The State of Delaware

State Employee Benefits Committee (SEBC)
Strategic Framework Development Discussion

August 22, 2016

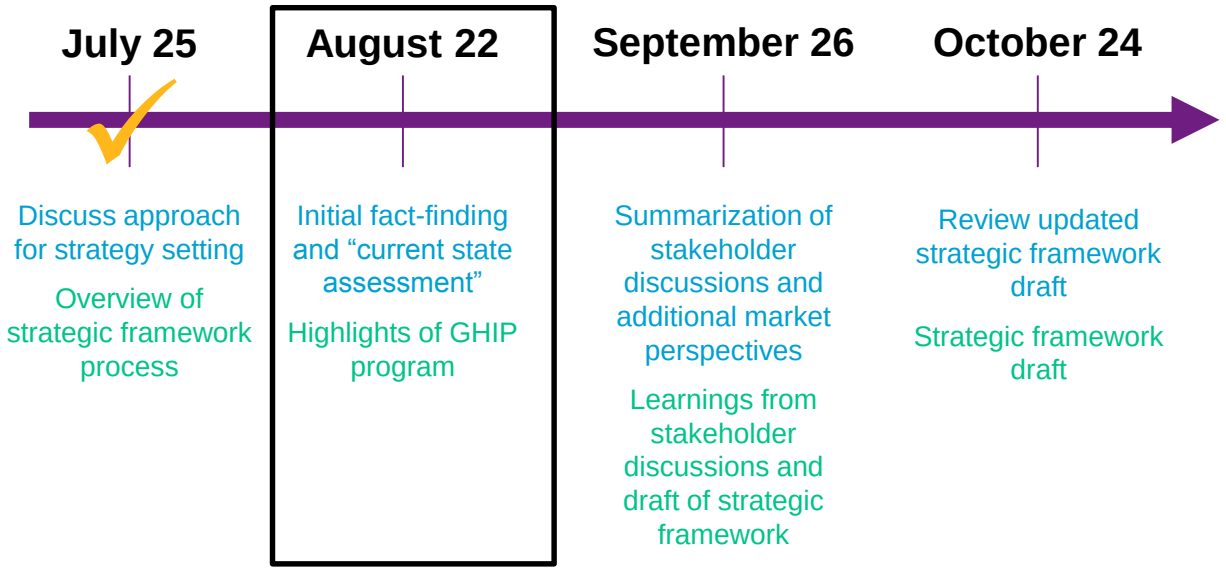
Willis Towers Watson

Today's discussion

- Revisiting plan for strategic development
- State of Delaware current state assessment
  - Demographic and plan highlights
  - Financial and utilization highlights
- Vision and future state

Revisiting project timeline

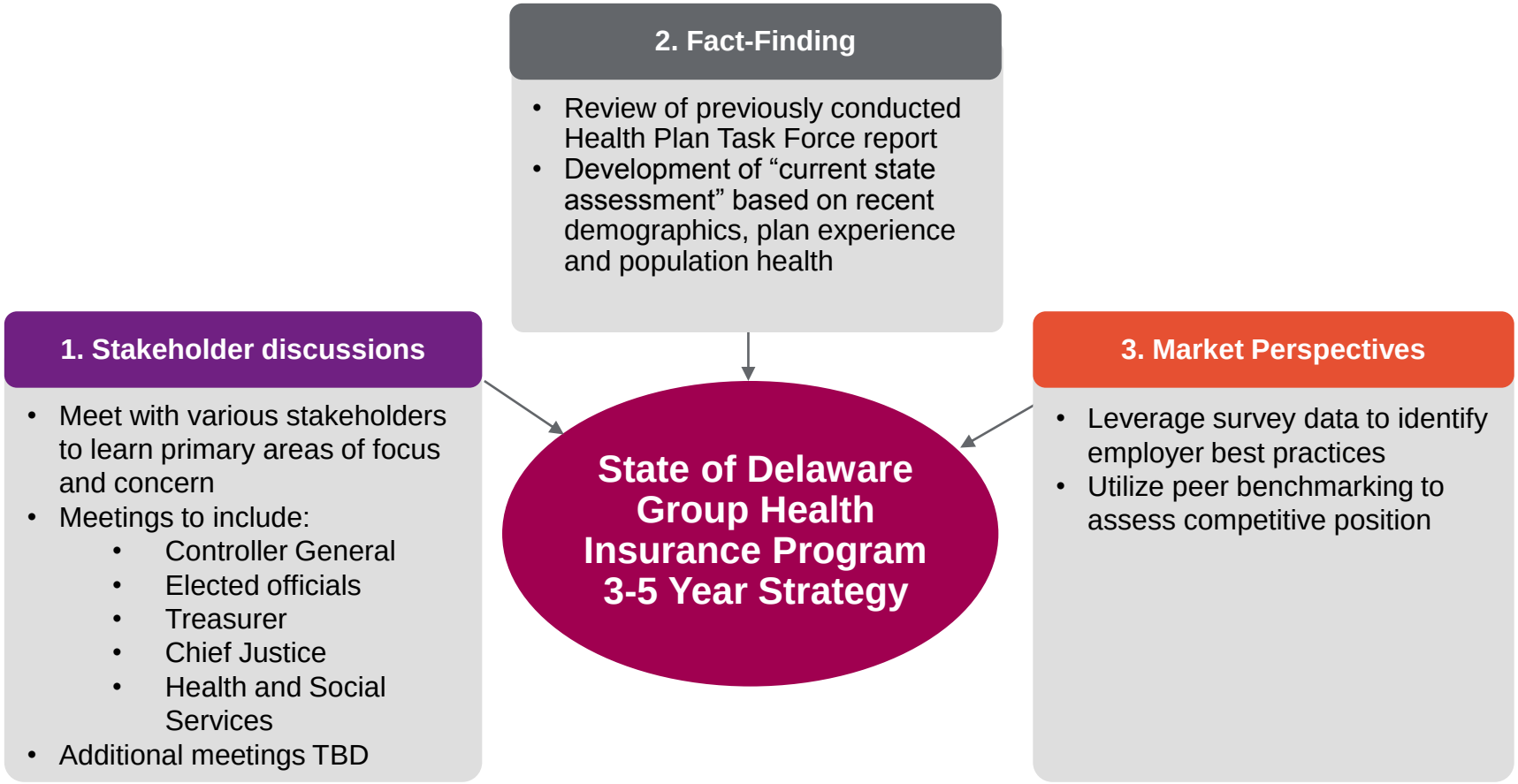
- The following timeline, aligned with upcoming SEBC meetings, outlines key objectives for the strategy development



Meeting Objective

Key Deliverable

Revisiting “primary inputs” for strategic development



Stakeholder discussions

Update

- Willis Towers Watson has met with several stakeholders of the GHIP to learn about their primary areas of focus and concerns
- Key themes from these conversations thus far:
  - More visible, transparent **financial stewardship** of the Health Fund
  - **Prioritization** of trend mitigation opportunities
  - Increased focus on **quality of care**
  - Concerns about **facility costs**
  - Interest in **opportunities to leverage** the State's large member population to achieve improved pricing terms on unit costs for services
- Additional discussions with other stakeholders will continue through August
- Complete findings will be presented at next SEBC meeting

Current State
Demographic and Plan Highlights

Key observations

Demographics and plan highlights

- The State of Delaware provides a fixed percentage subsidy for each plan (same percentage across plan tiers)
- Medical program subscribers are predominantly female
- The Comprehensive PPO and HMO plans have the highest enrollment
- 67% of Active and COBRA employees are over 40 years of age
- Only 36% of subscribers currently enrolled in employee only coverage
- 63% of the Post-65 retiree population are over 70 years of age
- Enrollees in the First State Basic and CDHP Gold plans are younger and more likely to have single coverage
- Enrollees in the Blue Select POS (limited to eligible employees of the Delaware Port Authority) are older, predominantly male, and more likely to have single coverage

Active and COBRA Only	Highmark First State Basic	Highmark and Aetna CDHP Gold	Highmark and Aetna HMO	Highmark Comprehensive PPO	Highmark BlueSelect POS	Total
Enrollment	974	1,822	14,818	19,535	267	37,416
Average Age	39.1	41.9	45.5	46.2	52.9	45.6
% Female	51%	60%	59%	63%	16%	61%
% Single Coverage	60%	47%	33%	35%	56%	36%
Plan Cost Share (EE / State)	4% / 96%	5% / 95%	7% / 93%	13% / 87%	0% / 100%	10% / 90%

Key observations

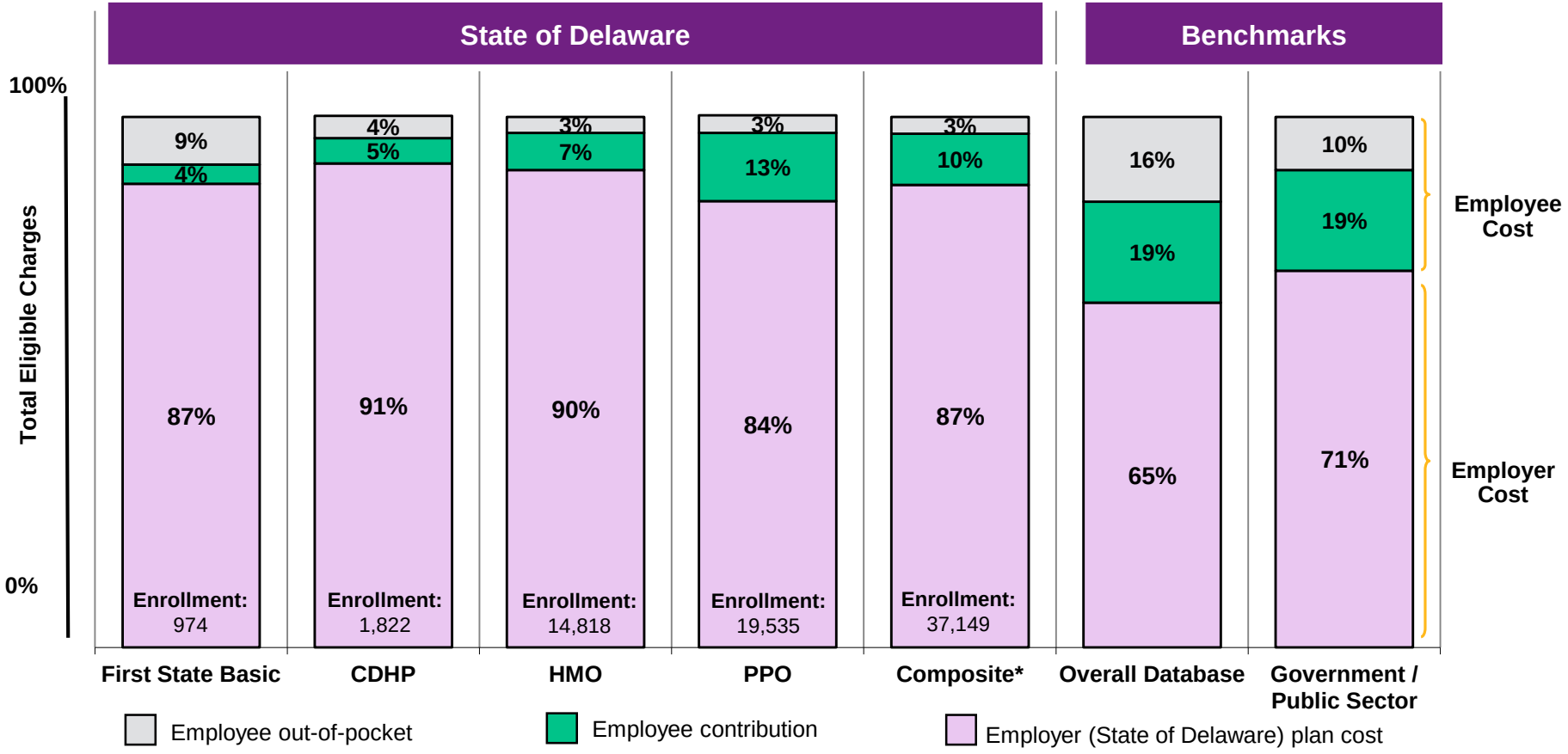
Demographics and plan highlights

- The State of Delaware medical program plan design is either comparable to or richer than the public sector and general industry benchmarking groups:
  - Highmark First State Basic PPO: Comparable to benchmark
  - Highmark/Aetna CDH Gold: Richer than benchmark
  - Highmark/Aetna HMO: Comparable to benchmark (but HMO plan type is less likely to be offered by either benchmark group)
  - Highmark Comprehensive PPO: Richer than benchmark
- The Rx benefit is richer than the peer groups for all plan types
- Broad wellness/health management program offerings, currently without any cash incentives:
  - Discounts on gym memberships, weight loss programs and healthy living products and services
  - Biometric screenings provided through an annual physical exam in addition to a wellness profile online survey that generates a health score
  - Aetna and Highmark employees receive separate, but comparable programs to access health coaches for weight-loss, tobacco cessation, chronic disease management, and pre-natal/pregnancy
  - Engagement and participation in wellness/health management programs are low. The Highmark wellness/health management program data shows significantly low participation among employees and spouses
  - Less than 5% engagement in virtually all programs, including wellness assessments, coaching and online programs
- Very limited evidence of decision support tools and resources to assist employees with medical plan selection at open enrollment and with using the plan and navigating the health care system following enrollment
  - The State's recent efforts to develop and launch a website dedicated to health care consumerism, along with future plans for employee training on this topic, is a positive step toward building out this infrastructure

Total cost share

Medical/Rx benchmarking for active medical plans

- The graph below illustrates how costs are shared with employees and considers both plan design (variable cost when services are used) and employee contributions (fixed cost)



Note: Benchmark plans based on average employers in the Willis Towers Watson 2016 Financial Benchmarking Survey
* Composite includes First State Basic, CDHP, HMO and PPO plans. It excludes 267 actives enrolled in the POS plan.

