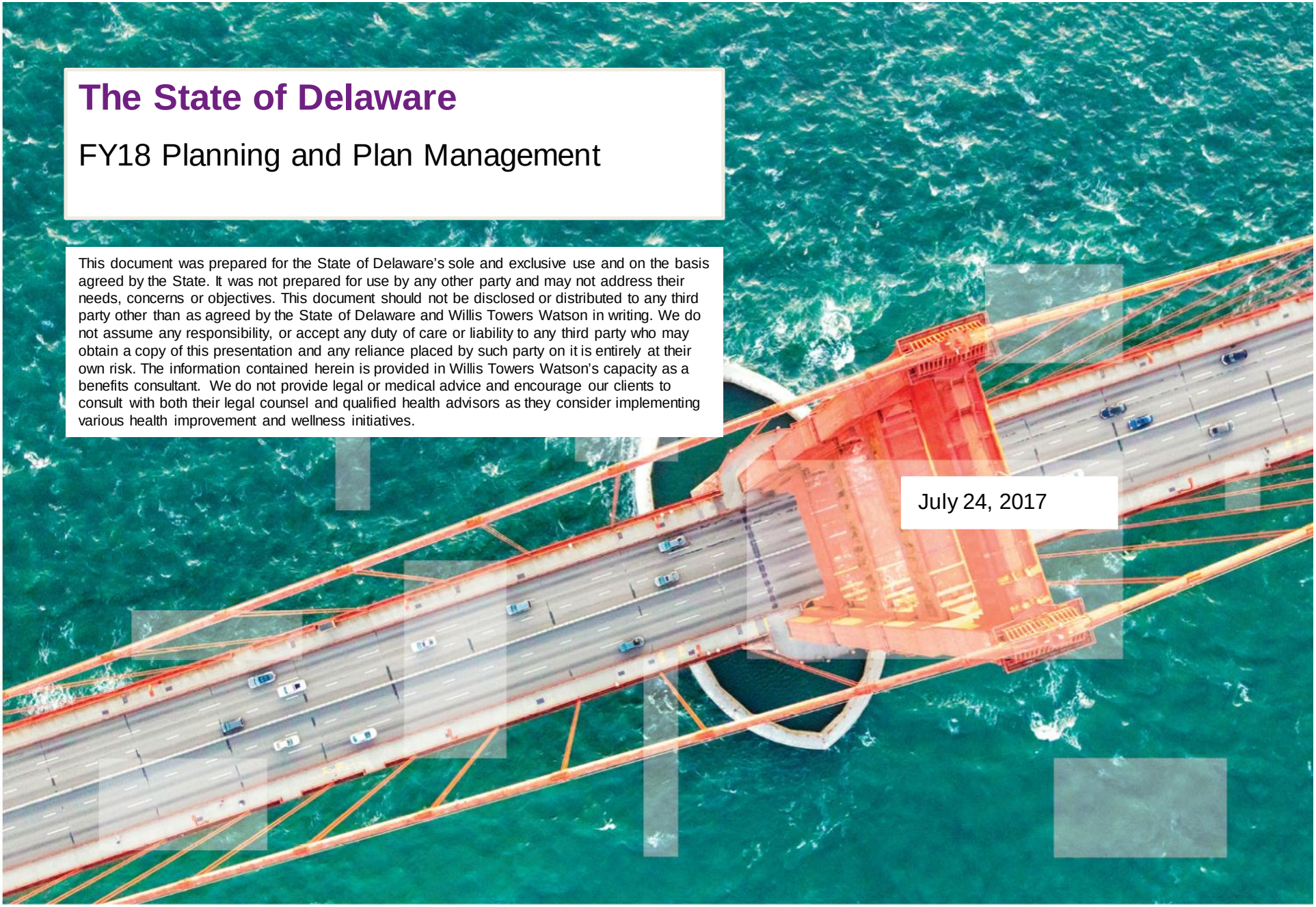

The State of Delaware

FY18 Planning and Plan Management

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July 24, 2017

Willis Towers Watson

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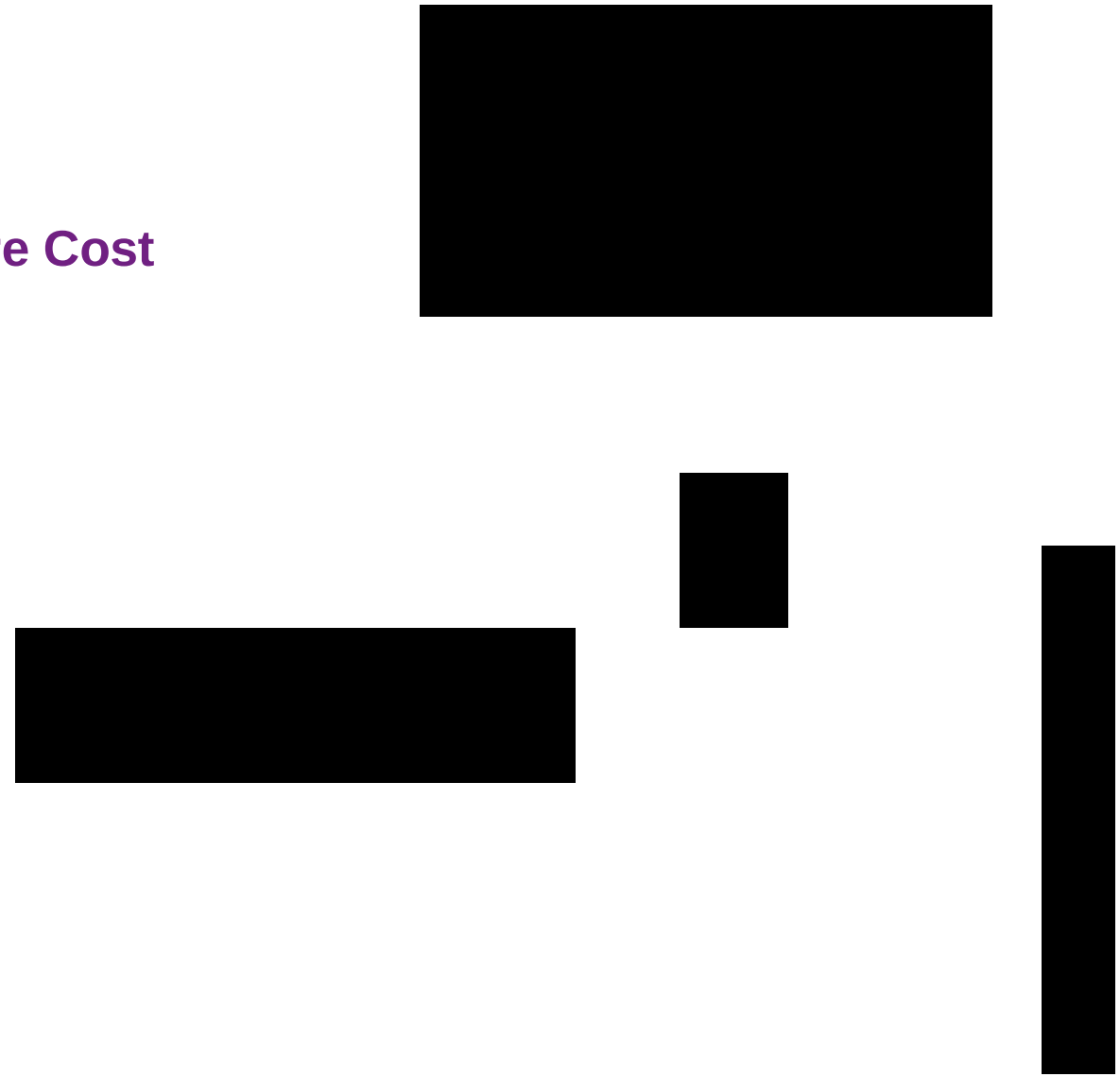
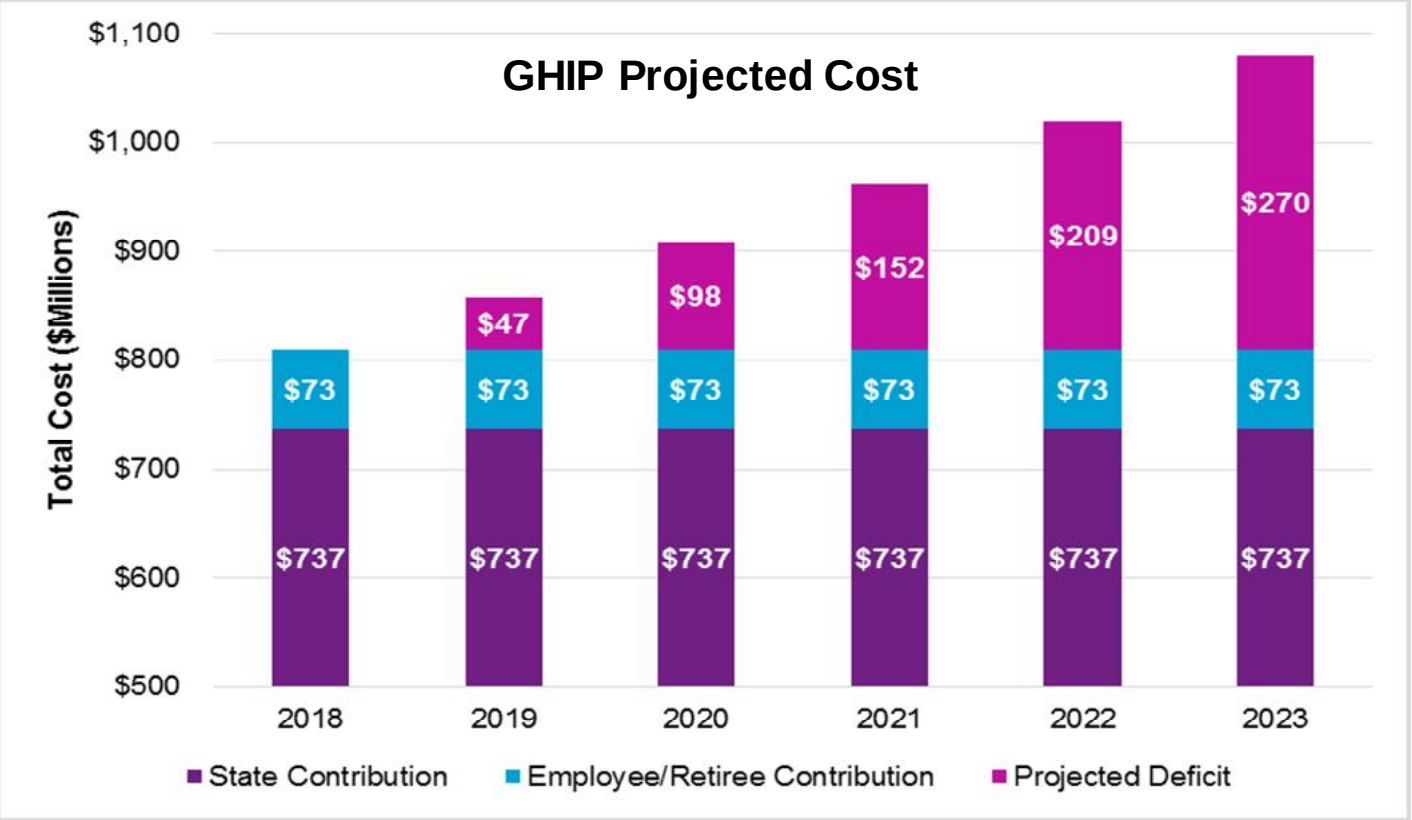
- Long Term Health Care Cost Projections for GHIP
- FY18 Planning – Reorienting Using the Strategic Framework
- Next Steps

Long Term Health Care Cost Projections for GHIP



