

The State of Delaware

FY19 Planning

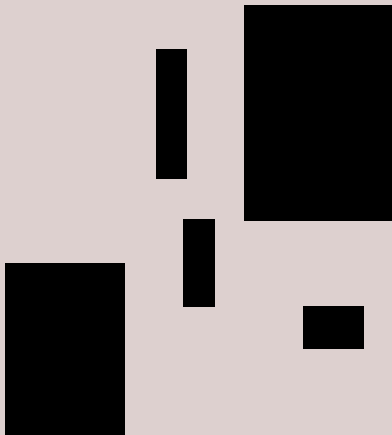
January 22, 2018

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CY2018 employee engagement initiatives



CY2018 employee engagement initiatives

Initiatives led by the SBO

- myBenefitsMentor tool will be provided again during 2018 OE to employees and non-Medicare pensioners enrolled in the GHIP prior to 1/1/18
- SBO and DTI Re-launch of health care consumerism course developed by the SBO and administered through Delaware Learning Center
- **New:** Targeted, health plan-specific educational emails to enrolled employees
- **New:** “Help us help you” communications campaign through early 2018 to encourage employees to update contact information and consent to receiving required plan notices electronically
- **New:** Enhancements to enrollment application for 2018 OE to improve user experience and monitor employee participation
- **New:** Presentations on health care cost and employee engagement challenges to HR Roundtable and various School District leadership and HR personnel and call to action for their assistance
- **New:** Outreach and meetings with each of the 19 school districts to provide overview of OE communication strategy, review district-specific engagement and utilization statistics and discuss approaches to future communication campaigns and health education initiatives
 - Discussion will be informed, in part, by SBO learnings from attendance at School District ISO/IT meeting to learn more about how District IT support HR in providing employees with computer/technology support during OE
- **New:** Outreach to DSEA, DSTA, COAD, AFSCME to provide overview of OE communication strategy, request support from union members to host and participate in employee education sessions, and discuss approaches to future communication campaigns and health education initiatives

CY2018 employee engagement initiatives (continued)

Initiatives led by GHIP medical vendors

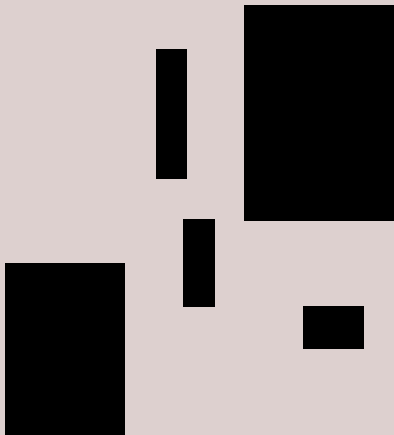
Aetna

- Telephonic outreach to members that do not have a PCP on file (started 12/4/17)
- Member home mailings on “Choosing the Right Care” (ER, Urgent Care, Telemedicine, PCP, 24/7 Nurse Line); “Diabetes Prevention and Management”; “Cancer”; and “Musculoskeletal Pain - Prevention and Management”
- Carelink CareNow
 - Welcome letter to members
 - Care coordinators/advisors make outbound calls to members (i.e., hospital use and post-discharge follow-up, chronic conditions, high-costs/utilization, abnormal lab results) to engage them in their care coordination programs
 - In-person outreach with members who are struggling with a combination of social barriers to health and poorly controlled medical diagnoses
 - Targeted mailing to women with confirmed pregnancy

Highmark

- Communication campaign in Q1 CY18 to outreach to members without a current PCP
- Member home mailings on “Choosing the Right Care” (ER, Urgent Care, Telemedicine, PCP, 24/7 Nurse Line); “Diabetes Prevention and Management”; “Cancer”; and “Musculoskeletal Pain - Prevention and Management”
- Custom Care Management Unit (CCMU) – Customer Care Advocates ask specific questions when members call Highmark, in order to develop a full understanding of the inquiry and identify opportunities to engage members clinically or non-clinically (with referrals to health coaches, case managers and outside resources)
- Blues On Call Health Coaching – Licensed professional health coaches make outbound calls to members based on chronic conditions, high-costs/utilization, transition of care, etc.

