Skin/Subcu Tiss	$124	$1,185
Injury - Musculoskeletal, NEC	$145	$1,112

1. ER Severity Levels: 'Low' = ER visit without a same day admission and potentially non-emergent primary ICD 9 diagnosis. 'Moderate' = ER visit without same day admission and primary diagnosis that does not include an ICD 9 emergent diagnosis. 'High' = ER visit with a same day admission
2. Urgent Care services defined using provider type and place of service without a service category of Emergency Room services.

*Allowed amount of emergency room services does not include admission costs

Plan Design Change Options – Promoting Consumerism Urgent Care vs Emergency Room Site of Service Total Population – Active, Non-Medicare Pensioner and Medicare Pensioner

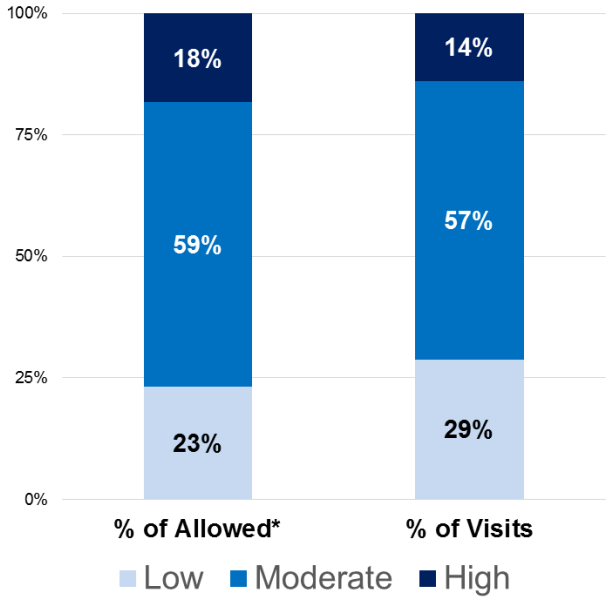
Site of Service	Incurred FY 2014				Incurred FY 2015				Change	
	Visits	Visits per 1000	Allowed Amount	Allowed Amount per Visit	Visits	Visits per 1000	Allowed Amount	Allowed Amount per Visit	Vists	Allowed
Urgent Care	36,501	308	$4.57M	$125	42,433	351	$5.25M	$124	16.3%	15.0%
ER (No Admission)	30,769	259	$45.25M	$1,471	32,577	270	$50.76M	$1,558	5.9%	12.2%
ER (Admission)	5,001	42	$12.25M	$2,540 ($22,210 with Admit)	5,242	43	$11.34M	$2,164 ($22,687 with Admit)	4.8%	-7.4%
Total	72,271	*	$62.07M	*	80,252	*	$67.35M	*	11.0%	8.5%

Summary Findings

- Use and cost of both urgent care and emergency room services without admissions increased in FY2015, resulting in the following:
  - $683K increase in urgent care costs
  - $5.5 million increase for emergency room visit without an admission
- Some of the common clinical conditions treated in an the urgent care setting could cost over 8 times as much to treat in the emergency room
- One third of the Emergency Room visits incurred in FY 2015 had primary diagnosis signifying potential non emergence. Some of these primary diagnosis included:
  - 7804 Dizziness & giddiness (473 visits resulting in $808K costs)
  - 7242 Lumbago (358 visits resulting in $405K costs)
  - 7820 Disturbance skin sensation (155 visits resulting in $356K costs)

Top 4 Urgent Care Visits in FY 2015		
Clinical Conditions	Allowed Amount / Visit	
	Urgent Care	ER
Infections - Ear, Nose, and Throat Ex Otitis Med	$117	$1,050
Infections - Respiratory, NEC	$120	$1,150
Infec/Inflam - Skin/Subcu Tiss	$120	$1,067
Injury - Musculoskeletal, NEC	$140	$987

ER Severity Levels[1]



1. ER Severity Levels: 'Low' = ER visit without a same day admission and potentially non-emergent primary ICD 9 diagnosis. 'Moderate' = ER visit without same day admission and primary diagnosis that does not include an ICD 9 emergent diagnosis. 'High' = ER visit with a same day admission

*Allowed amount of emergency room services does not include admission costs

Plan Design Change Options – Promoting Consumerism Urgent Care vs Emergency Room Site of Service