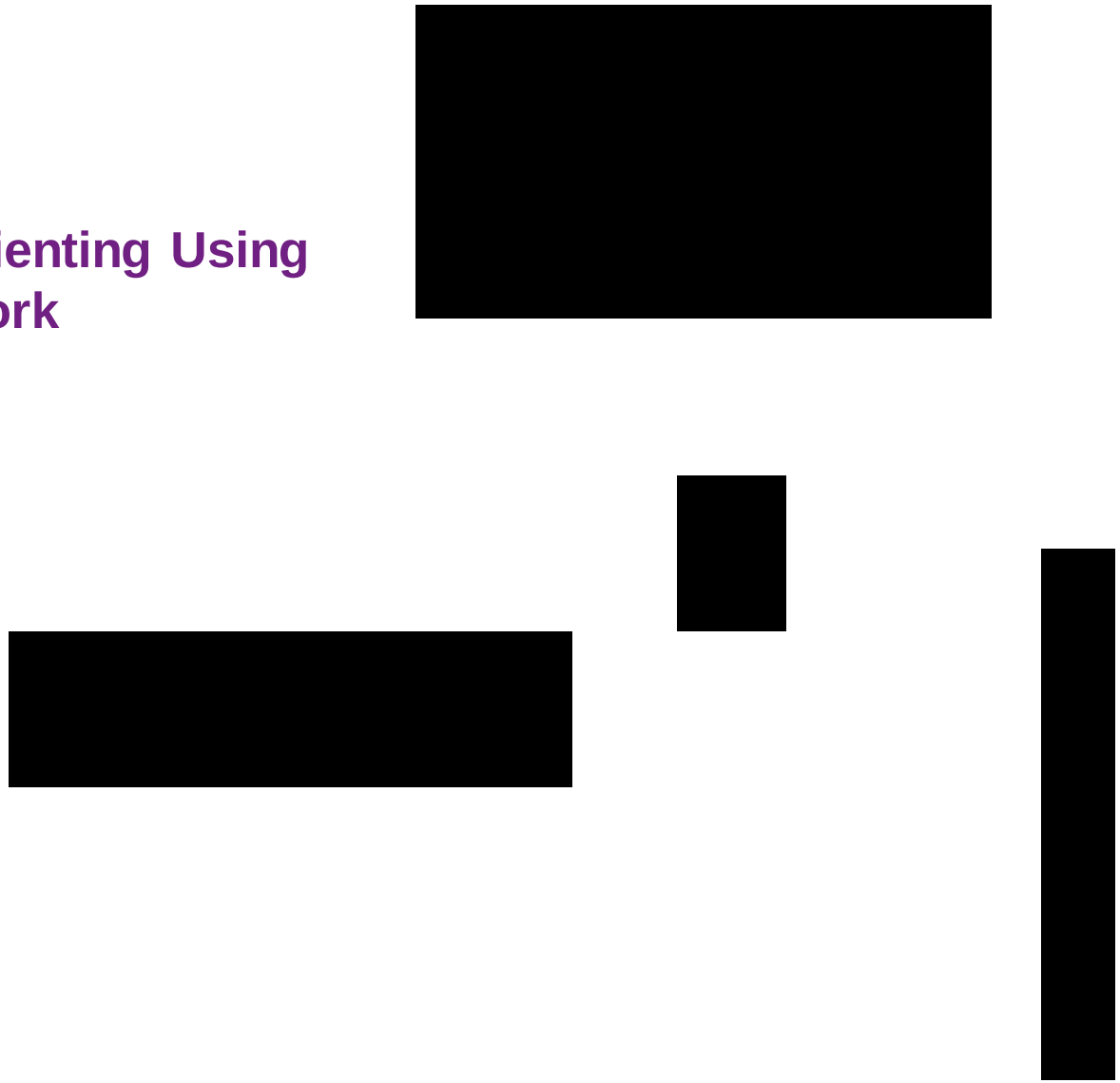
Long term health care cost projections

Long-term cost projections of the Group Health Insurance Plan, at intermediate trend value of 6%, with no increase in state or employee/retiree contributions factored in for 2018 forward (assuming no program changes)



Note: FY18 budget projections assume no change to FY17 rates, and FY18 open enrollment elections as of June 2017.
FY19 and beyond costs projected assuming 6% annual health care trend and no further program changes.