FY2019 preventive care modifications



Statin coverage

- Non-grandfathered plans are required under the Affordable Care Act (ACA) to cover certain preventive items at zero cost share for patients
 - Statin preventive requirement was the most recent requirement
 - In order to remain in compliance with the ACA requirements, the GHIP must cover statin as preventive medications
- ESI has presented two options for covering statins as preventive medications:
 - Option 1: Waive copay (\$0 copay) for all generic statins for members in a certain age range, which would catch both preventive and non-preventive usage (i.e., cast a wider net than required under ACA)
 - \$286k cost increase to the GHIP
 - Option 2: Waive copay for all generic statins for members in age range plus other constraints, which would narrow the set of members who would receive \$0 copay, and some non-preventive users in age range would have to pay original copay
 - ESI charges \$35k for this ACA Statin Trend Management Solution
 - \$231k net cost increase to the State with ESI fee
- Recommend Option 1
 - Simpler messaging to GHIP participants
 - Less to manage administratively (e.g., no need for exception process if other constraints in Option 2 not met)

3D Mammography (Breast Tomosynthesis)

- 3D Mammography (Breast Tomosynthesis) is increasingly being covered by major health plans for screening and diagnostic purposes
 - 50% of women have dense breast tissue and have a high risk for developing breast cancer. These women are also more likely to have a cancer that is missed by traditional (2D) mammography
 - Until recently, 3D mammography was covered for diagnostic purposes only — that is, to confirm a diagnosis of breast cancer after the completion of a screening mammogram with inconclusive results
- Recent guidance from the National Comprehensive Cancer Network (NCCN) has influenced national payers to adopt coverage of 3D mammography as an option for routine screenings
 - The NCCN cites multiple studies that show combined use of digital mammography and tomosynthesis appears to improve cancer detection and decreased call back rates
 - However, the US Preventive Services Task Force (USPSTF) concluded in a 2016 update that the current evidence was insufficient to assess the benefits and harms of digital breast tomosynthesis as a primary screening method for breast cancer, as it has not been proven to reduce mortality
- Recommend following the technical evaluation criteria recommended by Aetna and Highmark to determine whether to adopt coverage of 3D mammography for routine screenings

3D Mammography (Breast Tomosynthesis) (continued)

Medical TPA technical evaluation criteria and estimated annual cost

Aetna

- Considers digital breast tomosynthesis (3D mammography) as a medically necessary acceptable alternative to standard (2D) mammography¹
- Considers computer-aided detection (CAD) a medically necessary adjunct to mammography
- Guidelines for medically necessary annual mammography screening
 - For women aged 40 and older
 - For younger women who are judged to be at high-risk [further defined within the policy bulletin]
 - For men with a prior history of breast cancer

Per Aetna's coverage policy bulletin "Mammography", Number: 0584. Policy was last reviewed on 7/1/17 and is due for its next review on 6/7/18.
http://www.aetna.com/cpb/medical/data/500_599/0584.html

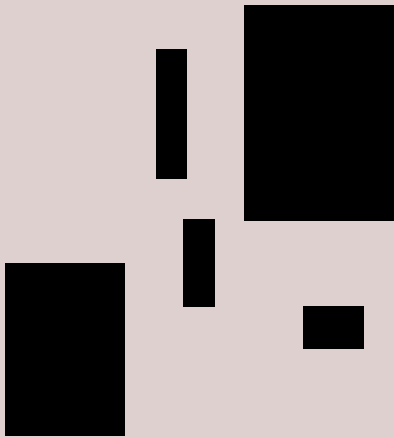
Highmark

- Covered as both preventive and diagnostic service for both fully insured and ASO (self-funded) membership²
- Payment will be made for one screening mammography including computer-aided detection (CAD) OR screening mammography with digital breast tomosynthesis per calendar year for asymptomatic individuals with female anatomy 40 years of age or older
- Self-referred screening mammograms for individuals with female anatomy under age 40 are not covered
- Diagnostic mammograms are covered according to a member's individual or group customer benefits, that includes standard diagnostic mammography and diagnostic digital breast tomosynthesis