Current State
Financial and Utilization Highlights

Key observations

Financial and utilization highlights

Financial

- Medical and pharmacy claims per member increased by 2% in Fiscal Year 2016, following a 10% increase in Fiscal Year 2015
  - Average two-year active and non-Medicare trend was slightly below national average, while two-year Medicare retiree trend exceeded national average
  - Pharmacy trend has been running higher than medical trend
- The State ended Fiscal Year 2016 with operating expenses (i.e., claims and fees) totaling $11 million less than operating revenues (i.e., premium rates)
- The State is projected to pay $10.4 million excise tax in 2020, assuming 7% medical trend and no changes to current program designs

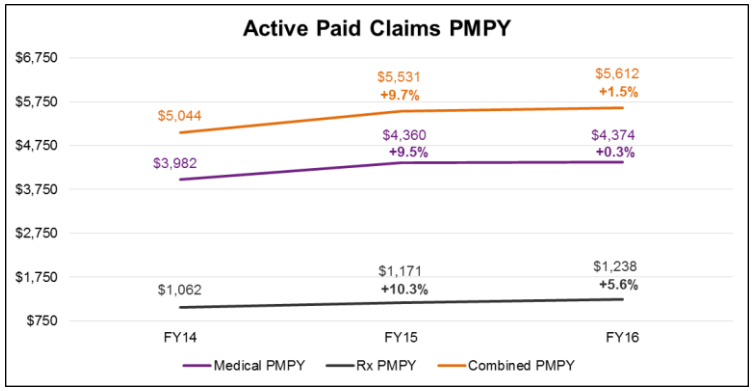
Utilization

- Inpatient hospital and emergency room utilization is higher than national average
- Generic dispensing rate ("GDR"), while continuing to increase, is lower than national average
- Specialty drug spend has increased significantly over two years and represents a significant driver of overall pharmacy trend

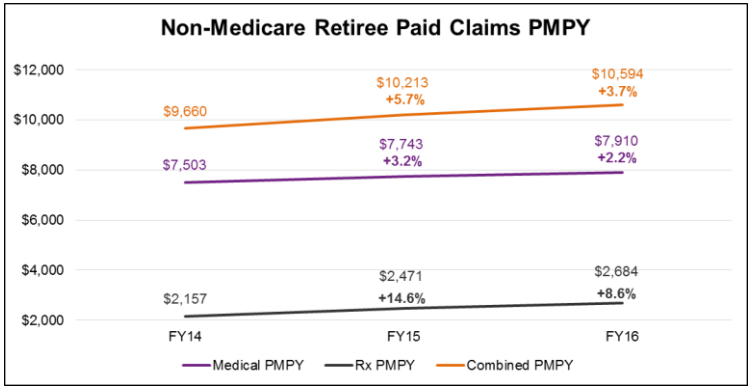
Benchmarking

- The State's active health care program is 1% more efficient than the average large employer *(based upon Willis Towers Watson's Financial Benchmarking Survey)*
- Overall, employee cost sharing is significantly less than the national average, both per paycheck contributions and out-of-pocket costs
- When comparing GHIP cost for the top 20 procedures and diagnoses in Delaware against Pennsylvania and Maryland, overall, Delaware services are more expensive

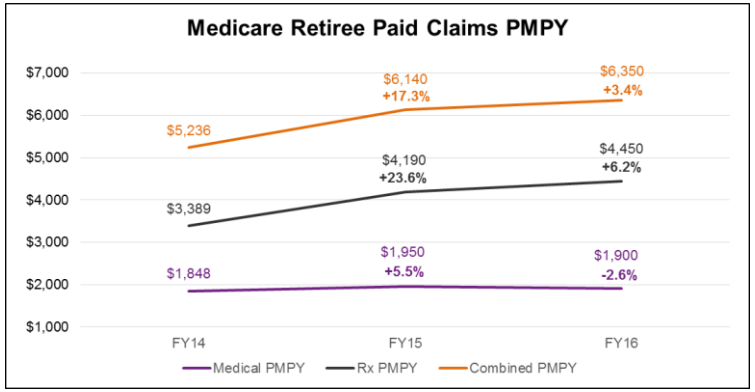
Financial review: paid claims per member per year



- Active medical/Rx claims per member increased by **5.5%** annually over the most recent 2 year period (FY14 to FY16) compared to **6.0%** national average



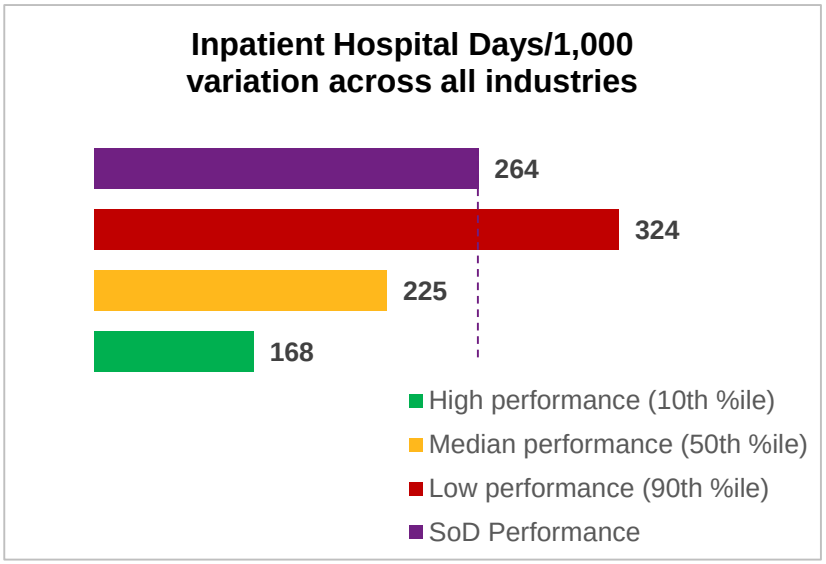
- Non-Medicare retiree medical/Rx claims per member increased by **4.7%** annually over the most recent 2 year period compared to **5.7%** national average

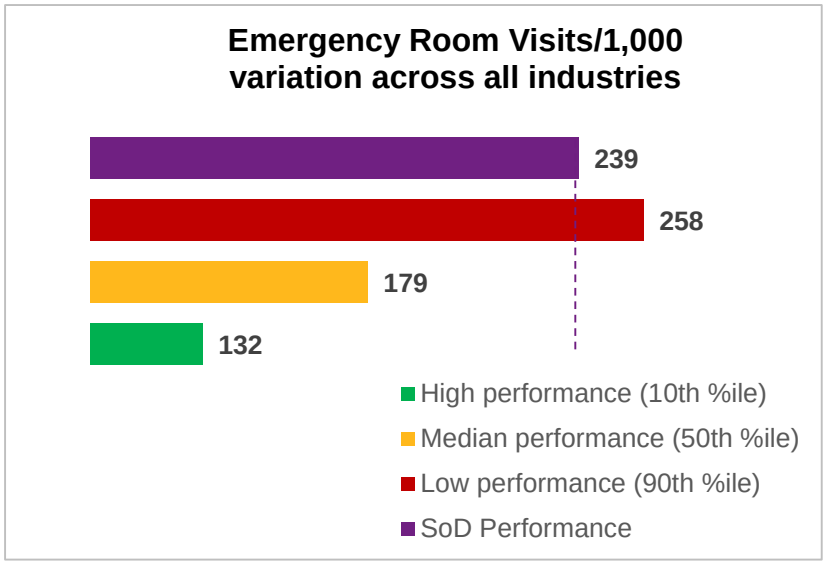


- Medicare retiree medical/Rx claims per member increased by **10.1%** annually over the most recent 2 year period compared to **3.3%** national average

Paid Claims Source: Truven paid claims data from July 2013 through June 2016; excludes Missing plan; pharmacy claims data does not reflect Rx rebates or EGWP payments
National average trend source: 2016 Willis Towers Watson Emerging Trends in Health Care Survey; average health care trends shown before plan changes

Medical program utilization: active/non-Medicare retiree

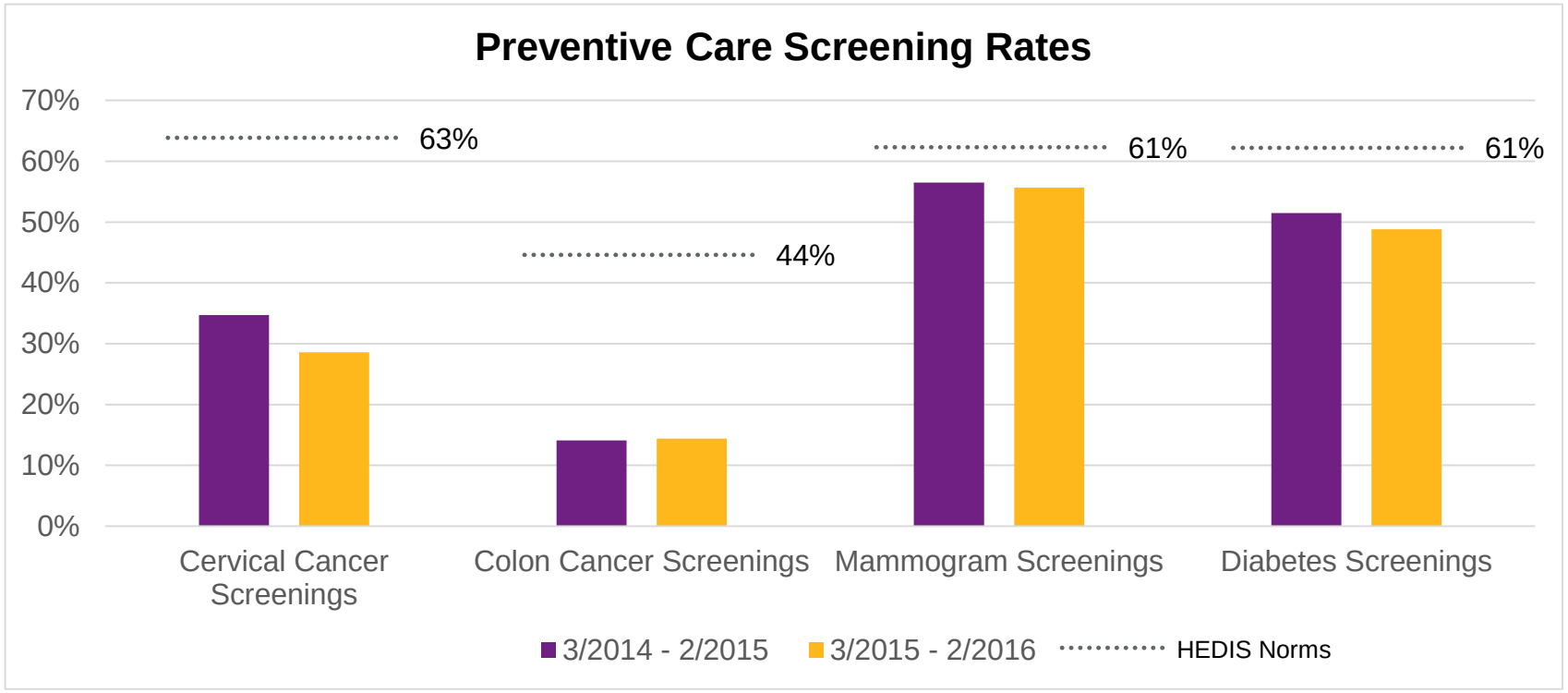




- The State's inpatient hospital and emergency room utilization falls between the 50th and 75th percentiles within the Willis Towers Watson database
  - May in part be driven by the inclusion of non-Medicare retirees in the State data
- Emergency room costs per visit increased by 10% in the most recent period
- Top clinical conditions include osteoarthritis/joint disease, gastrointestinal disorders, and spine/back disorders