FY18 Planning – Reorienting Using the Strategic Framework



Tracking the progress: GHIP mission statement & core concepts

GHIP Mission Statement and Core Concepts

Progress review date: July 24, 2017

Offer State of Delaware employees, retirees and their dependents adequate access to high quality healthcare that produces good outcomes at an affordable cost, promotes healthy lifestyles, and helps them be engaged consumers

Core Concepts Benchmarking

Core Concept	Definition	Metric Benchmark Description	Benchmark	State of Delaware Metrics
Adequate Access	Access to various types of healthcare providers that meets generally accepted industry standards	Vendor-provided GeoAccess reporting indicating average distance to provider based on industry-standard access parameters	1. Adequate network access ≥ 90% 2. 24% of employers offer ESHCs[1,3]	1 Highmark/Aetna combined networks yield 98.5% access to in-network providers[2] 2 Evaluated the ESHC[3] vendor marketplace
High Quality Healthcare that Produces Good Outcomes	Healthcare that meets nationally recognized standards of care established by various governmental and non-governmental health care organizations	Metrics as provided by GHIP's TPA which measure the effectiveness and quality of providers and care delivery within their given networks	1. Robust Care Management Program offering for all EEs 2. High Performance Networks (HPNs)/Value Based Care[5] a. 30% of employers have enhanced their care management offerings b. 23% of employers use HPNs	1 Highmark Custom Care Management Unit (CCMU) model implemented (FY2018) 1 Aetna Carelink enhanced care management program implemented (FY2018) 2 56% of Aetna's providers are in the Aexcel network in Delaware
Affordable Cost	Healthcare cost trend is favorable compared to national and statewide trend, plans meet PPACA requirements, and program promotes greater fiscal certainty for the State	Participants: Plan actuarial value (AV) and affordability requirements under ACA State: Annual trend rate for GHIP program	1. Plan AV ≥ 60% and at least one plan's contributions are ≤ 9.5% of single employee household income 2. Market average medical trend at 6% for 2017 3. Programs that provide lower cost alternatives	1 All of the GHIP's plans meet the 60% AV and 9.5% affordability metrics set forth under the ACA 2 GHIP medical trend projected at 5.3% for FY2017[4] 3 Hospital case rates have been implemented for select medical plans; reviewing other opportunities such as reference based pricing

Not yet started | On track | Completed

1. WTW 2016 Best Practices in Health Care Employer Survey
2. Based on FY2017 plan offerings for actives, pre 65 retirees and Medicare eligible retirees
3. ESHC: Employer Sponsored Health Center
4. Based on 3Q2017 financial reporting; includes actives, pre-65 retirees and Medicare eligible retirees enrolled in the GHIP
5. WTW 2016 Emerging Trends in Health Care Survey - Education, Government and Public Sector (30 employers)

Tracking the progress: GHIP mission statement & core concepts

GHIP Mission Statement and Core Concepts

Progress review date: July 24, 2017

Offer State of Delaware employees, retirees and their dependents adequate access to high quality healthcare that produces good outcomes at an affordable cost, promotes healthy lifestyles, and helps them be engaged consumers

Core Concepts Benchmarking

Core Concept	Definition	Metric Benchmark Description	Benchmark	State of Delaware Metrics
 **Healthy Lifestyles** Additional utilization metrics will be tacked in a separate scorecard	Combination of behaviors that reduce health risk factors	Preventative care utilization metrics. Participation in wellness coaching, disease management, tobacco cessation, and other programs that encourage presentation and management of disease	1. Preventative Care participation U.S. Norm[1]: a. Cervical cancer screening 63.1% b. Colon Cancer screening 42% c. Mammogram screening 67.4% d. Cholesterol Screening 79.9% e. Physical exam participation 29.9% 2. Care Management participation exceeding vendor-provided book-of-business[2]: a. 0.75% of unique MBRs targeted for outreach b. 0.39% engaged cases c. 18.4 % of MBRs Identified w DM Opportunity d. 4.4% of MBRs w Nurse Engagement	**Selected Preventive care though December 2016[1]:** 1.a 67% of the applicable population enrolled received cervical cancer screening 1.b 40% of the population enrolled participated in colon cancer screening 1.c 58% of applicable GHIP members currently receive mammograms 1.d 36% of the population enrolled engaged in cholesterol screening 1.e 36% of the population enrolled completed a physical exam 1 FY2018 State of Delaware and DHHS cancer screening initiative **Selected Care Management though December 2016[2]:** 2.a Aetna HMO: 0.07% of unique members targeted for outreach 2.b Aetna HMO: 0.02% engaged cases 2.c Aetna HMO 20.4% of MBRs Identified w DM Opportunity 2.d Aetna CDH Gold: 3.5% of MBRs w Nurse Engagement 2.e Highmark 8.1% engaged
 **Engaged Consumers**	Members using all available resources provided by the State to make informed decisions on how, where and when they seek care	On-line consumerism class utilization and utilization of vendor provider lookup, quality, and transparency tools	1. Ongoing member education on health care consumerism is provided	1 54.5% of the overall GHIP employee population participated in the consumerism website course as of 4/3/2017 1 Over 50% employees enrolled through Employee Self Service, up from 20% in prior years as of 7/1/2017 1 Over 33% of the population enrolled in a consumer or value based plan (CDH & AIM HMO) as of 7/1/2017

Not yet started On track Completed

1. Based on FY2016 screening rates by all plans provided by Truven; 2016 U.S. Norm from Truven's commercial database
2. Based on 2Q2017 Aetna performance and Customer Experience Review and Highmark 3Q2017 Operations Dashboard. Statistics include Aetna BOB

Tracking the progress: GHIP strategic framework goals

Strategic Framework Scorecard

Progress review date: July 24, 2017

Progress Evaluation - Tracking Against Goals

Goals	Progress	Timing	Steps Taken / Actions Planned
Goal 1: Addition of at least net 1 value-based care delivery (VBCD) model by end of **FY2018**			1 Introduction of AIM HMO model via Aetna/CareLink partnership, effective 7/1/2017 2 Continue to work with Highmark and the State's other carriers to identify opportunities to implement other VBCD models
Goal 2: Reduction of gross GHIP medical and prescription drug trend by 2% by end of **FY2020**			1 Adoption of cost reduction programs, i.e., CCMU, Diabetes Prevention Program, AIM HMO 2 Additional changes to promote use of high quality/efficient providers are under consideration
Goal 3: GHIP membership enrollment in a consumer-driven or value-based plan exceeding 25% of total population by end of **FY2022**			1 5% of employees enrolled in the CDH Gold plan[1] 2 28% of employees enrolled in the Aetna HMO AIM Model[1] 3 Introduction of Health Savings Account, under consideration for 1/1/2019