Per Highmark's commercial medical policy "Mammography", Number: X-21-013. Policy was last reviewed in November 2016 and is effective 1/1/18.
<https://secure.highmark.com/ldap/medicalpolicy/delaware-commercial-medical-policy/X-21-013.html>

- **Estimated annual cost** to cover preventive 3D mammography at no cost to members is approximately **\$837,000** (assumes 7/1/18 effective date)
- **Recommendation:** Adopt coverage for preventive 3D mammography for FY19

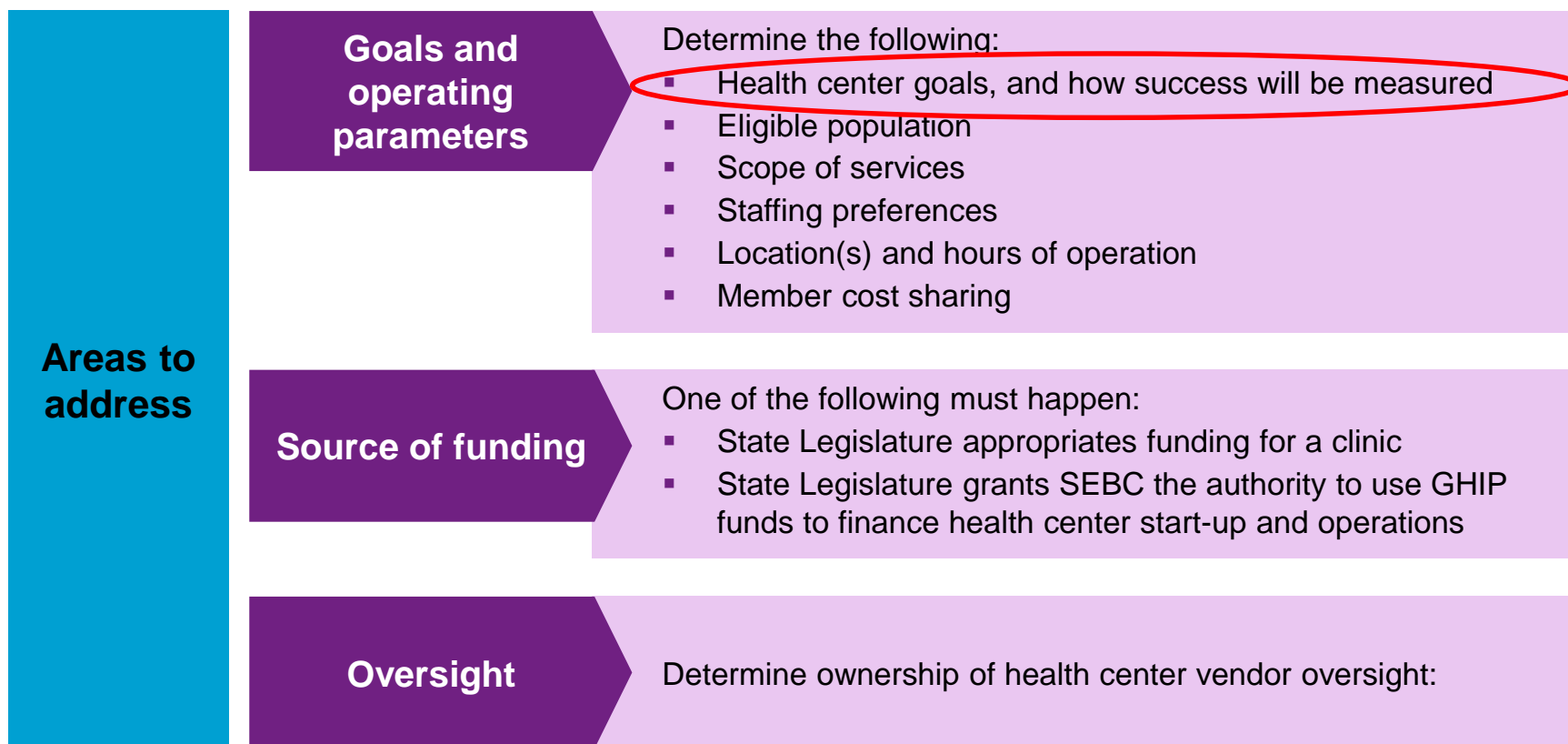
Employer-sponsored clinics



Employer-sponsored health care

Next steps for the State of Delaware (presented during 12/11/17 SEBC meeting)

- Today's discussion will focus on potential goals and success measurements of an employer-sponsored health center



Common goals for employer-sponsored clinics

Top 3 Primary Objectives for Initially Implementing a Clinic*

Reduce lost time and absence from work
Improve productivity

Improve access and convenience
Offer primary care

Reduce medical costs
Lower trend, shrink total cost of care and deliver ROI

Improve health outcomes

Manage worksite injuries and illnesses
Lower workers' compensation costs

Boost employee value proposition

Reduce employee out of pocket in consumer directed health plans
Lower family expenses

Drive greater engagement in health coaching and care management
Add important touch points

Offer higher quality and consistency of care than what is currently delivered in the community
Based on individual community medical system performance

*Willis Towers Watson 2015 Employer-Sponsored Health Care Centers Survey. N = 137 companies, of which 105 offered employer-sponsored health centers at time of survey.

Proposed employer-sponsored health care goals for Delaware

Based on SEBC feedback and consistent with GHIP strategic framework

**Expand
Access to
Care**



With focus on primary care, prevention and wellness, with selected specialty care as needed

**Improve
Quality of
Care**



Directly through the health center and indirectly via referrals to high performing providers

**Reduce
Total Cost
of Care**