Source: High-Performance Insights in Health Care: 2015 Towers Watson/NBGH Best Practices in Health Care Survey.
Utilization stats reflect Truven Active and Early Retiree dashboard Mar2015-Feb2016 data, presented on 6/23/2016; Inpatient hospital days reflect physician IP only; includes high cost claims

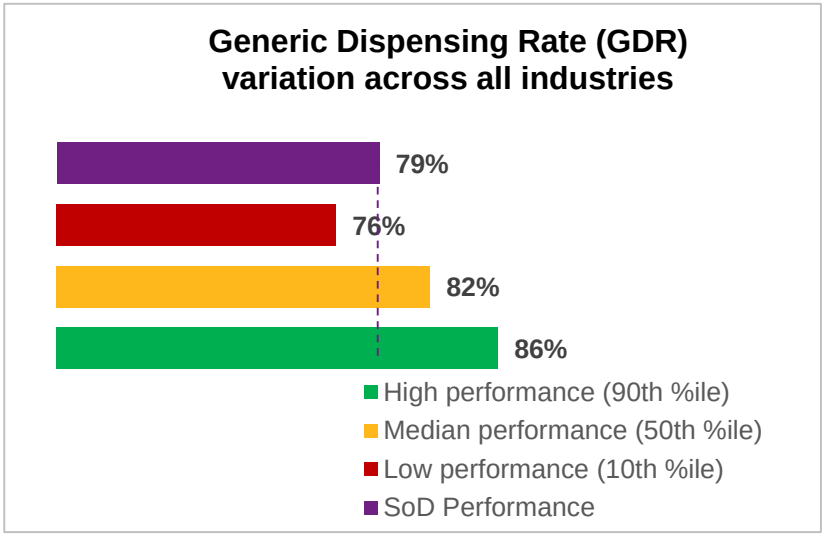
Preventive care compliance rates

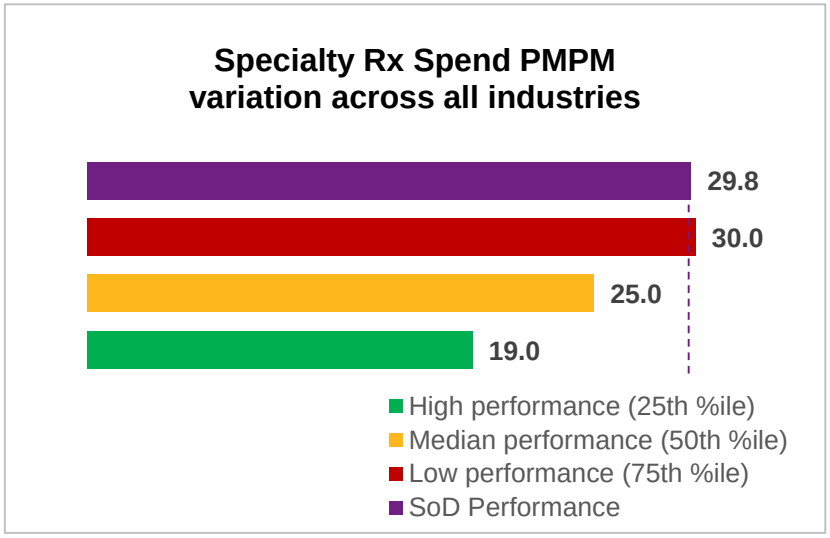


- The State's compliance rates with preventive care screenings fall below HEDIS norms

Utilization stats reflect Truven Active and Early Retiree dashboard Mar2015-Feb2016 data, presented on 6/23/2016
HEDIS Norms taken from "The State of Health Care Quality 2015," National Committee for Quality Assurance (NCQA)

Pharmacy program utilization: active/non-Medicare retirees



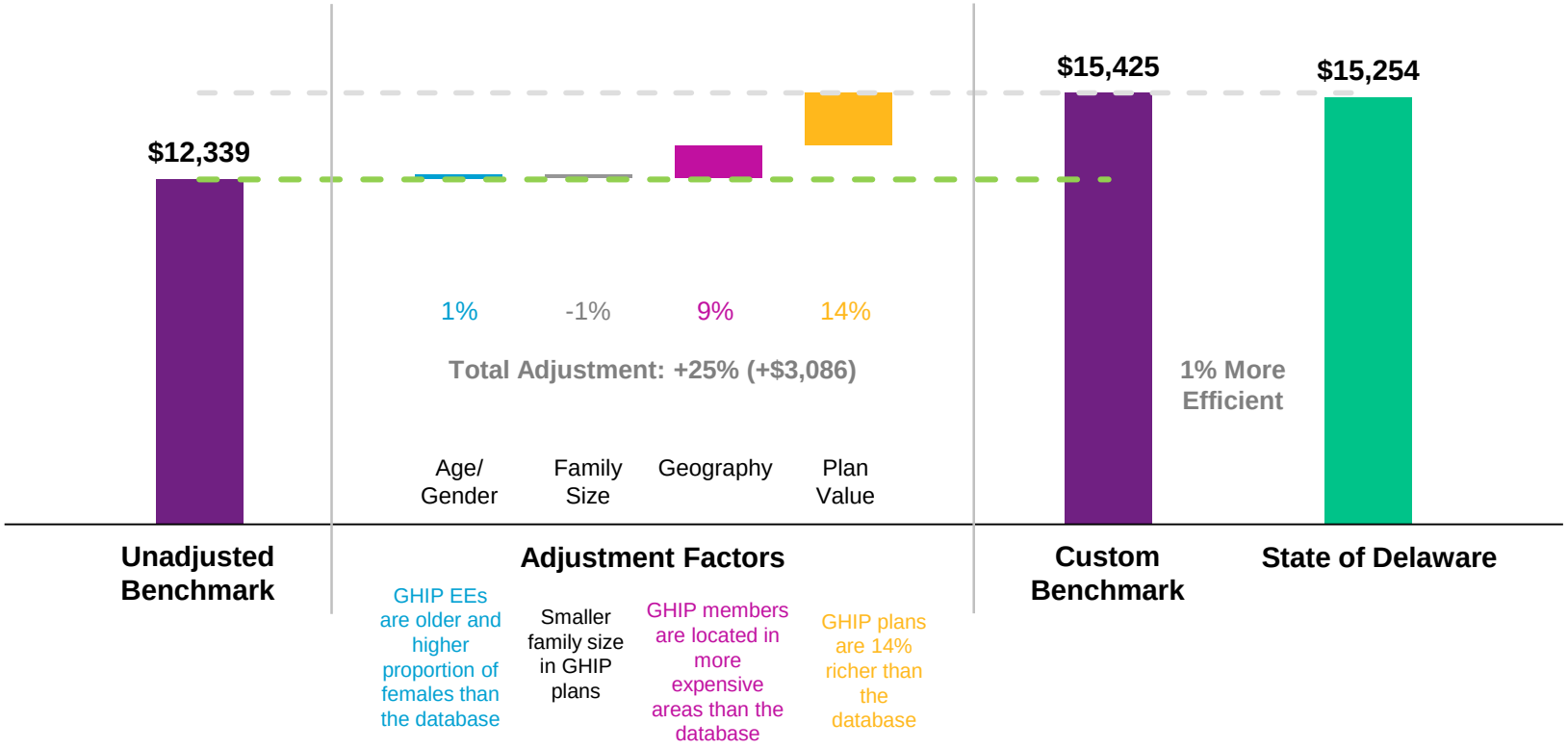


- The State's generic dispensing rate (GDR) has been steadily increasing over the most recent 2 year period, but the current GDR (79%) still falls below the database average
- Specialty drug spend per member per month is $29.80, close to the database 75th percentile
  - Specialty drugs represent 24.9% of the State's total drug spend, up from 22.3% in the prior period

Source: High-Performance Insights in Health Care: 2015 Towers Watson/NBGH Best Practices in Health Care Survey.
Utilization stats reflect Truven Active and Early Retiree dashboard Mar2015-Feb2016 data, presented on 6/23/2016

Medical cost benchmarking: program efficiency

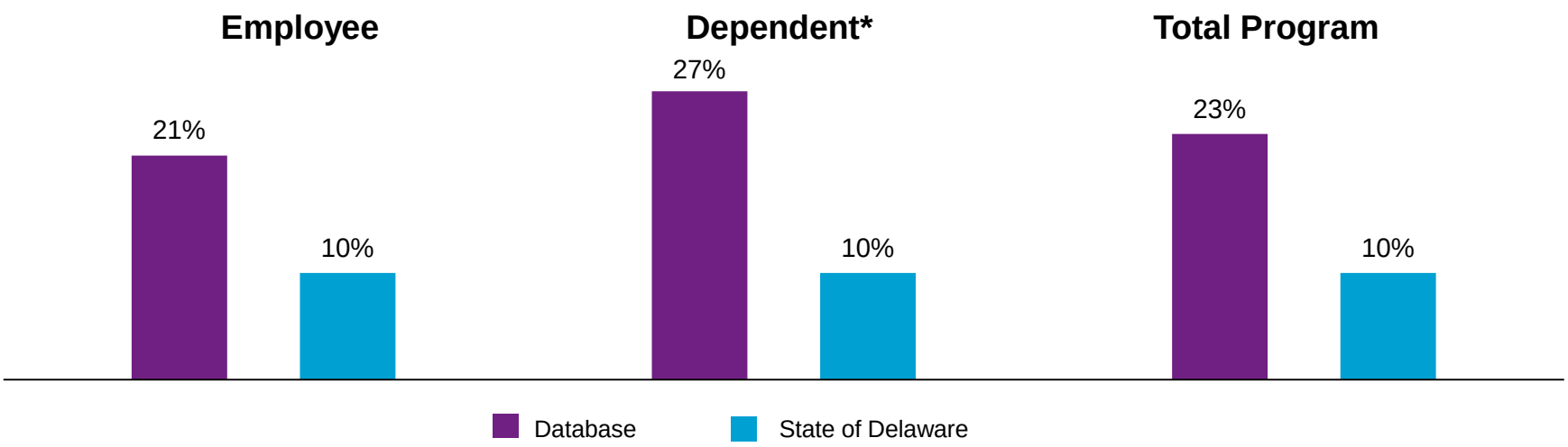
Program efficiency measures the performance of your total program after adjusting for the State's demographics and plan design. Key performance measures after adjustments are the effectiveness of your medical vendor and how employees utilize the plan.



Key Message

After adjusting for demographic and plan design differences, the State's total program is 1% more efficient than the average database performance.

Medical cost benchmarking: employee contributions as % of plan cost



Employee Contributions as a % of Total Cost	CDHP w/ HRA	PPO/POS	HMO/EPO
State of Delaware	5%	13%	7%
Database	24%	25%	24%

Key Message

The State's overall employee payroll contributions as a percentage of plan cost (10%) is significantly lower than the database average (23%). The State charges the same share of cost for employee only coverage and dependent coverage, while many employers have moved towards charging a greater share for dependents.

*Dependent includes spouse, children, family, etc.