1. Based on enrollment reported in the FY2018 Budget (6/21/2017)

Not yet started **On track** **Completed**

Revisiting Multi-year framework *(SEBC approved December 2016)*

Goal	To prepare for 2019 and beyond (7/1/17 – 6/30/2018)	To prepare for 2020 and beyond (7/1/18 – 6/30/2019)
Addition of at least 1 value-based care delivery (VBCD) model by end of FY2018	▪ Implementation of VBCD models from RFP (including COEs) ▪ Look for leveraging opportunities with the DCHI and DHIN to partner on promotion of value based networks (including APCD initiative)[1] ▪ Identify opportunities to partner and encourage participation in VBCD models using outside vendors, TPAs and DelaWELL[1] ▪ Educate GHIP population on other provider quality tools from CMS, Health Grades, Leapfrog, etc. [1]	▪ Continue to monitor and evaluate VBCD opportunities
Reduction of gross GHIP medical and prescription drug trend by 2% by end of FY2020	▪ Explore and implement medical TPA programs, such as tiered pricing for lab services, high cost radiology UM[2] and other medical and Rx UM[2] programs, where necessary ▪ Explore avenues for building "culture of health" statewide[1] ▪ Continuation of education of GHIP members on the importance of preventive care and the State's preventive care benefits (covered at 100% in-network) [1] ▪ Continuation of education of GHIP members on lower cost alternatives to seek care outside of the emergency room (i.e., telemedicine, urgent care centers, retail clinics) [1] ▪ Continuation of the evaluation of feasibility of reducing plan options and/or replacing copays with coinsurance—based on emerging market and value-based design[3]	▪ Explore and implement medical TPA programs, such as tiered pricing for lab services, high cost radiology UM[2] and other medical and Rx UM[2] programs, where necessary ▪ Continuation of education of GHIP members on the importance of preventive care and the State's preventive care benefits (covered at 100% in-network) ▪ Continuation of education of GHIP members on lower cost alternatives to seek care outside of the emergency room (i.e., telemedicine, urgent care centers, retail clinics) ▪ Continuation of the evaluation of feasibility of reducing plan options and/or replacing copays with coinsurance—based on emerging market and value-based design[3]
GHIP membership enrollment in a consumer-driven or value-based plan exceeding 25% of total population by end of FY2020	▪ Offer a medical plan selection decision support tool (e.g., Truven's "My Benefits Mentor" tool) ▪ Promote cost transparency tools available through medical TPA(s) [1] ▪ Evaluate feasibility of offering incentives for engaging in wellness activities[1]	▪ Change medical plan designs and employee/retiree contributions to further differentiate plan options[3] ▪ Change the number of medical plans offered[3]

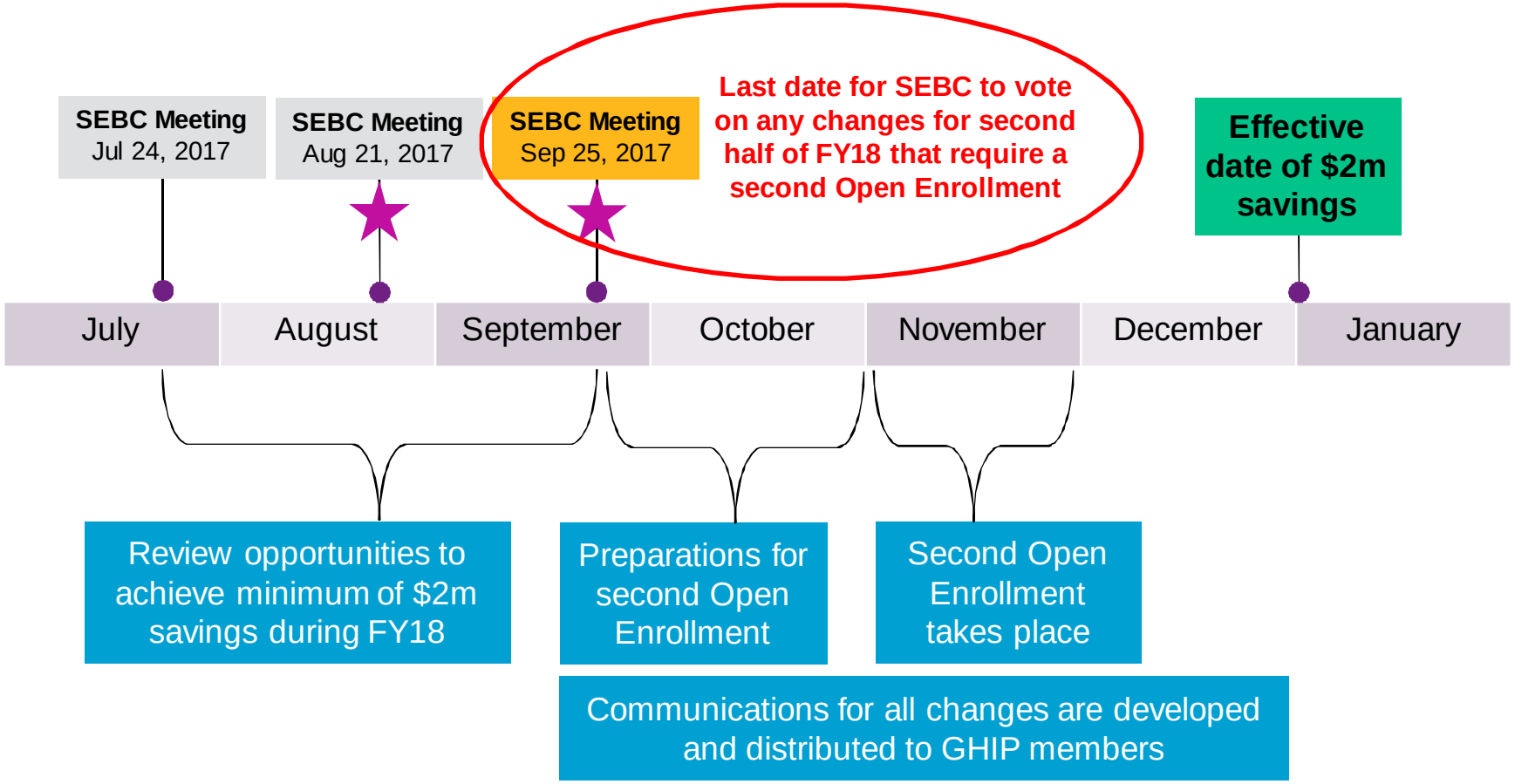
[1]Not noted on the GHIP Strategic Framework Goals scorecard but will be addressed during FY18.
[2]UM =Utilization Management.
[3]May require changes to the Delaware Code.

Opportunities for FY2018

FY2018 Epilogue Language (Section 25):

The State Employee Benefits Committee shall implement changes to be effective no later than January 1, 2018 which achieve a minimum savings of $2,000.0 [$2 million] during Fiscal Year 2018. These changes would include, but not be limited to, increasing member cost sharing through plan design changes which would include deductibles, copays, coinsurance in the active/non Medicare plans or Medicare plan for medical or prescription coverage; site of service steerage; centers of excellence and other high performing networks or providers; and tiered and/or reference based pricing.

Focal points for the SEBC – first half of FY18



Denotes opportunity for SEBC to vote on changes for second half of FY18

Opportunities for FY18 – prioritization

Type of change	Opportunity	Ease of implementation	Earliest timeframe for completion	Contribution toward FY18 savings[1]
Communications and member action	Cost transparency	Easy	By 1/1/18	$
	High performing providers	Easy	By 1/1/18	$
Plan changes without second open enrollment	Site-of-service steerage	Easy / Moderate[2]	By 1/1/18[3]	TBD[4]
	Reference-based pricing	Moderate	By 1/1/18[3]	TBD[4]
	Centers of Excellence	Complex	By 1/1/18[3]	TBD[4]
Second open enrollment likely required	Plan design changes	Moderate	By 1/1/18	$$$

[1] $ = Minimal savings | $$ = Moderate savings | $$$ = Significant savings
[2] Depending on the complexity of plan design offered.
[3] Pending confirmation from Aetna and Highmark.
[4] Pending estimates from Aetna and Highmark.