Through improved health of the covered population, and through redirection of care from expensive, suboptimal and inappropriate settings, when clinically appropriate

Do these proposed goals resonate with the SEBC?

What other strategies are in play that accomplish these goals?

Proposed measures of success

Proposed Goal: Expand Access to Care

Measure, Monitor	Benchmark	Baseline	Strategies to Accomplish
<p>Via GeoAccess reporting from medical TPAs, by zip code:</p> <ul style="list-style-type: none"> PCPs Urgent care Retail clinics <p>Utilization rates of the above provider types, plus telemedicine</p>	<p>Industry-standard parameter for adequate network access $\geq 90\%$ of members have access to in-network provider</p> <p>Utilization rates:</p> <ul style="list-style-type: none"> PCPs: 2,000 - 2,500 visits/1,000 Ratio of PCP:ER visits: <11 Urgent care: 83 - 115 visits/1,000 Telemedicine: $<10\%$ of eligible population Retail clinics: TBD based on input from Truven and medical TPAs 	<p>% members with in-network access (across all zip codes and both medical TPAs, unless otherwise noted):</p> <ul style="list-style-type: none"> PCPs: 100% Urgent care: 100% Retail clinics: varies by plan and vendor, up to 61% with access <p>Utilization – All members of active & non-Medicare retiree medical plans:</p> <ul style="list-style-type: none"> PCPs¹: 1,573 visits/1,000 Ratio of PCP:ER visits¹: 12.1 Urgent care¹: 485 visits/1,000 Telemedicine²: $<1\%$ of eligible population Retail clinics: TBD based on input from Truven and medical TPAs 	<ul style="list-style-type: none"> Member communications promoting these resources as alternatives to ER or for after-hours care Partner with a resource to offer “onsite” screenings via mobile health van or onsite visits with a traveling nurse / provider Leverage new resources via the medical vendors, e.g., Catapult Health via Highmark, to provide onsite health screenings Install kiosks in larger worksites to expand access to telemedicine

1. Based on Truven reporting, 12/8/17. Assumes FY17 average of 99,163 members in active employee and non-Medicare retiree medical plans.