Vision and Future State

Health Plan Task Force report

Summary of findings – ***current state***

- State Employees Health Plan Task Force report was completed in December, 2015
- Document articulated findings of report for GHIP's contemplation
- Findings, while relevant, did not place emphasis on prioritization

Implement tiered laboratory pricing

Benchmarking to understand previous findings, costs, and opportunities

Conduct audits of health plans and PBM

Incentivize member cost accountability

Use GHIP to negotiate changes and manage cost

Creation of advisory committee

Consider adoption of ELAP metric based pricing proposal

Implement ESI's proposed changes

Verify and compare benchmarking

Investigate pilot of high cost procedures or diagnostic tests

Increase member participation and engagement and reduce cost and risk

Research reduction in plan options and development of best in class programs

Research cost transparency promotion and financial incentives

Implement COE programs

Explore other incentives for chronic conditions, like surcharges

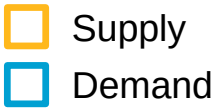
Summarization of findings from Section V of the Health Plan Task Force Report, dated December 15, 2015

Health Plan Task Force report

Summary of findings – ***organization of findings***

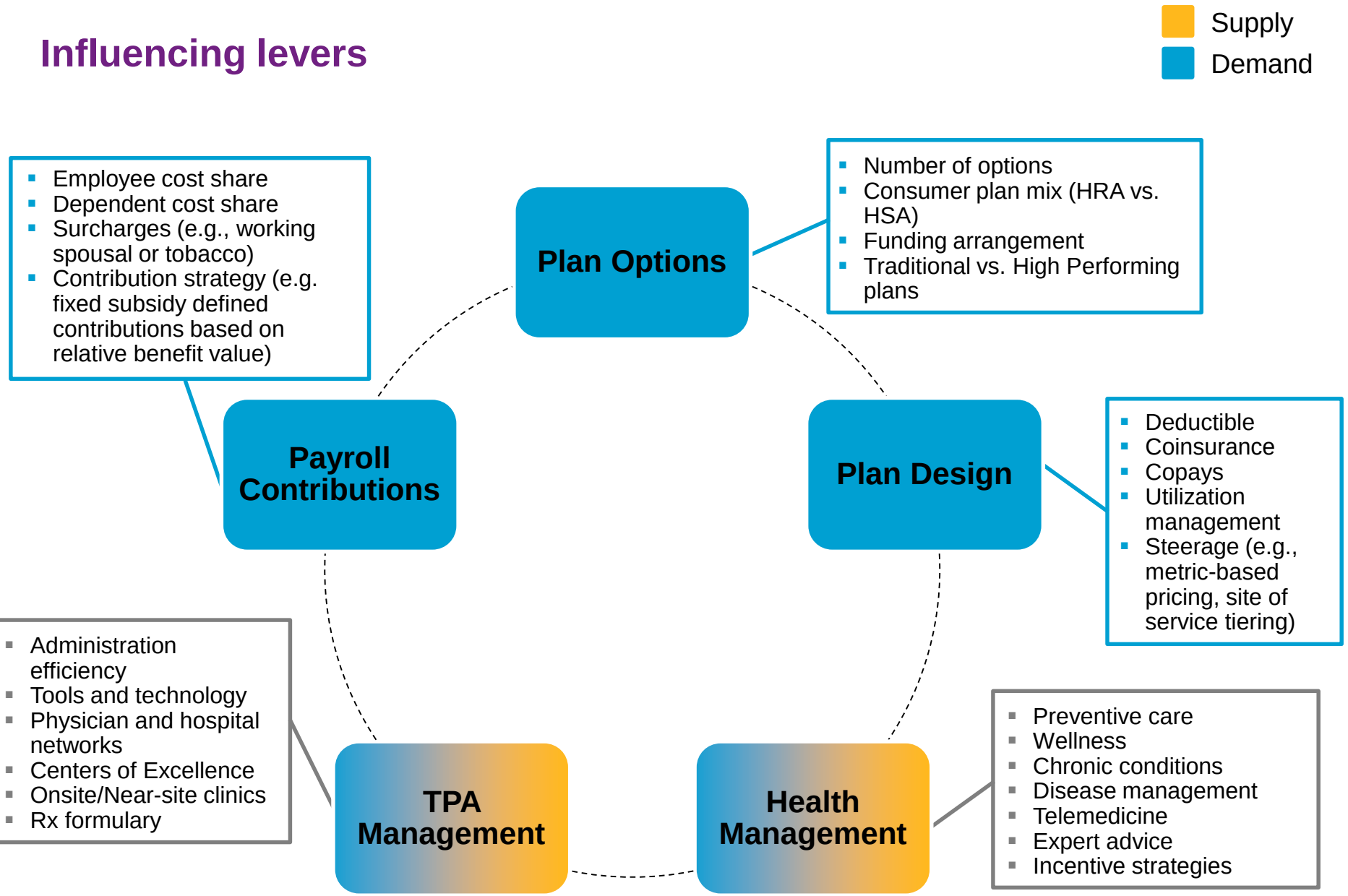
- The findings from the Health Plan Task Force report can be bucketed into two main categories: supply-related health care and demand-related health care
  - Supply-related health care: Focus on smarter production of care (i.e., network modifications, utilization of value-based care models, on-site clinics)
  - Demand-related health care: Focus on smarter consumption of care (i.e., use of consumer-driven plans, utilization of transparency tools, plan design diversity)
- Both of these categories should have the focal area changed from sickness-centric to wellness-centric

Supply	Demand
Use GHIP to negotiate changes and manage cost	Transparency and financial incentives
Implement Center-of-Excellence programs	Pilot of high cost procedures of diagnostic tests
Implement tiered laboratory pricing	Benchmarking
Metric-based pricing proposal	Incentivize member cost accountability
	Increase member participation and engagement and reduce cost and risk
	Validate number of plan offerings
	Health plan audits
	Implementation of special vendor programs



Summarization of findings from Section V of the Health Plan Task Force Report, dated December 15, 2015

Influencing levers



Illustrative vision of the future for the Group Health Insurance Program

Category	Current State	2020 – Moderate Modifications (Trend Mitigation of 1%/Year)	2020 – Bold Modifications (Trend Mitigation of 3%/Year)
Plan Options	4 Traditional Plan Options[1] - 2 PPO (63%) - 1 HMO (34%) - 1 CDHP (3%)	4 Traditional Plan Options - Broad Network PPO - Narrow Network PPO - HMO - CDHP	2 Traditional Plan Options - Broad Network PPO - CDHP 1 High Performance Plan Options - HMO/EPO with ACO
Plan Design	Flat dollar copays in highest enrolled plans	Coinsurance on specific plan offerings (high-tech imaging), COE steerage	Coinsurance on virtually all plan offerings. Steerage to high performing providers.
Health Management	Limited participation and low engagement in program without incentives	Moderate program participation with limited incentives (~$400/year). Broad communications encouraging utilization of tools and technology (i.e., transparency tools)	High program participation with robust incentives (~$800/year). Targeted communications directing utilization of tools and technology (i.e., decision support and transparency tools)
TPA Management	2 Medical vendors (Aetna and Highmark) with broad networks. 1 Prescription Drug vendor (ESI) with broad formulary.	Some differential among providers based on quality and efficiency, supported by limited plan design steerage. Broad formulary with some utilization management controls	Alignment with the highest performing providers with network limitations. Narrow prescription drug formulary encouraging generic usage.
Payroll Contributions	Payroll contributions ranging between 4% - 13% of plan cost	Greater contribution differentiation among plan options to align with plan value	Steerage to high-performing plans with low payroll contributions. Broad-based network options carrying substantial payroll contributions.
Projected 2020 Health Care Spend[2] *(FY2016 Spend = $800m)*	$1,050M (7% per annum from 2016 – 2020)	$1,000M (6% per annum from 2016 – 2020)	$930M (4% per annum from 2016 – 2020)
Excise Tax Exposure	$10.4M	$5.4M	$0.6M
Impact to Legislation	No changes to Delaware Code	May require changes to Delaware Code (i.e., payroll cost sharing)	Will require changes to Delaware Code (i.e., plan options offered, payroll cost sharing)

[1]5 total plans including Port Authority Plan. Port Authority Plan is currently a closed option
[2]Assumes 7% annual trend

Supply Demand

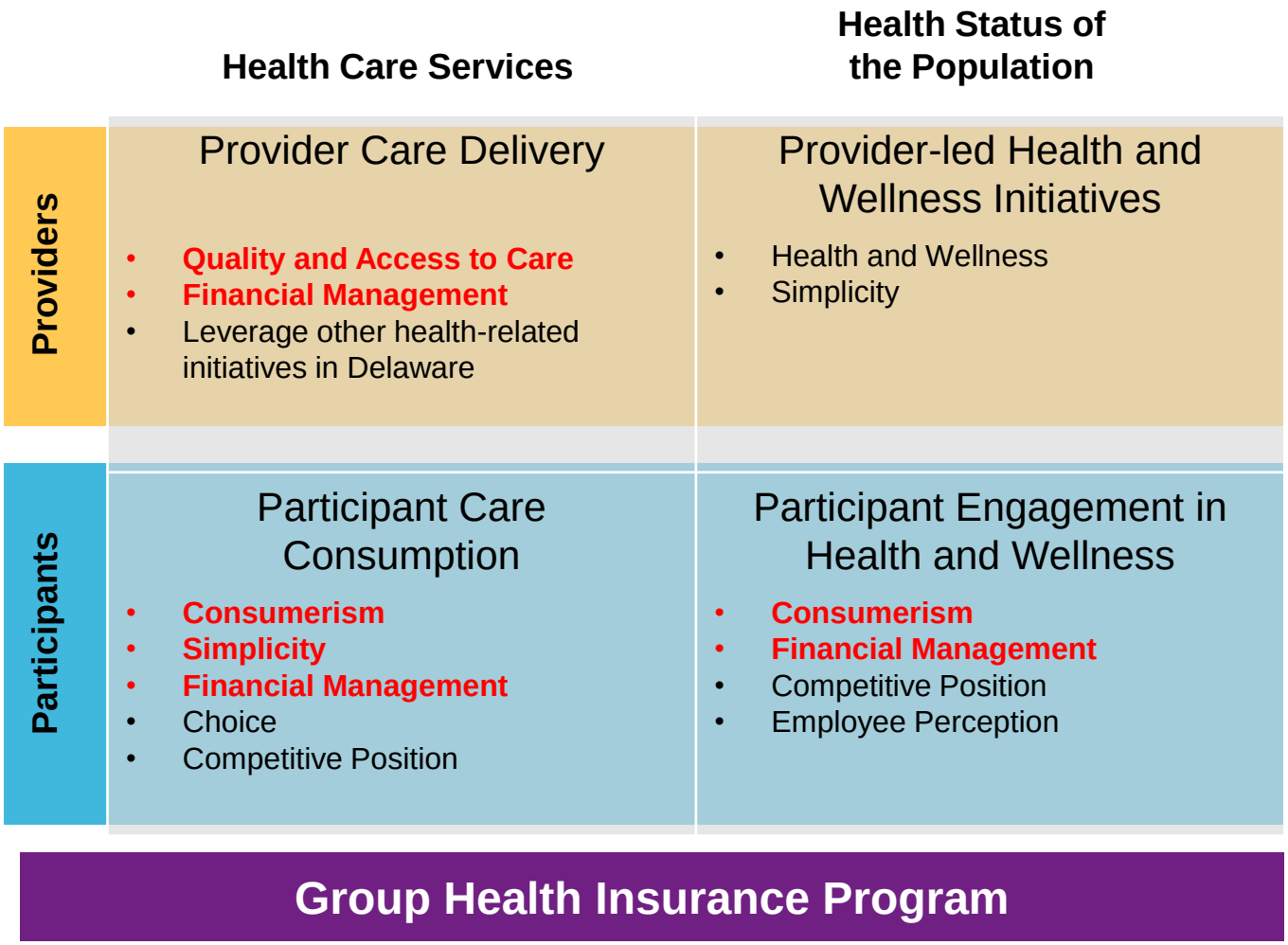
Benefit priority matrix

Reframing priorities in order to develop the GHIP's overarching mission

Attribute	Guiding Principle
Competitive Position	Implement changes to benefits that keep the value of the Total Rewards package at the competitive norm
Employee Perception	Focus on design and contribution strategies targeted to improve employee perception and understanding of the benefit program
Financial Management	Manage long-term program costs for the GHIP and plan participants while holding vendor partners accountable for maintaining their commitment to high performance and optimal service delivery
Choice	Offer employees choices that are meaningfully different in price and in value and meet the diverse needs of the GHIP participant population
Simplicity	Design and communicate the plan options so that they are easy for employees to understand and use, and are efficient to administer
Health and Wellness	Provide programs and incentives to support wellness and encourage GHIP participants' engagement in proactively managing their health
Consumerism	Empower employees using plan design, tools and resources, and communications to be thoughtful consumers of health care
Quality and Access to Care	Ensure the State is working with the appropriate TPA partner(s) that can provide the highest quality provider network with adequate access for GHIP participants

Framework for the health care marketplace

Key attributes and benefit objectives



Sample GHIP mission statements

For SEBC review and feedback

Provide State of Delaware employees and retirees with health care benefits that meet their needs and are affordable to plan participants and the State.

Offer State of Delaware employees and retirees access to care that produces high quality outcomes at an affordable cost.

Offer State of Delaware employees and retirees a benefits package that continues to allow the GHIP to remain solvent but does not shift the majority of cost increases to GHIP participants.