GHIP Strategic Framework Goals:

- ■ Addition of at least net 1 VBCD model by end of FY2018
- ○ Reduction of gross GHIP trend by 2% by end of FY2020
- ▲ Enrollment in a CDHP or value-based plan >25% by end of FY2020

Cost transparency

Describes tools that provide members with additional visibility into the total cost of health care services that they may incur.

- *May be used to estimate the total cost for a medical procedure, a prescription or the total annual amount spent on health care by an employee (i.e., payroll contributions and member out-of-pocket costs)*
- *Often include provider quality ratings too*

GHIP Current State

- Both Aetna and Highmark provide cost transparency tools on their member websites
- Truven "My Benefits Mentor" cost transparency tool implemented for the FY18 Open Enrollment in May 2017

Impact on the State:

- Potential for moderate savings over time due to GHIP member use of higher quality, cost efficient providers

Impact on employees:

- Better care experience: less surprises when the doctor's bill arrives
- Potential for lower long term costs and more HRA savings due to use of higher performing, cost efficient providers

Immediate next steps:

- Determine ways to educate GHIP members about the benefits of using cost transparency tools
- Consider plan design changes that will encourage use of cost transparency tools (i.e., adding a deductible or coinsurance)

GHIP Strategic Framework Goals:

- ■ Addition of at least net 1 VBCD model by end of FY2018
- ○ Reduction of gross GHIP trend by 2% by end of FY2020
- ▲ Enrollment in a CDHP or value-based plan >25% by end of FY2020

High performing providers

A high performing provider is an in-network provider that has been identified through the evaluation of cost and quality metrics, who may or may not have separate contract arrangements with the medical third party administrator. Plan design steerage to encourage use of high performing providers is optional.

GHIP Current State

- Not actively promoted today
- Access to Aetna Aexcel and Highmark True Performance providers (though not carved out of each vendor's broad provider network)
- Limited availability of stand-alone networks of high performing providers within Delaware

Impact on the State:

- Ensures GHIP members are using high quality providers
- Potential for moderate savings over time due to higher quality care delivered and lower risk of poor health outcomes

Impact on employees:

- Better care experience: higher quality, more efficient use of medical services

Immediate next steps:

- Determine ways to educate GHIP members about the methods to identify high performing providers and the benefits of using high performing providers, until such time when one or more high performing networks are robust enough in Delaware to offer on stand-alone basis

GHIP Strategic Framework Goals:

- ■ Addition of at least net 1 VBCD model by end of FY2018
- ○ Reduction of gross GHIP trend by 2% by end of FY2020
- ▲ Enrollment in a CDHP or value-based plan >25% by end of FY2020

Site-of-service steerage

Members pay lower out-of-pocket costs for using the most appropriate place of service for the care they need.

GHIP Current State

- Differences in member cost sharing for "preferred" medical providers exist within the medical plans today, including
  - Lower member cost sharing for use of urgent care centers (in lieu of ER) and free-standing radiology centers for high tech imaging (in lieu of hospitals), effective 7/1/16 – estimated savings of $3M for FY17
  - Lower member cost sharing for use of Transplant and Bariatric COEs
  - Travel and lodging benefit offered for use of Transplant COEs

Impact on the State:

- Potential for moderate savings over time due to redirecting members to less costly providers

Impact on employees:

- Encourages members to be more mindful of where they seek care
- Potential disruption when steering members to other providers

Immediate next steps:

- Begin modeling plan design changes where site-of-service steerage is appropriate

GHIP Strategic Framework Goals:

- Addition of at least net 1 VBCD model by end of FY2018
- Reduction of gross GHIP trend by 2% by end of FY2020
- Enrollment in a CDHP or value-based plan >25% by end of FY2020

Reference-based pricing

Plan sponsors pay a fixed amount or "reference" price toward the cost of a specific health care service, and health plan members must pay the difference in price if they select a more costly health care provider or service.

GHIP Current State

- Not in place today

Impact on the State:

- Potential for moderate savings over time due to redirecting members to less costly and equally effective providers

Impact on employees:

- Encourages members to be more mindful of where they seek care
- Potential disruption when steering members to other providers
- Balance billing/higher out-of-pocket cost for members that seek care with higher cost provider

Immediate next steps:

- Work with carriers to identify services where reference-based pricing could be implemented

GHIP Strategic Framework Goals:

- Addition of at least net 1 VBCD model by end of FY2018
- Reduction of gross GHIP trend by 2% by end of FY2020
- Enrollment in a CDHP or value-based plan >25% by end of FY2020

Centers of excellence

A Center of Excellence (COE) is a facility that has been identified as delivering high quality services and superior outcomes for specific procedures or conditions. COEs may incorporate separate contracting arrangements for a predetermined set of services (e.g., bundled payments). Plan design steerage to encourage use of COEs is optional.

GHIP Current State

- Lower member cost sharing at point of care is already in place for Bariatric and Transplant COEs
- Travel and lodging benefit offered for use of Transplant COEs
- Both Aetna and Highmark have COEs for Cardiac and Orthopedic services

Impact on the State:

- Ensures GHIP members are using high quality providers for certain procedures
- Potential for moderate savings over time due to higher quality care delivered and lower risk of poor health outcomes

Impact on employees:

- Better care experience: quicker recovery, better quality of life
- Potential for lower long term costs due to fewer doctor visits, lower risk of complications

Suggested next steps:

- Begin modeling plan design changes that would encourage use of COEs

GHIP Strategic Framework Goals:

- ■ Addition of at least net 1 VBCD model by end of FY2018
- ○ Reduction of gross GHIP trend by 2% by end of FY2020
- ▲ Enrollment in a CDHP or value-based plan >25% by end of FY2020

Plan design changes

**Revisit from prior discussions with the SEBC.*

Includes adding/increasing deductibles, increasing copays, and adding coinsurance.

May be limited to certain plans and/or member populations.

GHIP Current State

- No plan design changes for first 6 months of FY18 plan year
- Depending on nature of any changes for 1/1/18, may require another Open Enrollment in the fall 2017

Impact on the State:

- Contributes to the ongoing management of GHIP costs

Impact on employees:

- Additional responsibility for the cost of employees' own health care decisions
- Members become more conscious of being better health care consumers and choosing which providers are used for care

Immediate next steps:

- Revisit plan design changes that were previously modeled by WTW (slides in appendix)