2. Based on Aetna and Highmark quarterly reports, Q1 FY18.

Proposed measures of success

Proposed Goal: Improve Quality of Care

Measure, Monitor	Benchmark	Baseline	Strategies to Accomplish
<ul style="list-style-type: none"> ▪ Cancer screening rates ▪ Other age/gender appropriate screenings ▪ Member utilization of high performing providers 	<p>Cancer & age/gender-appropriate screening rates¹:</p> <ul style="list-style-type: none"> ▪ Cervical cancer: 63.1% ▪ Colon cancer: 42% ▪ Mammogram: 67.4% ▪ Cholesterol: 79.9% ▪ Adult physical exam: 29.9% <p>% of members attributed to high performing provider: TBD with input from medical TPAs</p>	<p>% of eligible population screened¹:</p> <ul style="list-style-type: none"> ▪ Cervical cancer: 67% ▪ Colon cancer: 40% ▪ Mammogram: 58% ▪ Cholesterol: 36% ▪ Adult physical exam: 36% <p>% of members attributed to high performing provider:</p> <ul style="list-style-type: none"> ▪ Aetna²: 46% ▪ Highmark³: 54% 	<ul style="list-style-type: none"> ▪ Leverage new resources via the medical vendors, e.g., Catapult Health via Highmark ▪ Leverage Aetna and Highmark care management programs to steer more members to high performing providers (including COEs) ▪ Member communications on the importance of using high performing community providers, ▪ Member communications on compliance with preventive screenings (driven by SBO and medical TPAs)

1. Based on FY2016 screening rates by all plans provided by Truven; 2016 U.S. Norm from Truven's commercial database.

2. Based on metrics provided by Aetna on 8/8/2017.

3. Based on metrics provided by Highmark on 8/8/2017.

Proposed measures of success

Proposed Goal: Reduce Total Cost of Care

Measure, Monitor	Benchmark	Baseline	Strategies to Accomplish
<ul style="list-style-type: none"> GHIP trend Health risk score Utilization of “preferred” sites of care 	<ul style="list-style-type: none"> Market average medical trend at 6% for 2017¹ “Average” health risk score³: 100 <p>Utilization rates:</p> <ul style="list-style-type: none"> Urgent care: 83 - 115 visits/1,000 Preferred labs: TBD based on input from Truven and medical TPAs Freestanding radiology facilities: TBD based on input from Truven and medical TPAs 	<ul style="list-style-type: none"> FY18 recast, projected trend²: 5.9% Health risk scores (for members of all medical plans combined)³: <ul style="list-style-type: none"> Actives: 146 Early Retirees: 277 Medicare Retirees: 686 <p>Utilization – All members of active & non-Medicare retiree medical plans:</p> <ul style="list-style-type: none"> Urgent care⁴: 485 visits/1,000 Preferred labs: 849.7 visits/1,000 Freestanding high-tech radiology facilities: 77.1 visits/1,000 	<ul style="list-style-type: none"> Increase member utilization of high performing providers Increase member utilization of preferred sites of care (i.e., urgent care, freestanding imaging centers, preferred lab facilities, centers of excellence) Communication campaigns on appropriate use of the emergency room, and on the importance of having a PCP/medical home

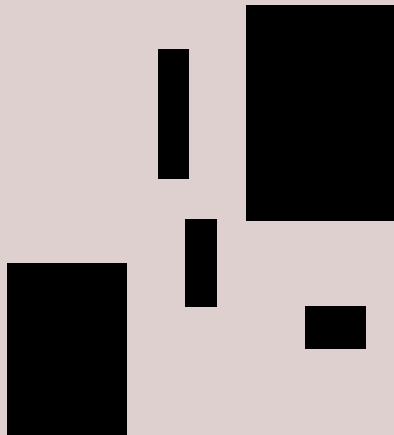
1. 2017 Willis Towers Watson Best Practices in Health Care Employer Survey. Trend before plan design changes.