Offer State of Delaware employees and retirees access to high quality providers at an affordable cost while promoting individual accountability

Next steps

- Confirm GHIP mission statement
- Next strategic framework meeting aligns with SEBC meeting on September 26
  - Review draft strategic framework

Appendix

Assumptions and methodology

Demographic analysis

- Modeling based on Truven's July 2016 medical enrollee census with the following assumptions:
  - Excluded "~Missing" employee statuses and "~Missing" plan codes
  - For duplicate records, included the record indicated by Truven in supplemental file delivered on 8/5/16
  - Excluded Active Full Time and COBRA Continuee records under age 18 since they are dependents
  - Excluded one COBRA Continuee record enrolled in Medicfill plan
  - Excluded Early Retiree records under age 18 since they are dependents
  - Excluded Surviving Spouse/Dependent records under age 65, enrolled in Medicfill plan since they are dependents

Benchmarking analysis

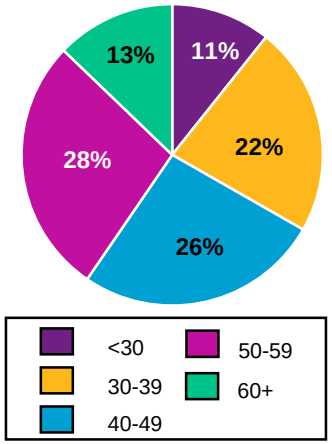
- Relative benefit values ("RBVs") using WTW proprietary tool, HealthMaps
  - Back-up data is as of 2013, and more recent than most publicly available actuarial plan value calculators, such as CMS' 2016 Actuarial Value Calculator
  - Plan designs modeled in WTW calculations were provided by the State through plan documents, SBC's, and FY17 open enrollment guides
  - CDH Gold HRA plan RBV shown throughout the document includes amounts funded in through the Health Reimbursement Account ($1,250 single / $2,500 family)
    - CDH Gold HRA plan value is 0.825 excluding HRA funding
- Modeling is based on final FY2016 plan offerings and budget rates/premiums
  - Budget rates provided in the State of Delaware – FY17 July 1 2016 PHRST Published Rates FINAL.xls document
- Modeling based on Truven's July 2016 medical enrollee census with the following assumptions:
  - Excluded "~Missing" employee statuses and "~Missing" plan codes
  - Excluded one COBRA Continuee record enrolled in Medicfill plan
  - Excluded Active Full Time and COBRA Continuee records under age 19 since they are dependents
  - Included only Active Full Time and COBRA Continuee records since this survey is intended to benchmark only the active population
  - Assumed the provided Age in Years was the age of that person on his/her birthday during 2016

Demographic review

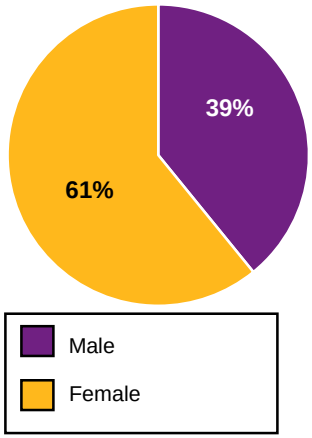
Active and COBRA — 37,416 employees

Age

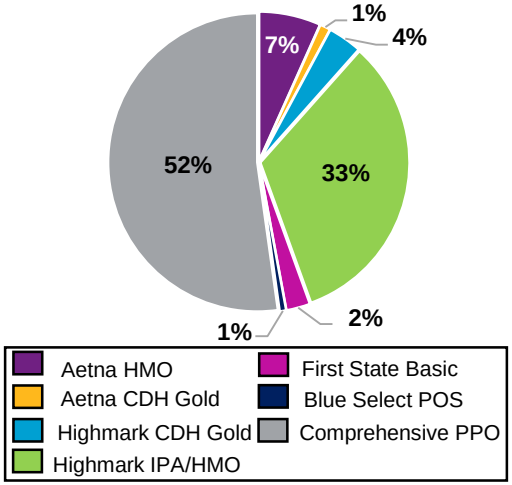
Avg = 45.6



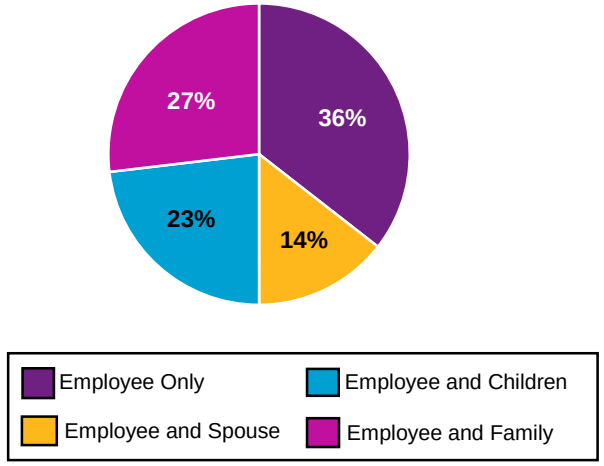
Gender



Medical Plan Without Waiver



Coverage Level



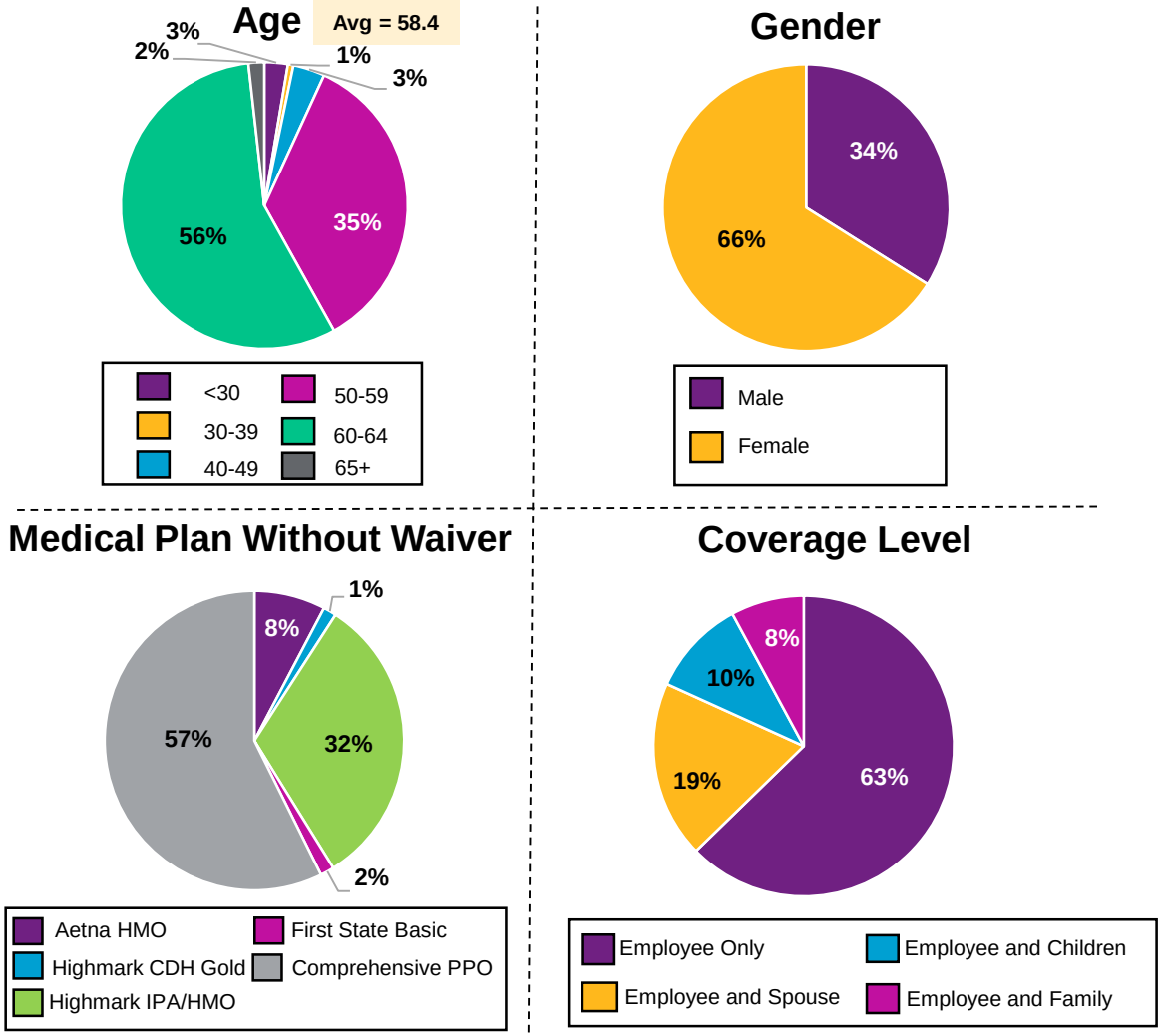
Observations

- 67% of the Active and COBRA population are over 40 years of age skewing the average age to ~46
- This segment has 61% female enrollment
- The highest enrolled plan is the Comprehensive PPO at 52%, followed by the HMO plan at 40%
- 64% of employees elected spouse/dependent coverage levels

Source: Truven July 2016 census data; includes unique record for duplicate pair as indicated by Truven; excludes active and COBRA participants 18 years of age and younger; excludes one COBRA participant enrolled in Medicfill

Demographic review

Non-Medicare — 5,855 retirees



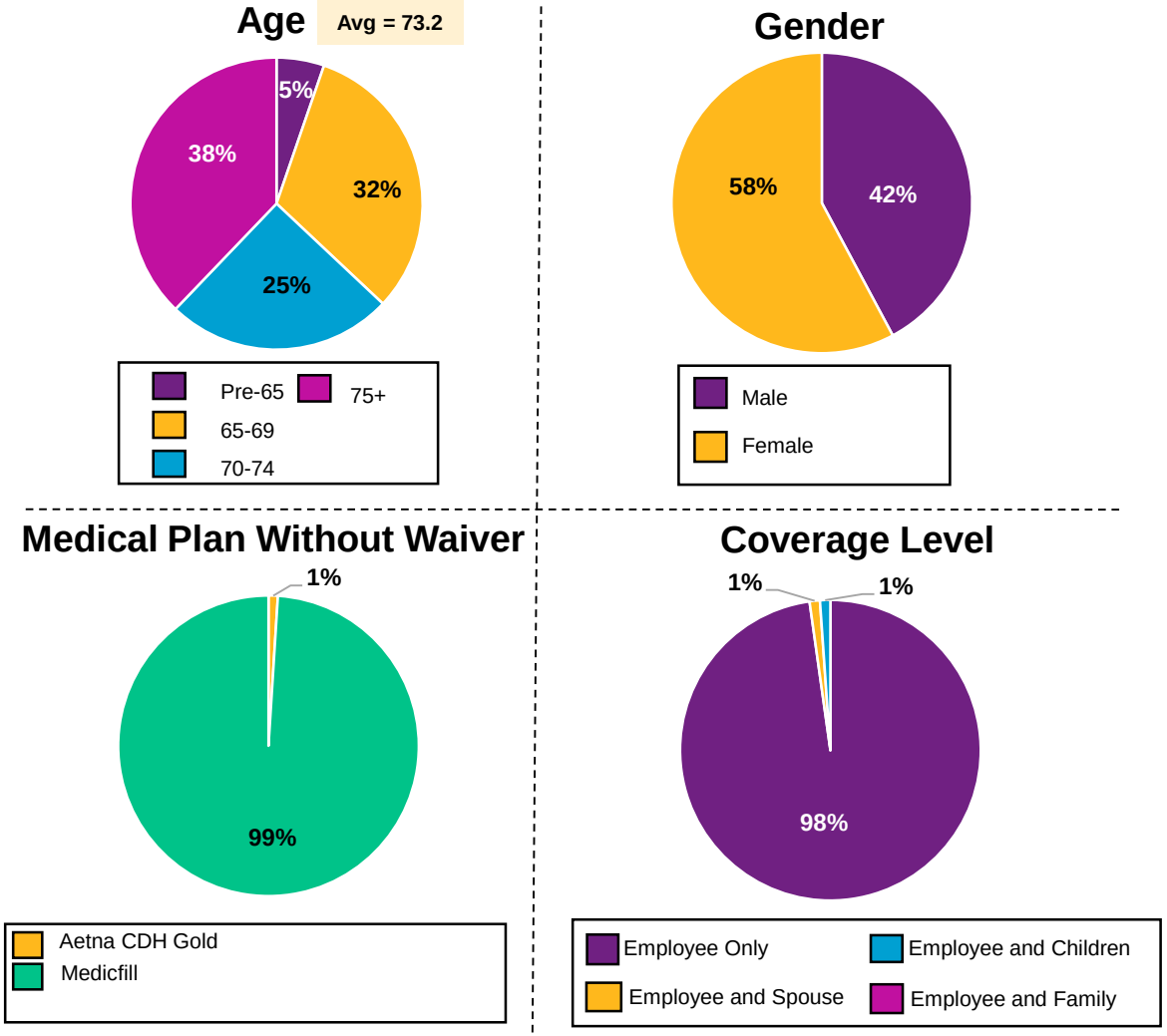
Observations

- 93% of the pre-65 population are older than 50
- Pre-65 retirees shown include 2% post-65 enrollees waiting to enroll in Medicare
- This segment has 66% female enrollment
- The highest enrolled plan is the Comprehensive PPO at 57%, followed by the HMO plan at 40%
- 37% of enrollees have chosen spouse/dependent coverage