Next Steps

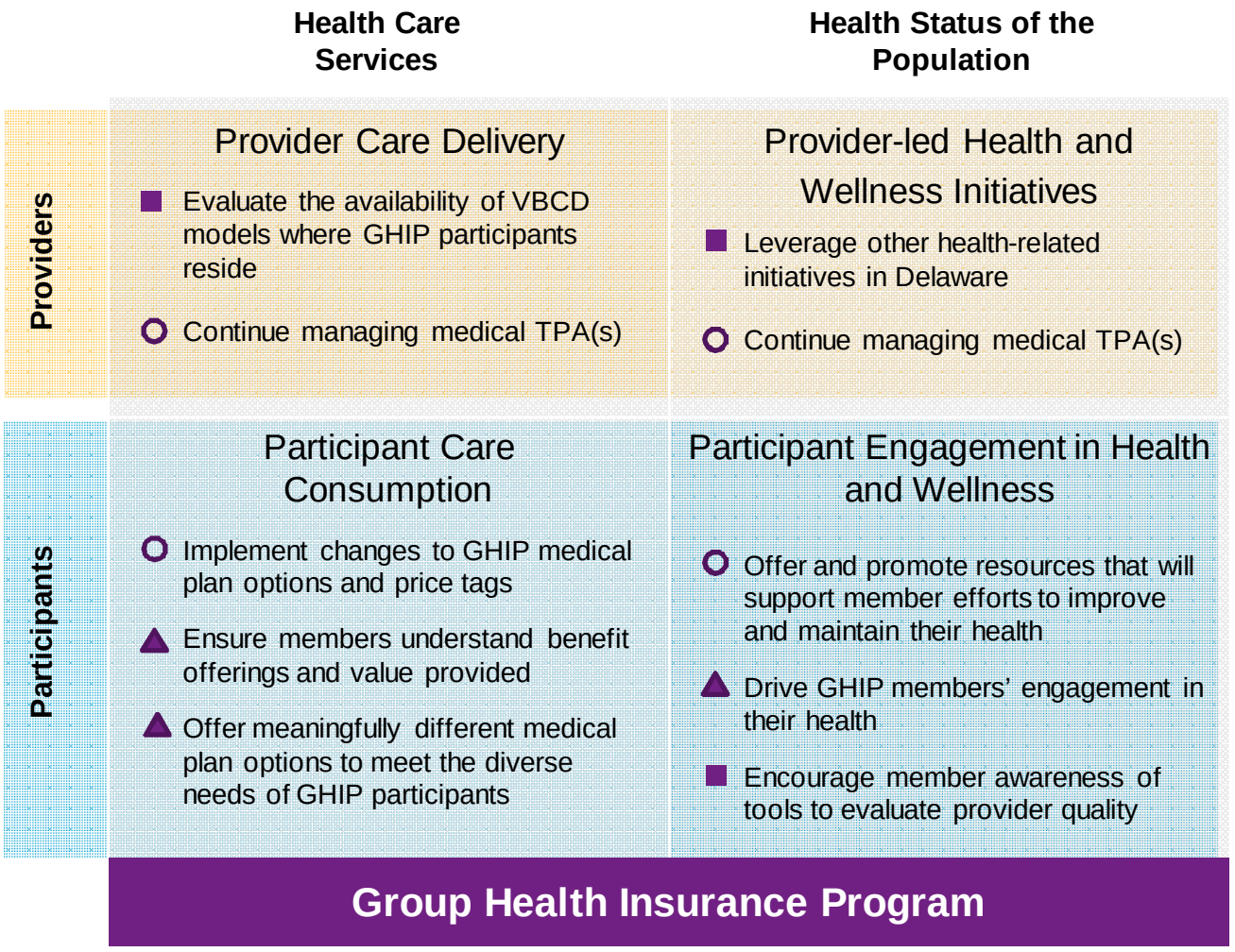
Next steps

- Continuation of FY18 planning
- Items to discuss at 8/21 SEBC meeting:
  - Continue evaluation of savings opportunities for 1/1/2018:
    - Cost transparency
    - High performing providers
    - Site-of-services steerage
    - Reference-based pricing
    - Centers of excellence
    - Plan design changes
  - Begin to explore opportunities for FY2019 (7/1/2018 and beyond):
    - Active enrollment
    - Health savings accounts
    - Possibility of modification to the plan year to align with calendar year (i.e., 7/1 to 1/1)

Appendix

Framework for the health care marketplace

Proposed GHIP strategies – *Linked to GHIP goals*



Goals:

- Addition of at least net 1 value-based care delivery (VBCD) model by end of FY2018
- Reduction of gross GHIP medical and prescription drug trend by 2% by end of FY2020[1]
- GHIP membership enrollment in a consumer-driven or value-based plan exceeding 25% of total population by end of FY2020[2]

Supply

Demand

Proposed GHIP strategies and tactics

Goal: Addition of at least net 1 value-based care delivery (VBCD) model by end of FY2018

	Strategies	Tactics
Supply	**Evaluate the availability of VBCD models where GHIP participants reside**	Evaluate local provider capabilities to deliver VBCD models via medical third party administrator (TPA) RFP
		Implementation of VBCD models from RFP (including COEs)
		State-sponsored Health Clinic Request for Information (RFI)
		Evaluation of clinical data to implement more value-based chronic disease programs
	Leverage other health-related initiatives in Delaware to drive better outcomes	Look for leveraging opportunities with the DCHI and DHIN to partner on promotion of value based networks (including APCD initiative)
		Identify opportunities to partner and encourage participation in value-based care delivery model using outside vendors, TPAs and DelaWELL
Demand	**Encourage member awareness of tools to evaluate provider quality**	Promote medical plan TPAs' provider cost/quality transparency tools
		Educate GHIP population on other provider quality tools from CMS, Health Grades, Leapfrog, etc.

Value-based Care Delivery (VBCD) Models

- Center of Excellence (COE)
- High Performance Network (HPN) and Narrow Networks
- Advanced Primary Care / Patient-centered Medical Home (PCMH)
- Accountable Care Organization (ACO)

Proposed GHIP strategies and tactics

Goal: Reduction of gross GHIP medical and prescription drug trend by 2% by end of FY2020

	Strategies	Tactics
Supply	Continue managing medical TPA(s)	Negotiate strong financial performance guarantees
		Select vendor(s) with most favorable provider contracting arrangements
		Select vendor(s) that can best manage utilization and population health
Demand	Implement changes to GHIP medical plan options and pricetags	Evaluate bidder capabilities surrounding Centers of Excellence via medical TPA RFP
		Explore and implement medical TPA programs, such as tiered pricing for lab services, high cost radiology UM* and other medical and Rx UM programs, where necessary
		Evaluate feasibility of reducing plan options and/or replacing copays with coinsurance
		Change certain plan inequities, e.g., double state share and Medicfill subsidy
	Offer and promote resources that will support member efforts to improve and maintain their health	Educate GHIP members on the importance of preventive care and the State's preventive care benefits (covered at 100% in-network)
		Evaluate vendor capabilities surrounding UM/DM/CM* via medical TPA RFP
		Promote wellness tools and resources available through the GHIP medical TPA(s) (e.g., tobacco cessation, DelaWELL resources)
		Educate GHIP members on lower cost alternatives to seek care outside of the emergency room (i.e., urgent care centers, retail clinics, telemedicine)
		Evaluate incentive opportunities through incentive-based activities and/or challenges
		Explore avenues to building of "culture of health" statewide

*UM = Utilization Management | DM = Disease Management | CM = Case Management

Proposed GHIP strategies and tactics

Goal: GHIP membership enrollment in a consumer-driven or value-based plan exceeding 25% of total population by end of FY2020

Demand

Strategies	Tactics
Ensure members understand benefit offerings and value provided	Launch healthcare consumerism website
	Roll out and promote SBO consumerism class to GHIP participants
	Offer a medical plan selection decision support tool (e.g., Truven's "My Benefits Mentor" tool)
	Promote cost transparency tools available through medical TPA(s)
Offer meaningfully different plan options to meet the diverse participant needs	Change medical plan designs and employee/retiree contributions to further differentiate plan options*
	Change the number of medical plans offered*
	Communicate plan offerings, in conjunction with decision support tool to guide members into appropriate plans
Drive GHIP members' engagement in their health	Evaluate recommendations for creative ways to drive engagement and participation in consumer driven health plans via medical TPA RFP through leveraging vendor tools and technologies
	Evaluate feasibility of offering incentives for engaging in wellness activities