2. From WTW materials presented at the 12/11/17 SEBC meeting.

3. Truven. Baseline health risk scores for 7/2015 – 6/2016.

4. Based on Truven reporting, 12/8/17. Assumes FY17 average of 99,163 members in active employee and non-Medicare retiree medical plans.

Health Savings Account plan considerations



Health Savings Account plan – defined

Definitions

Consumer Directed Health Plan (CDHP)

A type of medical plan offered together with a personal account (i.e., health savings account or health reimbursement arrangement) that can be used to pay a portion of the medical expense not paid by the plan.

Also called a High Deductible Health Plan (HDHP).

Health Savings Account (HSA)

A tax-advantaged medical savings account available to taxpayers in the United States who are enrolled in an IRS-qualified HDHP.

Health Reimbursement Arrangement (HRA)

Employer-funded account that reimburses employees for out-of-pocket medical expenses.

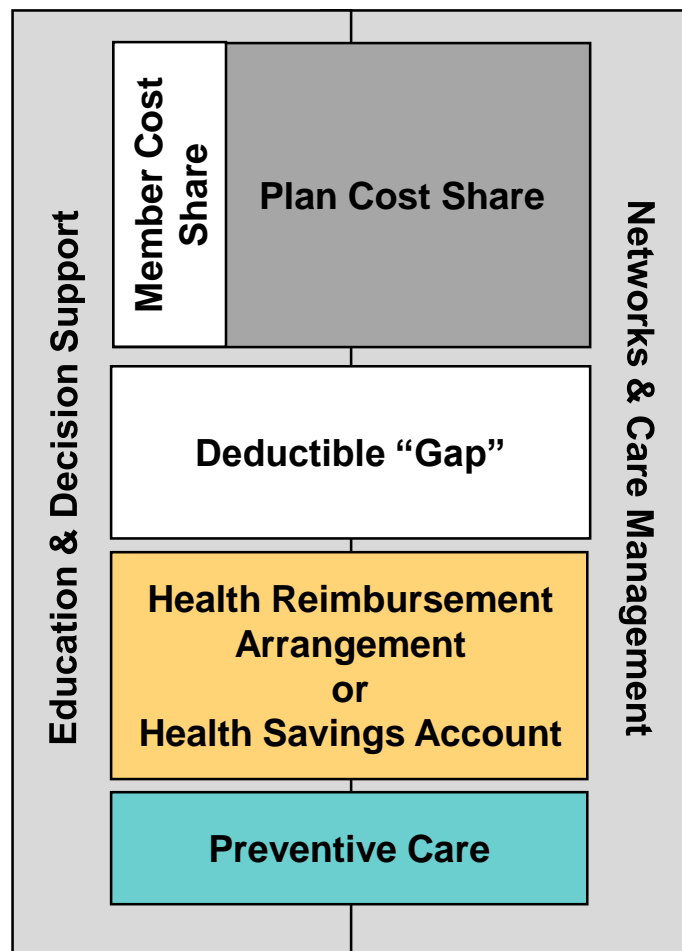
References to a ***Health Savings Account plan*** are intended to describe an IRS-qualified Consumer Directed Health Plan with a Health Savings Account

Health Savings Accounts vs. Health Reimbursement Accounts

Health Savings Account (HSA)

- An individual bank account that can be funded with employer and employee dollars – “real money”
- Triple tax free – contributions, interest and reimbursements (when used for qualified medical expenses)
- Contributions to an Health Savings Account may be made only if account holder has IRS-qualified HDHP coverage and no other impermissible coverage – limits design flexibility
- Contributions made to the Health Savings Account can be invested and grow with interest over time – allowing for retirement savings
- The account is owned by employee and goes with the employee upon termination of employment