Source: Truven July 2016 census data; includes unique record for duplicate pair as indicated by Truven; excludes NME retirees 18 years of age and younger; includes 104 NME over age 65, average age of population excluding post-65 retirees is 58.2

Demographic review

Medicare — 22,541 retirees



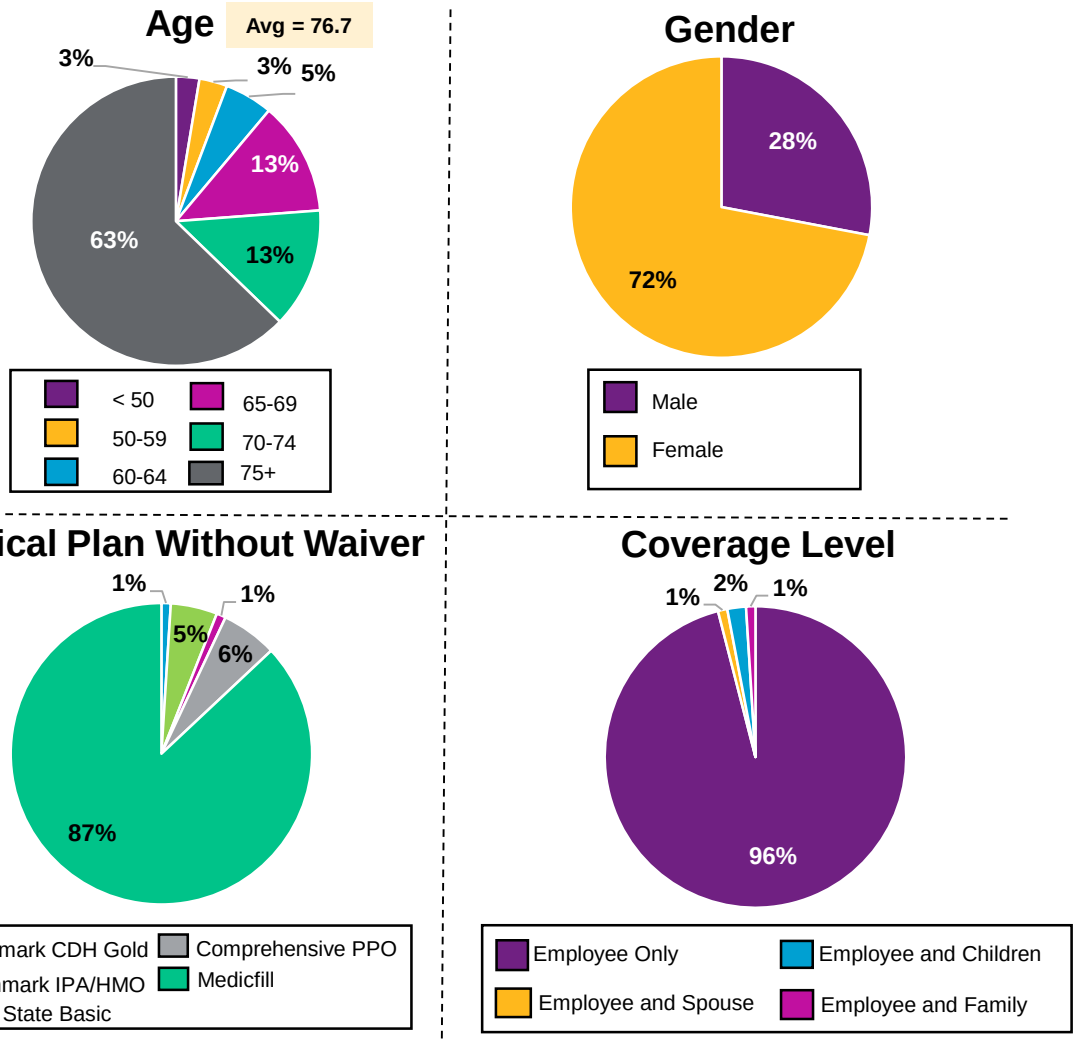
Observations

- 63% of the post-65 population are over 70 years of age
- The 5% shown under age 65 are non-Medicare eligible dependents enrolled in a separate plan
- This segment has 58% female enrollment
- Post-65 retiree medical plan election and coverage level shown include non-Medicare eligible dependent elections

Source: Truven July 2016 census data; includes unique record for duplicate pair as indicated by Truven; includes 1,189 ME retirees younger than 65, average age excluding pre-65 retirees is 74.2; includes 29 records enrolled in Aetna CDHP, average age excluding Aetna CDHP enrollees is 73.3

Demographic review

Surviving Spouses/dependents — 2,176 enrolled



Observations

- 89% of spouses/dependents are over 65 years of age
- The surviving spouse/dependent segment has 72% female enrollment
- 11% of the surviving spouse/dependents shown are non-Medicare eligible
- 2% of those enrolled in non-Medicfill plans are Medicare eligible

Source: Truven July 2016 census data; includes unique records for duplicate pair as indicated by Truven; excludes surviving spouses under age 65 and enrolled in Medicfill; includes surviving spouse over age 65 enrolled in a non-Medicfill plan.

Medical/Rx program design and contributions

Comprehensive and First State Basic Plans (PPO Options)

Plan Design (In-network)	Comprehensive	First State Basic	Peer Group	
			Public Sector and Education	General Industry
Vendor	Highmark	Highmark		
Enrollment[1]	23,032	1,074		
Plan Type	PPO		PPO	
Individual Deductible	None	$500	$280	$460
Family Deductible	None	$1,000	$620	$710
Coinsurance	100%	90%	100%	80%
Individual Out-of-Pocket Maximum	$4,500	$2,000	$2,500	$2,370
Family Out-of-Pocket Maximum	$9,000	$4,000	$3,750	$3,430
Primary Care Physician Office Visit	$20 copay	90%	$25	$20
Specialist Office Visit	$30 copay	90%	$35	$30
Emergency Room	$150 copay[2]	90%	$100	$90
Inpatient Care	$100 copay/day[3]	90%	90%	80%
Prescription Drug[4]				
Out-of-Pocket Maximum (Ind./Fam.)	$2,100 / $4,200		-	-
▪ Retail Generic	$8		$10	$10
▪ Retail Brand Formulary	$28		$30	$30
▪ Retail Brand Non-Formulary	$50		$70	$50
▪ Mail Order Generic	$16		$30	$20
▪ Mail Order Brand Formulary	$56		$70	$60
▪ Mail Order Brand Non-Formulary	$100		$150	$100
Relative Benefit Value (RBV)	**0.97**	**0.91**	**0.91**	**0.89**
Employee Contributions (Monthly)				
▪ Employee Only	$105.18	$27.84	$110	$120
▪ Employee & Spouse	$218.26	$57.52	-	-
▪ Employee & Child(ren)	$162.08	$42.26	-	-
▪ Family	$272.86	$71.92	$440	$350

Source: Willis Towers Watson BDS database
1. Enrollment based on July 2016 census provided by the State of Delaware
2. Waived if admitted
3. $200 maximum per admission
4. Retail 30 day supply; mail order 90 day supply

Medical/Rx program design and contributions

Highmark IPA and Aetna HMO Plans (HMOs)

Plan Design (In-network)	Highmark IPA[1]	Aetna HMO	Peer Group	
			Public Sector and Education	General Industry
Vendor	Highmark	Aetna		
Enrollment[2]	14,286	2,957		
Plan Type	HMO		HMO/EPO	
Individual Deductible	None		None	None
Family Deductible	None		None	None
Coinsurance	100%		100%	100%
Individual Out-of-Pocket Maximum	$4,500		$1,500	$1,800
Family Out-of-Pocket Maximum	$9,000		$3,500	$3,360
Primary Care Physician Office Visit	$15 copay		$20	$20
Specialist Office Visit	$25 copay		$20	$30
Emergency Room	$150 copay[3]		$80	$90
Inpatient Care	$100 copay/day[4]		100%, with co-pay	100%, with co-pay
Prescription Drug[5]				
Out-of-Pocket Maximum (Ind./Fam.)	$2,100 / $4,200		-	-
▪ Retail Generic	$8		$10	$10
▪ Retail Brand Formulary	$28		$30	$30
▪ Retail Brand Non-Formulary	$50		$60	$50
▪ Mail Order Generic	$16		$15	$20
▪ Mail Order Brand Formulary	$56		$70	$60
▪ Mail Order Brand Non-Formulary	$100		$130	$100
Relative Benefit Value (RBV)	**0.97**		**0.98**	**0.97**
Employee Contributions (Monthly)				
▪ Employee Only	$47.18	$47.16	$70	$120
▪ Employee & Spouse	$99.80	$99.50	-	-
▪ Employee & Child(ren)	$72.26	$72.18	-	-
▪ Family	$124.52	$124.12	$200	$340

Source: Willis Towers Watson BDS database
1. IPA - Independent Practice Association
2. Enrollment based on July 2016 census provided by the State of Delaware
3. Waived if admitted
4. $200 maximum per admission
5. Retail 30 day supply; mail order 90 day supply

Medical/Rx program design and contributions

Consumer-Driven Health Plans

Plan Design (In-network)	CDH Gold	CDH Gold	Peer Group	
			Public Sector and Education	General Industry
Vendor	Highmark	Aetna		
Enrollment[1]	1,475	461		
Plan Type	PPO with HRA		Account Based Health Plan	
Individual HRA Seed	$1,250		None	None
Family HRA Seed	$2,500		None	None
Individual Deductible	$1,500		$1,550	$1,720
Family Deductible	$3,000		$3,100	$3,610
Coinsurance	90%		90%	80%
Individual Out-of-Pocket Maximum	$4,500		$3,500	$3,250
Family Out-of-Pocket Maximum	$9,000		$7,000	$6,240
Primary Care Physician Office Visit	90%		90%	80%
Specialist Office Visit	90%		90%	80%
Emergency Room	90%		90%	80%
Inpatient Care	90%		90%	80%
Prescription Drug[2]				
Out-of-Pocket Maximum (Ind./Fam.)	$2,100 / $4,200		-	-
▪ Retail Generic	$8		$10	$10
▪ Retail Brand Formulary	$28		$40	$30
▪ Retail Brand Non-Formulary	$50		$70	$55
▪ Mail Order Generic	$16		$25	$20
▪ Mail Order Brand Formulary	$56		$90	$70
▪ Mail Order Brand Non-Formulary	$100		$170	$120
Relative Benefit Value (RBV)[3]	**0.96**		**0.84**	**0.82**
Employee Contributions (Monthly)				
▪ Employee Only	$35.98		$10	$80
▪ Employee & Spouse	$74.58		-	-
▪ Employee & Child(ren)	$54.96		-	-
▪ Family	$94.78		$30	$260

Source: Willis Towers Watson BDS database
1. Enrollment based on July 2016 census provided by the State of Delaware
2.Retail 30 day supply; mail order 90 day supply
3. RBV estimate includes HRA seed (seed dollars are $1,250 Individual/$2,500 Family)

Medical/Rx program design and contributions

BlueSelect Plan (POS)

Plan Design (In-network)	BlueSelect	Peer Group	
		Public Sector and Education	General Industry
Vendor	Highmark		
Enrollment[1]	267		
Plan Type	POS	POS	
Individual Deductible	None	$500	$250
Family Deductible	None	$1,500	$630
Coinsurance	90%	90%	80%
Individual Out-of-Pocket Maximum	$500	$3,000	$2,400
Family Out-of-Pocket Maximum	$1,500	$9,000	$3,330
Primary Care Physician Office Visit	$10	$30	$20
Specialist Office Visit	90%	$45	$30
Emergency Room	$50[2]	$350	$170
Inpatient Care	90%	90%, with co-pay	80%, with no co-pay
Prescription Drug[3]			
Out-of-Pocket Maximum (Ind./Fam.)	$2,100 / $4,200	-	-
▪ Retail Generic	$8	$10	$10
▪ Retail Brand Formulary	$28	$35	$30
▪ Retail Brand Non-Formulary	$50	$90	$50
▪ Mail Order Generic	$16	$20	$20
▪ Mail Order Brand Formulary	$56	$70	$65
▪ Mail Order Brand Non-Formulary	$100	$185	$110
Relative Benefit Value (RBV)	**0.96**	**0.88**	**0.89**
Employee Contributions (Monthly)[4]			
▪ Employee Only	$0.00	$160	$130
▪ Employee & Spouse	$0.00	-	-
▪ Employee & Child(ren)	$0.00	-	-
▪ Family	$0.00	$410	$440