*May require changes to the Delaware Code

Multi-year framework

Goal	To prepare for 2018 and beyond (7/1/16 – 6/30/2017)	To prepare for 2019 and beyond (7/1/17 – 6/30/2018)	To prepare for 2020 and beyond (7/1/18 – 6/30/2019)
Addition of at least 1 value-based care delivery (VBCD) model by end of FY2018	★ Evaluate local provider capabilities to deliver VBCD models via medical third party administrator (TPA) RFP • State-sponsored Health Clinic Request for Information (RFI) ★ Implementation of VBCD models from RFP (including COEs) • Evaluation of clinical data to implement more value-based chronic disease programs ★ Promote medical plan TPAs' provider cost/quality transparency tools	★ Implementation of VBCD models from RFP (including COEs) • Look for leveraging opportunities with the DCHI and DHIN to partner on promotion of value based networks (including APCD initiative) • Identify opportunities to partner and encourage participation in VBCD models using outside vendors, TPAs and DelaWELL • Educate GHIP population on other provider quality tools from CMS, Health Grades, Leapfrog, etc.	• Continue to monitor and evaluate VBCD opportunities
Reduction of gross GHIP medical and prescription drug trend by 2% by end of FY2020	★ Negotiate strong financial performance guarantees ★ Select vendor(s) with most favorable provider contracting arrangements ★ Select vendor(s) that can best manage utilization and population health ★ Evaluate bidder capabilities surrounding Centers of Excellence via medical TPA RFP • Educate GHIP members on the importance of preventive care and the State's preventive care benefits (covered at 100% in-network) ★ Evaluate vendor capabilities surrounding UM/DM/CM* via medical TPA RFP • Evaluate feasibility of reducing plan options and/or replacing copays with coinsurance* • Educate GHIP members on lower cost alternatives to seek care outside of the emergency room (i.e., telemedicine, urgent care centers, retail clinics) • Evaluate incentive opportunities through incentive-based activities and/or challenges • Change certain plan inequities, e.g., double state share and Medicfill subsidy*	★ Explore and implement medical TPA programs, such as tiered pricing for lab services, high cost radiology UM* and other medical and Rx UM programs, where necessary • Explore avenues for building "culture of health" statewide • Continuation of education of GHIP members on the importance of preventive care and the State's preventive care benefits (covered at 100% in-network) • Continuation of education of GHIP members on lower cost alternatives to seek care outside of the emergency room (i.e., telemedicine, urgent care centers, retail clinics) • Continuation of the evaluation of feasibility of reducing plan options and/or replacing copays with coinsurance—based on emerging market and value-based design*	★ Explore and implement medical TPA programs, such as tiered pricing for lab services, high cost radiology UM* and other medical and Rx UM programs, where necessary • Continuation of education of GHIP members on the importance of preventive care and the State's preventive care benefits (covered at 100% in-network) • Continuation of education of GHIP members on lower cost alternatives to seek care outside of the emergency room (i.e., telemedicine, urgent care centers, retail clinics) • Continuation of the evaluation of feasibility of reducing plan options and/or replacing copays with coinsurance—based on emerging market and value-based design*
GHIP membership enrollment in a consumer-driven or value-based plan exceeding 25% of total population by end of FY2020	• Launch healthcare consumerism website • Roll out and promote SBO consumerism class to GHIP participants ★ Evaluate recommendations for creative ways to drive engagement and participation in consumer driven health plans via medical TPA RFP through leveraging vendor tools and technologies	• Offer a medical plan selection decision support tool (e.g., Truven's "My Benefits Mentor" tool) ★ Promote cost transparency tools available through medical TPA(s) • Evaluate feasibility of offering incentives for engaging in wellness activities	• Change medical plan designs and employee/retiree contributions to further differentiate plan options* • Change the number of medical plans offered*

*May require changes to the Delaware Code

★ Denotes activity through TPA RFP process

Active/Pre-65 retiree combination design/cost sharing scenarios

- The following table illustrates the FY18 State and General Fund savings associated with the following alternatives effective 1/1/18:
  - Add deductibles to the HMO and PPO plans, and
  - Increase the overall active/pre-65 retiree cost share by 1%, 2% and 3%

Deductible (single/family)	Current (10.6% Cost Share)		1% Increase (11.6% Cost Share)		2% Increase (12.6% Cost Share)		3% Increase (13.6% Cost Share)	
	State Total	General Fund[1]	State Total	General Fund[1]	State Total	General Fund[1]	State Total	General Fund[1]
Current Plan Design	$0.0 M	$0.0 M	$3.4 M	$2.2 M	$6.7 M	$4.4 M	$10.1 M	$6.5 M
$50 / $100	$1.2 M	$0.7 M	$4.4 M	$2.8 M	$7.7 M	$5.0 M	$11.1 M	$7.2 M
$100 / $200	$2.1 M	$1.4 M	$5.3 M	$3.4 M	$8.6 M	$5.6 M	$11.9 M	$7.7 M
$150 / $300	$3.2 M	$2.1 M	$6.2 M	$4.0 M	$9.5 M	$6.2 M	$12.8 M	$8.3 M
$200 / $400	$4.3 M	$2.8 M	$7.2 M	$4.7 M	$10.5 M	$6.8 M	$13.8 M	$9.0 M
$250 / $500	$5.2 M	$3.4 M	$8.0 M	$5.2 M	$11.3 M	$7.3 M	$14.6 M	$9.5 M
$500 / $1000	$9.2 M	$6.0 M	$11.6 M	$7.5 M	$14.9 M	$9.6 M	$18.1 M	$11.8 M

- Note: savings from adding deductibles are partially offset by a reduction in premium revenue since employee/pensioner contributions are a percentage of plan premium
- Expected FY18 active/pre-65 retiree premium cost share is 10.6%[2]; increases shown above moves cost sharing in the direction towards market norms

[1] Splits calculated using GHIP group percentages based on Truven census and actual Fiscal Year 2016 Premium Contributions and Revenue as reported by OMB Financial Operations/PHRST

[2] Based on expected enrollment used to develop FY18 budget; reflects final TPA RFP decisions and anticipated migration

Active/Pre-65 retiree design/cost sharing scenarios – employee impact

- The table below illustrates FY18 employee/pensioner annual contribution as a percent of pay, based on current contribution levels and for each the plan design and cost sharing alternatives under consideration
  - Illustrated for sample employees earning $25,000 and $50,000 annually

Annual Payroll Contribution as % of Pay[1]	Employee earning $25,000 annually				Employee earning $50,000 annually			
	Status Quo	Cost Share Increase			Status Quo	Cost Share Increase		
		+1%	+2%	+3%		+1%	+2%	+3%
HMO - Employee Only								
Current Plan Design	2.3%	2.5%	2.7%	2.9%	1.1%	1.2%	1.3%	1.5%
$50 Deductible	2.3%	2.5%	2.7%	2.9%	1.1%	1.2%	1.3%	1.5%
$500 Deductible	2.2%	2.4%	2.7%	2.9%	1.1%	1.2%	1.3%	1.4%
HMO - Family								
Current Plan Design	6.0%	6.5%	7.1%	7.6%	3.0%	3.3%	3.5%	3.8%
$50 Deductible	5.9%	6.5%	7.1%	7.6%	3.0%	3.3%	3.5%	3.8%
$500 Deductible	5.9%	6.4%	7.0%	7.5%	2.9%	3.2%	3.5%	3.8%
PPO - Employee Only								
Current Plan Design	5.0%	5.5%	6.0%	6.5%	2.5%	2.8%	3.0%	3.2%
$50 Deductible	5.0%	5.5%	6.0%	6.5%	2.5%	2.8%	3.0%	3.2%
$500 Deductible	5.0%	5.5%	5.9%	6.4%	2.5%	2.7%	3.0%	3.2%
PPO - Family								
Current Plan Design	13.1%	14.3%	15.6%	16.8%	6.5%	7.2%	7.8%	8.4%
$50 Deductible	13.1%	14.3%	15.5%	16.8%	6.5%	7.2%	7.8%	8.4%
$500 Deductible	12.9%	14.2%	15.4%	16.6%	6.5%	7.1%	7.7%	8.3%

[1] Reflects payroll contribution only; does not reflect out-of-pocket expense.