- ER vs Urgent Care Copay Tiering
  - To encourage members to utilize urgent care facilities, lower copay for urgent care facilities to equal PCP copay for a year evaluation period
    - HMO plans from $25 to $15
    - PPO plan from $30 to $20
    - Cost for reduction of copay is estimated at $300K if no change in behavior or movement from ER to urgent care
    - Movement of approximately 200 visits would cover reduction in urgent care copay – ($300,000 copay reduction/$1434 difference in price)
  - Monitor utilization for 1 year. If movement does not cover costs of copay reduction and result in additional savings resume urgent care copay at previous level effective January 1, 2018

Prescription Drug Plan Change Options – Over the Counter Equivalent Medications

- 14 medications currently covered under the Commercial plan (active employees & non Medicare retirees) where an Over the Counter equivalent is available
- Exclusion of these Over the Counter equivalent medications would reduce plan costs
- Member would purchase equivalent outside of prescription benefit
- Member Impacts: 3,529 members purchased one or more of these 14 medications under the commercial plan in FY2015

Total Estimated Annualized Savings Opportunity

$44,000

Savings are based on State of De. Utilization and are not guaranteed.

Over the Counter Equivalent Medications (cont.)

- Ranitidine HCL – heartburn; short-term use
- Polyethylene Glycol 3350 – constipation or bowel prep before colonoscopy; short-term use
- Cetirizine HCL – upper respiratory allergies or urticaria; short-term use
- Meclizine HCL – motion sickness or vertigo; short-term use
- Ammonium Lactate – dry, itchy skin; short-term use
- Clotrimazole – vaginal yeast infections; short-term use
- Famotidine – heartburn; short-term use
- Lansoprazole – heartburn; short-term use
- Hydrocortisone – dermatoses (poison ivy, insect bite, etc.); short-term use
- Loperamide – diarrhea; short-term use
- Diphenhydramine HCL – anti-tussive, insomnia, common cold symptoms; short-term use
- Omeprazole-Sodium Bicarb – heartburn; short-term use
- Mentax – athlete's foot, jock itch, ringworm; short-term use
- Cimetidine – heartburn; short-term use

Excluding over the counter equivalent medications
Implementation Steps

- Identify members with recent prescription history of use of prescription medications that have exact over the counter equivalents (same strength and dosage form)

- Send pre-notification letters 30 days prior to advise them that these medications will no longer be covered through the State's prescription benefit

Prescription Drug Plan Change Options – Medicare Retiree EGWP Part B/D Current Process

- CMS requires that plans subject a subset of medication to a Medicare Part B vs. Medicare Part D determination. What this means is that there are medications that can either pay as Medicare Part B or Medicare Part D. The way in which they pay is based on the indication for which the medication is being used and can also be dependent on the route of administration or dosage.
- Plans can decide how they would like to pay for the Medicare Part B medications.
- State of DE currently covers as the primary payor, Part B medications filled at the pharmacy through the non Medicare (enhanced benefit) portion of the Medicare Part D EGWP benefit.
- State of DE Medicare members who fill a Part B drug at a hospital or doctor's office, the medication will process as Part B. Part B pays 80% of the cost of the medication. The member is responsible for submitting a COB request to ESI to pick up the remaining 20% (member pays the copay and the State of DE non Medicare (enhanced benefit) pays the difference).

Medicare Part B- limited drug and supplies coverage*

Examples of drugs and supplies that may be covered under Medicare Part B

- Drugs used with Durable Medical Equipment- infusion pumps, nebulizers
- Injectable Osteoporosis Drugs
- Some antigens
- Blood clotting Factors
- Diabetic Testing Supplies
- Vaccines: Flu, Pneumonia and Hepatitis B
- Injectable and infused medications administered by a licensed medical provider
- Oral cancer medications
- Oral Anti Nausea medications

*this is not an inclusive list of covered products and services

Achieving Medicare Part B Savings at Retail Pharmacy

- At Retail – Identification of drugs and supplies that may meet criteria to be billed to Medicare Part B as primary.
- Express Scripts solution prospectively facilitates billing Medicare Part B as the primary payor for eligible drugs/supplies.
- State of DE non Medicare (enhanced benefit) pays the remaining balance AFTER member pays prescription copay.
- Impact on the Patient
  - Minimal or no disruption to the patient
  - Patients may experience reduced out of pocket expense depending on their co-payment structure and secondary coverage

Total Estimated Annualized Savings Opportunity

$650,000

Savings are based on State of De. Utilization and are not guaranteed.