Source: Willis Towers Watson BDS database

1. Enrollment based on July 2016 census provided by the State of Delaware

2. Waived if admitted

3. Retail 30 day supply; mail order 90 day supply

4. For the State, non-contributory to full time employees (all tiers); non-contributory to part-time employees enrolled in employee only tier, if enrolled in any other tier the employee pays for the difference

Wellness and health management program

Fiscal Year 2017[1]

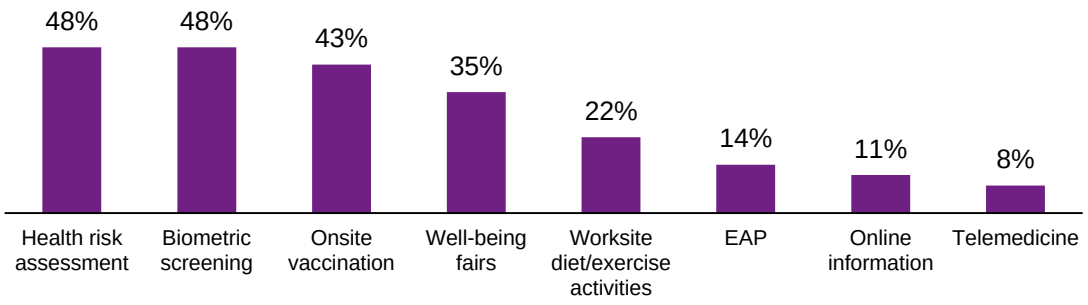
	Highmark DelaWell	Aetna Health Connections
Incentives	▪ Blue 365 Discount Program: ○ Gym memberships, weight loss programs, massage therapy and healthcare products and services	▪ Aetna discount program: ○ Gym membership, eyeglasses and contacts, weight-loss programs, chiropractic and more
	▪ No cash incentives for employees in the 2016-2017 program ▪ GlobalFit discounts: ○ Gym memberships, membership freeze for up 2 months per year and gym access nationwide for travelers	
Screening	▪ Two step program for Highmark and Aetna members: 1. Annual physical exam for biometric screening 2. Wellness profile online survey provides a health score based on biometric inputs, a plan of action and program recommendations	
Coaching	▪ Blue On Call Health Coaches (available 24/7) ○ Weight-loss, tobacco cessation and stress management ○ Diabetes, heart disease and other disease management ○ Information and support at no cost ▪ Baby Blue Prints Program ○ For expecting mothers and women planning to become pregnant	▪ Healthy Lifestyle Coaching ○ Coach assigned upon enrollment ○ Coaching for more than 35 diseases ○ Enrollee sets own goals ▪ Aetna's Beginning Right maternity program ○ For expecting mothers and women planning to become pregnant
Technology and Resources	▪ Website and mobile app resources: ○ My Health Assistants: Support with diet, tobacco, stress and exercise ○ Health trackers: Tracks progress based on biometric data ○ Health information: Health articles, e-newsletters, etc. ○ Symptom checker: Symptom research and guidance to determine need for medical attention ○ Get Up and Do Something: Motivational and educational site with Facebook page ▪ Phone coaching sessions and support	▪ Website and mobile app resources: ○ Aetna secure member site ▪ Phone coaching sessions and support ○ Informed health line with 24/7 access to registered nurses ▪ Email ▪ Group coaching
Initiatives	▪ Running 101 Training Program: Free 10-week physical activity program, online tools and support to train for a 5K race. (Open to Highmark members and non-members alike. Registration through September 30,2016) ▪ Governor's cup 5K run/walk: Available to State of Delaware employees and pensioners (excludes spouses and dependents) ▪ Motivate The First State: Online activity tracker with point accumulation or "kudos" that turn into cash donations for charity	

1. State of Delaware 2016 Open Enrollment guide and benefits site: *ben.omb.delaware.gov*

Incentive participation benchmarking

State of Delaware Results[1]	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
Incentive Dollars eligible	$75	$100	None	$100 / $200	$100 / $200	$100 / $200	$100 / $200	**$100 / $200**
Online Wellness Assessment	21%	14%	3%	8%	7%	9%	8%	**6%**
Onsite Health Screenings	N/A	13%	N/A	6%	6%	7%	6%	**5%**
Health Coaching	6%	7%	2%	3%	2%	3%	3%	**4%**
Disease Management	N/A	N/A	N/A	4%	2%	2%	2%	**3%**

Incentive participation benchmarking (average participation rates)[2]



Key Incentive Benchmarks	State of Delaware	Overall Database[2]
Average Incentive Dollar Opportunity	$100 - $200	$880
Overall Participation (FY15)	3% – 6% depending on activity	50%

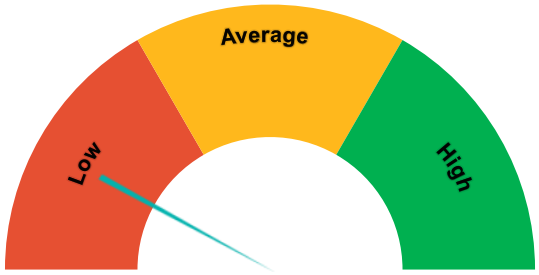
[1] State of Delaware results provided in State Benefits Office DelaWELL Health Management planning meeting; FY15 disease management statistics are still preliminary
[2] Overall database benchmarks provided by Willis Towers Watson/NBGH Best Practices in Health Care Employer Survey

Highmark wellness and health management program participation

FY16 results

Contracts	40,061[1]
Employees and Spouses	56,076
Children	34,342
Total Members	90,418

Summary of FY16 Participation



State of Delaware Results[2]	**FY16 Program**		
Incentive Dollars	No cash incentives		
Activity Type	**Activity volume (phone calls or website hits)**	**# Members Engaged**	**Participation Rates for Employees and Spouses**
Member Outreach (via phone)	12,802	3,820	6.8%
Health Coaching[3]	N/A	3,759	4%
Online Programs	205	122	< 1%
Personal Health Record	2,358	248	< 1%
Wellness Coaching[3]	275	273	< 1%
Wellness Profile	219	199	< 1%

- On average, a member received 2.7 interventions and an engaged member received 5.7 interventions
  - Intervention types: Target mailings (most commonly used), health coaches and automated phone calls
- 55% of those contacted could not be reached (16% provided invalid numbers + 84% did not return the call)
- From the target population, members with diabetes, hypertension and asthma were the least engaged

1. Active employees only
2. Based on data provided by Highmark FY2016 Quarterly Operations Dashboard
3. Not mutually exclusive

Fiscal Year 2016 fund equity balance summary

- While the last month of FY 2016 produced a net loss for the health care budget, overall FY 2016 ended with operating expenses totaling $11 million less than operating revenues and a cumulative fund equity balance of $39 million

	June-16	FY16
FUND EQUITY - BALANCE FORWARD	**$ 40,353,993.72**	**$ 27,722,833.99**
OPERATING REVENUES		
Premium Contributions	$ 62,683,314.40	$ 738,343,084.93
Other Revenues	$ 13,723,360.41	$ 69,128,461.78
TOTAL OPERATING REVENUES	**$ 76,406,674.81**	**$ 807,471,546.71**
OPERATING EXPENSES		
Claims	$ (74,934,173.89)	$ (756,651,804.15)
Program Fees and Costs	$ (2,722,702.92)	$ (37,053,173.62)
Office Operational Costs	$ (177,855.43)	$ (2,563,466.64)
TOTAL OPERATING EXPENSES	**$ (77,834,732.24)**	**$ (796,268,444.41)**
NET INCOME/(LOSS)	**$ (1,428,057.43)**	**$ 11,203,102.30**
FUND EQUITY BALANCE	**$ 38,925,936.29**	**$ 38,925,936.29**
PROJECTED FUND EQUITY BALANCE - 06/30/2016		**$ 38,925,936.29**

Source: June 2016 Monthly Fund Equity Report provided by State of Delaware

Excise tax: overview

- ACA excise tax on high cost plans (aka the Cadillac Tax) originally effective in 2018
  - Intent: compel employers to cut back on the “actuarial value” of their benefits*
- Key terms for original 2018 effective date
  - Nondeductible 40% tax on excess of actual plan cost over annual thresholds of $10,200 for single coverage and $27,500 for family coverage
  - Pending regulatory guidance on defining includible costs and on development of plan cost for self insured programs
  - Thresholds to rise after 2018 at CPI (CPI + 1% for 2019); thresholds also to increase based on employer population age/gender adjustments (method to be determined)
    - For this estimate, age/gender adjustments were not considered as the method is not yet finalized
- Delay to 2020 announced in late 2015 in response to broader push for repeal
  - Thresholds continue to index; tax will now be tax deductible
  - Further delay or outright repeal is possible but cannot be predicted
- Administration recently announced intent to propose raising thresholds based on average cost of ACA “Gold” coverage for each state, if higher

* Actuarial value represents the average share of allowable costs paid under a particular plan design for a standard risk population

Excise tax: estimated impact for total population

- Excise tax liability is highly sensitive to projected health care trend
- 2020 projected excise tax amount ranges from $5.4 million at 6% annual trend to $18.1 million at 8% annual trend
- Most of the State's plans are expected to hit the excise tax threshold starting in 2020, with the Comprehensive PPO plan representing the greatest portion of the excise tax liability

Excise Tax by Trend Assumption ($m)	2020	2021	2022	2023	2024	2025	Total 2020-2025
6%	$5.4	$10.7	$19.2	$28.6	$38.4	$49.1	$151.4
7%	$10.4	$20.7	$32.1	$44.6	$60.4	$78.7	$246.9
8%	$18.1	$31.1	$45.7	$65.0	$88.5	$114.8	$363.3

Excise Tax by Plan @ 7% Trend ($m)	2020	2021	2022	2023	2024	2025	Total 2020-2025
First State Basic	$0	<$0.1	$0	$0.6	$0.8	$1.1	$2.8
CDH Gold (Highmark)	<$0.1	$0.1	$0.2	$0.3	$0.4	$0.6	$1.6
CDH Gold (Aetna)	<$0.1	$0.3	$0.7	$1.1	$1.5	$1.9	$5.4
Aetna HMO	$0.1	$0.8	$1.6	$2.4	$3.3	$4.3	$12.5
Highmark HMO	$0.6	$4.0	$7.6	$11.6	$15.9	$21.3	$61.0
Comprehensive PPO	**$9.6**	**$15.4**	**$21.7**	**$28.6**	**$38.5**	**$49.5**	**$163.3**
Highmark POS	$0.0	$0.0	$0.0	$0.0	<$0.1	<$0.1	<$0.1
Medicfill	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0

Notes:

- Assumes 2020 excise tax thresholds of $10,700 single / $28,900 family, increasing annually at CPI assuming 2%
- FY2016 final budget rates provided by the State of Delaware (FY17 July 1 2016 PHRST Published Rates FINAL.xls)
- Headcount as of July 2016 provided by Truven

Active/non-Medicare retiree FY15 top 20 procedures by state

Procedure	FY15 Avg Paid Claim Per Service	
	DE % difference compared to PA	DE % difference compared to MD
BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC	272.4%	193.5%
COLLECTION VENOUS BLOOD VENIPUNCTURE	**66.0%**	352.6%
THERAPEUTIC PX 1/> AREAS EACH 15 MIN EXERCISES	270.3%	**45.8%**
Hosp OP visit for assess & mgmt of pt	**67.2%**	**81.4%**
COMPREHENSIVE METABOLIC PANEL	215.0%	137.7%
ECG ROUTINE ECG W/LEAST 12 LDS TRCG ONLY W/O I&R	246.1%	118.3%
MANUAL THERAPY TQS 1/> REGIONS EACH 15 MINUTES	**40.2%**	**70.8%**
BASIC METABOLIC PANEL CALCIUM TOTAL	344.9%	334.0%
RADIOLOGIC EXAM CHEST 2 VIEWS FRONTAL&LATERAL	104.4%	145.8%
EMERGENCY DEPARTMENT VISIT HIGH/URGENT SEVERITY	234.8%	148.4%
Injection ondansetron hydrochloride, per 1 mg	526.5%	45.6%
EMERGENCY DEPARTMENT VISIT MODERATE SEVERITY	665.6%	**96.0%**
THERAPEUT ACTVITY DIRECT PT CONTACT EACH 15 MIN	235.8%	**57.0%**
PROTHROMBIN TIME	158.5%	227.2%
LIPID PANEL	108.8%	**84.2%**
COMPUTER-AIDED DETECTION SCREENING MAMMOGRAPHY	**48.8%**	**65.0%**
ASSAY OF THYROID STIMULATING HORMONE TSH	215.9%	**99.4%**
LOCM 300 - 399 mg/ml iodine conc per ml	0.0%	256.1%
URNLS DIP STICK/TABLET REAGENT AUTO MICROSCOPY	200.7%	545.1%
EMERGENCY DEPT VISIT HIGH SEVERITY&THREAT FUNCJ	194.9%	173.2%
All	**189.6%**	**132.9%**