Consumer Directed Health Plan



Health Reimbursement Arrangement (HRA)

- An employer-funded (only) notional account that pays for qualified medical and pharmacy expenses
- No HDHP requirements – greater design flexibility
- Unused balances may accumulate year after year, but generally cannot be taken when the employee retires or leaves the company
- General purpose Flexible Spending Account permitted

Plan design requirements for a Health Savings Account plan

- The IRS mandates certain plan design provisions to maintain tax-favored status of the Health Savings Account

Calendar Year 2018 Limits	IRS-qualified HDHP / HSA
Minimum Deductible (Ind./Fam.)	\$1,350 / \$2,700
Maximum Out-of-Pocket Max (Ind./Fam.)	\$6,650 / \$13,300
Maximum Health Savings Account contribution (combined employer and employee, Ind./Fam.)	\$3,450 / \$6,900
Catch-up Health Savings Account contributions (for individuals attaining age 55 by 12/31 until enrolled in Medicare)	\$1,000

- Deductible applies to all services covered by the plan – i.e., medical **and** prescription drug
- Health Savings Account plan enrollee cannot have any other coverage that provides first-dollar coverage of medical expenses (e.g., dual coverage on a spouse’s plan) and cannot have a health care Flexible Spending Account (FSA) to pay for medical expenses (i.e., “limited purpose” health care FSA for dental and vision expenses only)
- The FY18 CDH Gold plan meets the above plan design provisions but offers a Health Reimbursement Account (HRA) instead of an Health Savings Account
 - HRA is not tax-advantaged, is funded only by the State, and is forfeited by the employee upon disenrollment in the GHIP for any reason (i.e., is “notional” funding)

Employee advantages to offering a Health Savings Account plan

- There are multiple advantages to offering a Health Savings Account plan that are not available in the current GHIP plans

Employee savings vehicle	<ul style="list-style-type: none">A Health Savings Account allows employees to save for future medical expenses, including but not limited to retiree medicalEmployees decide when and how to use Health Savings Account funds, or whether to save them for future qualified medical expenses, including after retirementEmployees can start, stop, or adjust Health Savings Account contributions at any timeFunds can be invested once the Health Savings Account balance exceeds a certain threshold
No “use it or lose it” rule	<ul style="list-style-type: none">Unused funds carry over from year to year and are always the employee’s to keep, unlike employee contributions to a health care Flexible Spending Account (FSA)
Triple tax incentives	<ul style="list-style-type: none">No federal taxes (or state taxes, except in NJ and CA)¹ on the funds the employee deposits, the employer-provided funds, the interest earned, or the funds spent on qualified medical expensesTaxes and penalties do apply if Health Savings Account funds are used to pay for anything other than qualified medical expenses
Competitive position	<ul style="list-style-type: none">The marketplace has been moving in this direction, with 73% of all large employers and 63% of public sector and education employers offering a consumer directed health plan (either Health Savings Account or Health Reimbursement Arrangement plan) in 2017²New hires may have open Health Savings Accounts from a prior employer

- Health Savings Account contributions made by the State or by the employee via pre-tax payroll deductions are not eligible for tax-favored treatment for state tax purposes in NJ and CA. In AL, pre-tax contributions are tax-free, but any post-tax employee contributions to the Health Savings Account are taxable by the state.
- 2017 Willis Towers Watson Best Practices in Health Care Employer Survey. Sample: Companies with at least 1,000 employees.