Premium cost share savings

Employee/Pensioner impact

Employee/Pensioner Monthly Contribution	FY18 Status Quo Contribution	+1% Cost Share Increase			
		Contribution	% Change	Monthly $ Change	Annual $ Change
First State Basic[1]	**4.00%**	**4.38%**			
Employee	$27.84	$30.46	9%	$2.62	$31.44
Employee & Spouse	$57.52	$62.92	9%	$5.40	$64.80
Employee & Child(ren)	$42.26	$46.23	9%	$3.97	$47.64
Family	$71.92	$78.68	9%	$6.76	$81.12
CDH Gold[1]	**5.00%**	**5.47%**			
Employee	$35.98	$39.36	9%	$3.38	$40.56
Employee & Spouse	$74.58	$81.59	9%	$7.01	$84.12
Employee & Child(ren)	$54.96	$60.12	9%	$5.16	$61.92
Family	$94.78	$103.69	9%	$8.91	$106.92
HMO[1]	**6.50%**	**7.11%**			
Employee	$47.16	$51.59	9%	$4.43	$53.16
Employee & Spouse	$99.50	$108.85	9%	$9.35	$112.20
Employee & Child(ren)	$72.18	$78.96	9%	$6.78	$81.36
Family	$124.12	$135.78	9%	$11.66	$139.92
PPO[1]	**13.25%**	**14.49%**			
Employee	$105.18	$115.06	9%	$9.88	$118.56
Employee & Spouse	$218.26	$238.77	9%	$20.51	$246.12
Employee & Child(ren)	$162.08	$177.31	9%	$15.23	$182.76
Family	$272.86	$298.50	9%	$25.64	$307.68

[1] Percentages shown represent the employee/pensioner share of plan premium

Premium cost share savings

Employee/Pensioner impact

Employee/Pensioner Monthly Contribution	FY18 Status Quo Contribution	+2% Cost Share Increase			
		Contribution	% Change	Monthly $ Change	Annual $ Change
First State Basic[1]	**4.00%**	**4.76%**			
Employee	$27.84	$33.07	19%	$5.23	$62.76
Employee & Spouse	$57.52	$68.33	19%	$10.81	$129.72
Employee & Child(ren)	$42.26	$50.20	19%	$7.94	$95.28
Family	$71.92	$85.44	19%	$13.52	$162.24
CDH Gold[1]	**5.00%**	**5.94%**			
Employee	$35.98	$42.74	19%	$6.76	$81.12
Employee & Spouse	$74.58	$88.60	19%	$14.02	$168.24
Employee & Child(ren)	$54.96	$65.29	19%	$10.33	$123.96
Family	$94.78	$112.59	19%	$17.81	$213.72
HMO[1]	**6.50%**	**7.72%**			
Employee	$47.16	$56.02	19%	$8.86	$106.32
Employee & Spouse	$99.50	$118.20	19%	$18.70	$224.40
Employee & Child(ren)	$72.18	$85.74	19%	$13.56	$162.72
Family	$124.12	$147.45	19%	$23.33	$279.96
PPO[1]	**13.25%**	**15.74%**			
Employee	$105.18	$124.95	19%	$19.77	$237.24
Employee & Spouse	$218.26	$259.28	19%	$41.02	$492.24
Employee & Child(ren)	$162.08	$192.54	19%	$30.46	$365.52
Family	$272.86	$324.14	19%	$51.28	$615.36

[1] Percentages shown represent the employee/pensioner share of plan premium

Premium cost share savings

Employee/Pensioner impact

Employee/Pensioner Monthly Contribution	FY18 Status Quo Contribution	+3% Cost Share Increase			
		Contribution	% Change	Monthly $ Change	Annual $ Change
First State Basic[1]	**4.00%**	**5.13%**			
Employee	$27.84	$35.69	28%	$7.85	$94.20
Employee & Spouse	$57.52	$73.73	28%	$16.21	$194.52
Employee & Child(ren)	$42.26	$54.17	28%	$11.91	$142.92
Family	$71.92	$92.19	28%	$20.27	$243.24
CDH Gold[1]	**5.00%**	**6.41%**			
Employee	$35.98	$46.12	28%	$10.14	$121.68
Employee & Spouse	$74.58	$95.60	28%	$21.02	$252.24
Employee & Child(ren)	$54.96	$70.45	28%	$15.49	$185.88
Family	$94.78	$121.50	28%	$26.72	$320.64
HMO[1]	**6.50%**	**8.33%**			
Employee	$47.16	$60.45	28%	$13.29	$159.48
Employee & Spouse	$99.50	$127.55	28%	$28.05	$336.60
Employee & Child(ren)	$72.18	$92.53	28%	$20.35	$244.20
Family	$124.12	$159.11	28%	$34.99	$419.88
PPO[1]	**13.25%**	**16.98%**			
Employee	$105.18	$134.83	28%	$29.65	$355.80
Employee & Spouse	$218.26	$279.79	28%	$61.53	$738.36
Employee & Child(ren)	$162.08	$207.77	28%	$45.69	$548.28
Family	$272.86	$349.78	28%	$76.92	$923.04

[1] Percentages shown represent the employee/pensioner share of plan premium

Selected “Healthy Lifestyles” metrics

Benchmark	State of Delaware Metrics
1. Preventative Care participation U.S. Norm[5]: a. Cervical cancer screening 63.1% b. Colon Cancer screening 42% c. Mammogram screening 67.4% d. Cholesterol Screening 79.9% e. Physical exam participation 29.9% 2. Care Management participation exceeding vendor-provided book-of-business[6]: a. 0.75% of unique MBRs targeted for outreach b. 0.39% engaged cases c. 18.4 % of MBRs Identified w DM Opportunity d. 4.4% of MBRs w Nurse Engagement	**Preventive care though December 2016[5]:** 1.a 67% of the applicable population enrolled received cervical cancer screening 1.b 40% of the population enrolled participated in colon cancer screening 1.c 58% of applicable GHIP members currently receive mammograms 1.d 36% of the population enrolled engaged in cholesterol screening 1.e 36% of the population enrolled completed a physical exam 1 FY2018 State of Delaware and DHHS cancer screening initiative **Care Management though December 2016[6]:** 2.a Aetna HMO: 0.07% of unique members targeted for outreach 2.b Aetna HMO: 0.02% engaged cases 2.c Aetna HMO 20.4% of MBRs Identified w DM Opportunity 2.c Aetna CDH Gold 12.2% of MBRs Identified w DM Opportunity 2.d Aetna HMO: 3.3% of MBRs w Nurse Engagement 2.d Aetna CDH Gold: 3.5% of MBRs w Nurse Engagement 2.a Highmark 19.1% attempts 2.a Highmark 11.2% reached 2.d Highmark 8.1% engaged

1. WTW 2016 Best Practices in Health Care Employer Survey
2. Based on FY2017 plan offerings for actives, pre 65 retirees and Medicare eligible retirees
3. ESHC: Employer Sponsored Health Center
4. Based on 3Q2017 financial reporting; includes actives, pre-65 retirees and Medicare eligible retirees enrolled in the GHIP
5. WTW 2016 Emerging Trends in Health Care Survey - Education, Government and Public Sector (30 employers)