Number of Procedures by State

- Delaware: 194,534
- Pennsylvania: 9,361
- Maryland: 12,078

Total cost for all Procedures: $15.3M

- Overall, the State of Delaware paid more if a procedure was performed in Delaware than if performed in Pennsylvania or Maryland, based on the top 20 procedures on a net payment per service basis
- The State paid 89.6% more for procedures performed in Delaware, compared to Pennsylvania
  - Only 4 procedures were less expensive in Delaware than in Pennsylvania (shown in green above)
  - The procedure “LOCM 300 -399 mg/ml iodine” was not performed in Pennsylvania during FY15; could not be compared to the Delaware net payment per service cost
- The State paid 32.9% more for procedures performed in Delaware, compared to Maryland
  - 8 procedures were less expensive in Delaware than in Maryland (shown in green above), which is twice as many procedures in comparison to Delaware vs. Pennsylvania procedure costs

Source: Truven provided statistics in the Top 20 DRGS and Top 20 Procs by Regional Utilization and State.xlsx file; data reflects entire population (actives, non-Medicare & Medicare retirees).
Note: The net payment per service has not been adjusted for the population’s risk score in each state.

Active/non-Medicare retiree FY15 top 20 DRGs by state

DRG	FY15 Avg Paid Claim Per Service	
	DE % difference compared to PA	DE % difference compared to MD
BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC	114.6%	136.8%
COLLECTION VENOUS BLOOD VENIPUNCTURE	106.8%	111.2%
THERAPEUTIC PX 1/> AREAS EACH 15 MIN EXERCISES	265.1%	122.9%
Hosp OP visit for assess & mgmt of pt	107.9%	119.1%
COMPREHENSIVE METABOLIC PANEL	**88.2%**	**55.1%**
ECG ROUTINE ECG W/LEAST 12 LDS TRCG ONLY W/O I&R	135.1%	204.9%
MANUAL THERAPY TQS 1/> REGIONS EACH 15 MINUTES	**77.6%**	198.0%
BASIC METABOLIC PANEL CALCIUM TOTAL	105.5%	257.4%
RADIOLOGIC EXAM CHEST 2 VIEWS FRONTAL&LATERAL	**87.9%**	118.4%
EMERGENCY DEPARTMENT VISIT HIGH/URGENT SEVERITY	215.0%	160.3%
Injection ondansetron hydrochloride, per 1 mg	**99.4%**	308.6%
EMERGENCY DEPARTMENT VISIT MODERATE SEVERITY	101.3%	123.9%
THERAPEUT ACTVITY DIRECT PT CONTACT EACH 15 MIN	190.6%	**66.5%**
PROTHROMBIN TIME	231.7%	365.5%
LIPID PANEL	**64.4%**	309.0%
COMPUTER-AIDED DETECTION SCREENING MAMMOGRAPHY	2585.0%	222.2%
ASSAY OF THYROID STIMULATING HORMONE TSH	206.9%	363.4%
LOCM 300 - 399 mg/ml iodine conc per ml	**54.7%**	245.8%
URNLS DIP STICK/TABLET REAGENT AUTO MICROSCOPY	389.3%	401.7%
EMERGENCY DEPT VISIT HIGH SEVERITY&THREAT FUNCJ	328.7%	**62.0%**
All	**106.1%**	**124.6%**

Number of DRGs by State

- Delaware: 3,515
- Pennsylvania: 189
- Maryland: 177

Total cost for all DRGs: $40.8M

- Overall, the State of Delaware paid more if a diagnosis was made in Delaware than if made in Pennsylvania or Maryland, based on the top 20 DRGS (diagnosis-related group) on a net payment per service basis
- The State paid 6.1% more overall when diagnosed in Delaware compared to Pennsylvania
  - 6 diagnoses were less expensive in Delaware than in Pennsylvania (shown in green above), which is twice as many diagnoses in comparison to Delaware vs. Maryland DRG costs
  - Compared to procedures, there were more diagnoses that are less expensive in Delaware than Pennsylvania
- The State paid 24.6% more overall when diagnosed in Delaware, compared to Maryland
  - Only 3 diagnoses were less expensive in Delaware than in Maryland (shown in green above)
  - Compared to procedures, there were fewer diagnoses that were less expensive in Delaware than in Pennsylvania

Source: Truven provided statistics in the Top 20 DRGS and Top 20 Procs by Regional Utilization and State.xlsx file; data reflects entire population (actives, non-Medicare & Medicare retirees).
Note: The net payment per service has not been adjusted for the population's risk score in each state.

Confines of strategic development

Requirement of legislation

Potential tactic to address strategy	Illustrative example(s)	Requires legislative change?
Traditional plan design changes	Increase deductible by $100	No
Non-traditional plan design changes	Implement reference-based pricing Add a third coverage tier for a narrow network	No
Adding a new medical plan	Adding CDHP/HSA or adding a PPO option that has a narrow network	No*
Removing a plan option specified by the Delaware Code	Removing the First State Basic plan	Yes**
Freezing enrollment in a medical plan	1. Freeze to new entrants 2. Freeze to new hires	Yes
Adding a vendor	Wellness vendor or engagement vendor	No
Adjustments in employee cost share	Increasing the payroll contribution for an employee from 12% to 15%	Yes
Adjustments in dependent cost share	Increasing the dependent cost sharing by 10%	Yes
Addition of surcharges	1. Add a tobacco and/or spousal surcharge 2. Wellness “dis-incentive” for non-participation	Yes
Addition of an incentive program	Paying an employee $100 to get their biometric screening from their PCP	No
Implement a medical or Rx utilization management programs	1. Implement high cost radiology management program 2. Discontinue coverage of certain high cost specialty drugs and/or compound drugs	No

*Procurement would be involved in reviewing any amendments to vendor contracts for the new plan(s). Additionally, cost share would have to fit within one of the existing plans to avoid legislative change.
**May require legal input regarding Delaware Code.

State of Delaware health care initiatives

Terminology	Acronym	Explanation	Goal
All Payers' Claims Database	APCD	A large scale database created by state mandate that systematically collects medical claims, pharmacy claims, dental claims (typically, but not always), and eligibility and provider files from private and public payers. The Governor of Delaware recently signed an APCD into law.	To fill critical information gaps for state agencies, to support health care and payment reform initiatives, and to address the need for transparency in health care at the state-level to support consumer, purchaser, and state agency reform efforts. Additionally, to provide comprehensive, multipayer data that allows the state and other stakeholders to understand the cost, quality, and utilization of health care for their citizens.
Delaware Center for Health Innovation	DCHI	Created to develop, facilitate, and oversee the implementation of collaborative efforts aimed at transforming the delivery of health care services in the State. The DCHI has been convening stakeholders to establish goals for primary care transformation as a key element of *Delaware's Health Innovation Plan*.	To encourage payers to offer Total Cost of Care or Pay-for-Value models to primary care providers, to base outcomes measurement on quality and efficiency measures primarily from the DCHI Common Scorecard, and to support practice transformation and care coordination to help PCPs to be successful in outcomes-based payment models.
Delaware Health Information Network	DHIN	The State of Delaware's *Health Information Exchange (HIE)*. One of the most advanced *Health Information Exchanges* (HIE) in the country, DHIN has a high rate of adoption among providers and hospitals and communicates lab findings and imaging reports along with hospital Admission Discharge Transfer reports and medication history.	To give providers an enhanced patient view to improve efficiency and effectiveness of care.

State of Delaware health care initiatives

Terminology	Acronym	Explanation	Goal
DelaWELL Health Management Program	DelaWELL	The DelaWELL Health Management Program is designed through the State of Delaware and Aetna to address specific health and wellness needs. The program reflects the State's commitment to healthy lifestyles. Eligible participants include benefit-eligible employees (state agency, school district, charter school, higher education and participating groups), state non-Medicare eligible pensioners, and their spouses and dependents over the age of 18 who are currently enrolled in a State of Delaware Group Health Plan. While there are no cash incentives (the reward is good health) for participation, and participation in DelaWell is voluntary, it is strongly encouraged.	Through wellness and disease management programs, DelaWELL aims to help participants become more involved in their health and make real health improvements. By encouraging participants to be proactive about wellness, engage in preventive care, control chronic conditions, and be a wise health care consumer, the State hopes to control health care costs.
Health Information Exchange	HIE	The electronic movement of health-related information among organizations which allows doctors, nurses, pharmacists, other health care providers and patients to appropriately access and securely share a patient's vital medical information electronically—improving the speed, quality, safety and cost of patient care.	To allow health care professionals to collaborate in delivering the best possible care to patients. This electronic collaboration can improve the completeness of patient's records, (which can have a big effect on care), as past history, current medications and other information is jointly reviewed during visits.
Healthy Neighborhood Campaign	n/a	A program supported by the Delaware Center for Health Innovation (DCHI) that will design and implement locally tailored solutions to some of the State's most pressing health needs including: healthy lifestyles, maternal and child health, mental health and addiction, and chronic disease and prevention. The State has been split up into ten Healthy Neighborhoods and three local Healthy Neighborhoods councils will be launched during 2016.	To bring local communities together to harness the collective resources of all of the organizations in their community to enable healthy behavior, improve prevention, and enable better access to primary care for their residents.

National health care initiatives

Terminology	Acronym	Explanation	Goal
Medicare Shared Savings Program	MSSP	Established by the Affordable Care Act, the Medicare Shared Savings Program is a key component of the Medicare delivery system reform initiatives included in the Affordable Care Act and is a new approach to the delivery of health care which includes facilitating coordination and cooperation among providers to improve the quality of care for Medicare Fee-For-Service beneficiaries and reduce unnecessary costs. Eligible providers, hospitals, and supplier may participate in the program by creating or participating in ACOs. The Program will reward ACOs that lower their growth in health care costs while meeting performance standard on quality of care and putting patients first. Participation in an ACO is purely voluntary.	To improve beneficiary outcomes and increase value of care by providing better care for individuals, better health for populations, and lowering growth in expenditures by reducing unnecessary costs.
State Health Care Innovation Plan	SHCIP	Developed by the State in February 2013 after being awarded a *SIM* grant, the program develops and implements a plan for broad-based health system transformation including new payment and delivery models. This health transformation will be organized into six work streams: delivery system, population health, payment model, data and analytics, workforce, and policy.	To improve the health of Delawareans, improve the patient experience of care, and reduce health care costs.
State Innovation Models	SIM	A national grant program administered by the Center for Medicare and Medicaid Innovation to support states to move toward value-based payment models and to improve population health. The State was awarded a "design grant" in February 2013 to fund the development of the *State Health Care Innovation Plan* and received an additional grant in July of 2014 to support the implementation and testing of the *State Health Care Innovation Plan*.	To encourage states to move towards value-based payment models in order to reduce unnecessary costs while improving population health.

Desired end state

Mission Statement

- Statement articulating GHIP purpose
- Varying level of specificity (can be a single statement or multiple bulleted missions)
- *Example: "Offer State of Delaware employees and retirees access to care that produces high quality outcomes at an affordable cost"*

Program Goals

- Provides an outline of what the GHIP strives to accomplish over the 3-5 year time period
- Goals will be SMART (Specific, Measureable, Attainable, Relevant and Time-bound)
- *Example: "GHIP employee enrollment in a consumer-driven health plan exceeding 25% of total population by EOY 2019"*

Strategies

- Advances the goals
- Strategies will tie specifically to goals (each may advance >1 goal)
- *Example: "Utilize incentives (financial or otherwise) to drive behavior change"*

Tactics

- Action-items intended to advance a specific strategy
- Tactics are a means of achieving program goals through furthering specific strategies
- *Example: "Health Insurance Request-for-Proposal"*

Desired end state includes all four components above and should be revisited on an ongoing basis to ensure continued applicability based on GHIP objectives and experience