Achieving Medicare Part B Savings Implementation Steps

- 90-day lead time required for standard implementations
- Program implementations start on the 1st of the month

Program Action	State of Delaware
Eligibility	Confirm Medicare Part B or Medicare Part D indicators are sent to Express Scripts
Communications	Review standard announcement letters & mailing pull criteria
Establish COB Options	Confirm how to handle 20% balance after Medicare pays primary
Contract Amendment	Sign Med B Solution Contract Addendum or Add to Current Contract

Prescription Drug Plan Change Options – Advanced Utilization Management Options

- As a follow up to discussions in February regarding expansion of our utilization management program – currently at the Advanced level – to Advance Plus or Unlimited, we have determined that a high number of members would be disrupted for therapeutic classes where disruption may be problematic.
- In addition, to grandfather current members and apply the programs to only future members, removes all rebates from grandfathered members and new members causing the savings to be low.
- Therefore we are not recommending any change at this time.
- We will continue to monitor for programs where effective therapy and savings may warrant consideration of adoption.

Health Plan Task Force– Short Term Findings and Recommendations

Bending the Cost Curve Too many plan options leads members to choose plans with greater value and higher contributions	Investigate simplifying plan options and creating best in class program with base plan and buy-up options (will be done in conjunction with health plan RFP during FY17 for FY18 planning)
Prescription drug trend reflects increasing use and cost of prescription drugs	Research and consider all utilization and cost containment programs offered by prescription benefit manager (in process – presented in February, for vote 3/18)
Centers of Excellence can provide cost savings and improved outcomes	Research and implement such programs established in Delaware and surrounding hospital systems (in process of collecting all data from providers to present in April 2016)
Copayment cost sharing structure does not promote member to understand cost of care	• Investigate methods and ability of members to understand full costs of healthcare • Implement tools and plan structure that drive members to most cost effective care delivery (in process – consumerism website launched 3/15, educational sessions beginning in April 2016)

Health Plan Task Force– Short Term Findings and Recommendations (cont.)

Payments to Providers Reference based pricing for common high cost procedures and diagnostic imaging and tiered network pricing for laboratory testing has proven cost benefits to employer sponsored plans	Investigate pilot programs for a select group of high cost procedures and diagnostic tests (in process – discussions with carriers and other parties occurring, meetings end of March)
Lack of transparency around provider costs compared to charges exists	Pursue and select through request for proposal, firms to conduct audits of medical and prescription plans (in process – recommendation for vendor award 3/18)
Metric based pricing for inpatient services has proven cost benefits to employer sponsored plans	Research and consider firms that can conduct analysis of health plan payments to hospitals and identify opportunities to negotiate improved pricing through comparing payments made by other govt sponsored and private health plans (in process – discussions with carriers and other parties occurring with additional meeting end of March)
Health Improvement Chronic conditions drive a significant portion of health plan costs	Explore options for driving better participation and engagement in programs intended to reduce cost and risk burden (in process – more discussion on FY17 DelaWELL at April SEBC meeting)

Health Plan Task Force– Long Term Findings and Recommendations

Bending the Cost Curve Continued research, analysis and updates to consider options for impactful changes to complex health care system	Create deep dive committee to serve in an ongoing advisory role to the Legislature and SEBC
Members of health plan have higher health risks associated with more frequent and costly use of services	• Conduct additional data analysis and benchmarking • Gain access to provider costs to access impact of pricing and rates on use and costs • Identify opportunities for incenting wellness/health prevention
Plan designs do not promote consumerism	• Investigate methods for promoting cost transparency • Consider options for plan designs that create financial incentives
Payments to Providers Little information is available on Delaware hospital payment methodology	Leverage size of health plan population to realize quicker adoption of changes (ie pay for performance, bundled pymts, provider incentives, metric based pricing, regulatory rate setting)
Benchmarking Data suggests health plan benefits are richer than average; plan participants contribute less	Pursue additional benchmarking using appropriate peer/comparison group; conduct in context of overall compensation of employee
Health Improvement Increasing risk burden/disease prevalence supports greater use and understanding of wellness and preventive tools and services	Explore pricing mechanisms that encourage participation in healthy behaviors (i.e. surcharges such as tobacco/wellness)

Recommendations for FY17

- Vote to adopt rate changes based on $33.3M General Fund allocation
- Vote on proposed plan option changes
  - ESI Over-the-Counter
  - ESI – Med B vs D coordination
  - ER/Urgent care steerage and copay change
  - High Tech Radiology Steerage and copay change
- Continue to discuss FY17 Dela*WELL* and member engagement strategy – April meeting