Health Savings Account plan design – illustrative scenarios

Plan Design (In-network)	Scenario 1	Scenario 2
Deductible (Ind./Fam.)	\$2,000 / \$4,000	\$1,500 / \$3,000
Account Funding (Ind./Fam.)	\$1,000 / \$2,000	\$1,000 / \$2,000
Coinsurance	80%	80%
Out-of-Pocket Max (Ind./Fam.)	\$4,500 / \$9,000	\$4,500 / \$9,000
PCP Office Visit	80%	80%
Specialist Office Visit	80%	80%
Emergency Room	80%	80%
Inpatient Care	80%	80%
Prescription Drug¹		
Out-of-Pocket Max (Ind./Fam.)	Combined with medical	Combined with medical
▪ Retail	\$8 / \$28 / \$50 after deductible	\$8 / \$28 / \$50 after deductible
▪ Mail Order	\$16 / \$56 / \$100 after deductible	\$16 / \$56 / \$100 after deductible

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

Financial impact of a Health Savings Account plan on the GHIP

- Financial impact of a Health Savings Account plan will vary based on:
 - Which participant groups are offered this plan
 - Availability of other plan options and/or changes to existing plan options
 - Final plan design and employer Health Savings Account contribution (“seed”)
 - Employee contributions relative to existing plan options

Estimated GHIP Savings ¹	Scenario 1	Scenario 2
Per 5% Migration to Health Savings Account plan	\$2.8M (\$1.9M General Fund)	\$2.1M (\$1.4M General Fund)
Full Replacement (100% enrollment in Health Savings Account plan)	\$56.7M (\$37.6M General Fund)	\$41.3M (\$27.4M General Fund)

1. Savings assumes migration from current plans (if offered alongside) or full-replacement of active employees and pre-65 retirees enrolled in the First State Basic, CDH Gold, HMO, and PPO plans; this does not include Port POS or post-65 retiree Medicfill participants.

Drivers of enrollment and engagement

- Impact of this plan option is highly dependent on enrollment and member engagement

Enrollment drivers – examples

- Offering this plan at no/very low cost to employees
- Freezing enrollment in other medical plans¹
- Offering this plan as the only option for employees hired on or after a certain date or as a full-replacement option¹

Engagement drivers – examples

- Offering cost transparency tools
- Seeding the Health Savings Account at the beginning of the plan year with employer-provided funding
- Offering additional employer Health Savings Account contributions as an incentive for participating in desired health behaviors (i.e., getting an annual physical)

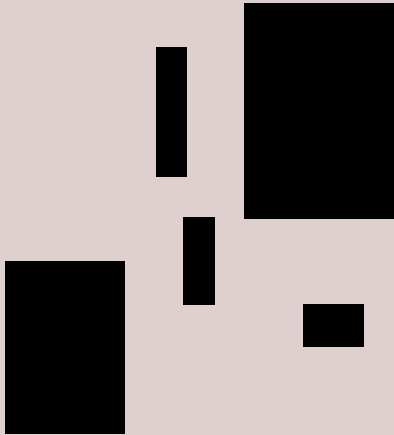
- A Health Savings Account plan is more complicated than existing GHIP plans and will require members to understand the mechanics of the plan (requires member education and involvement not currently required by the existing GHIP plan architecture or observed in the member population)
- The addition of a Health Savings Account plan would promote shared responsibility for impact of members' health care decisions

¹ Requires legislative changes.

Considerations and next steps

- Advantages to the GHIP/State of Delaware to offering a Health Savings Account plan
 - Attractive plan offering for recruitment/retention
 - Encourages wise consumerism and health care decision making
 - May impact Other Post Employment Benefits (OPEB) liability (dependent upon enrollment)
- Considerations for the SEBC
 - Possible option for new and/or existing employees?
 - Implementation period longer than for “traditional plans”
 - Interest in continued discussion?

Next steps



Next steps

- Items to discuss at the February 12th SEBC meeting:
 - Follow-up from today's topics
 - Vote on FY19 preventive care modifications
 - Vote on Securian renewal
 - FY18 Q2 Financial reporting
 - Final FY19 Budget Projection Recast
- Continued discussion on upcoming items at future SEBC meetings