

The State of Delaware

GHIP Health FY19 Planning

April 23, 2018

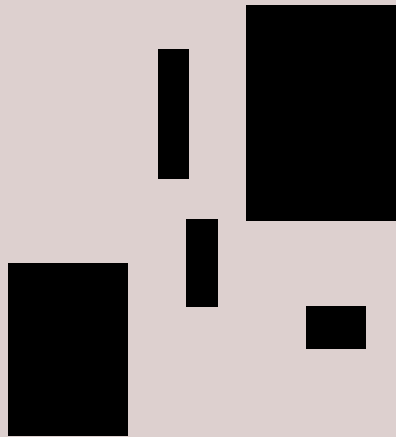
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Preventive medications update



Coverage options for Shingrix

- Today the GHIP covers Zostavax at \$0 copay and Shingrix at \$28 copay¹ per dose (2-dose vaccine)
- Coverage options for Shingrix until ACA-mandated deadline for coverage at no member cost share:
 1. Continue Zostavax coverage with no member cost sharing and wait to remove member cost sharing for Shingrix until the mandated deadline of July 1, 2019
 2. Remove member cost sharing for Shingrix prior to the mandated deadline of July 1, 2019, and maintain coverage for Zostavax at no member cost share
 3. Remove member cost sharing for Shingrix prior to the mandated deadline of July 1, 2019, and opt to exclude Zostavax from list of drugs covered at no member cost share (\$28 copay would apply for one-time dose)
 - Some plan sponsors are opting to exclude Zostavax due to ACIP recommendation that patients who previously received Zostavax should still receive Shingrix due to its superior efficacy
- Recommendation to SEBC is Option 1 at the present time for the reasons cited below:
 - Providers may be hesitant to prescribe Shingrix before 1-2 years of safety data is collected
 - Uncertainty over uptake and adequate supplies of Shingrix

Annual Zostavax Utilization ²	Patients	Total Plan Cost	Plan Cost per Rx
Express Scripts (Pharmacy)	853	\$179,000	\$209.98
Aetna/Highmark (Medical)	188	\$38,000	\$204.18

Efficacy Estimates per CDC ³	Ages 60 to 69 Years	Ages 70 to 79 Years	Older Than 80 Years
Shingrix	97%	91%	91%
Zostavax	64%	41%	18%

1. Based on Express Scripts utilization data from 12/1/2017 – 3/31/2018; pharmacies coding each dose at \$28 copay assuming 30-day supply
 2. Express Scripts and Aetna/Highmark utilization reflect data from 12/1/16 – 11/30/17 provided by Truven; utilization includes active and retiree patients ages 50 and over
 3. Centers for Disease Control and Prevention. Dooling KL, Guo A, Patel M, et al. Recommendations of the Advisory Committee on Immunization Practices for Use of Herpes Zoster Vaccines. MMWR Morb Mortal Wkly Rep 2018;67:103–108. DOI: <http://dx.doi.org/10.15585/mmwr.mm6703a5>

Zostavax and Shingrix coverage

Incremental cost of Shingrix – 5% utilization

GHIP Plan Cost (Active and non-Medicare eligible members) – FY2019				
Age Band	Eligible members ¹	Zostavax ²	Shingrix ³	
		\$0 copay (age 50+)	\$28 copay	\$56 copay
50 - 59	1,006	\$232,000	\$224,000	\$168,000
60 - 74	705	\$163,000	\$157,000	\$117,000
75 and Older	14	\$3,000	\$3,000	\$2,000
GHIP Total	1,725	\$398,000	\$384,000	\$287,000
\$ Δ from Zostavax (age 50+)	-	-	(\$14,000)	(\$111,000)
% Δ from Zostavax (age 50+)	-	-	-4%	-28%

GHIP Plan Cost (active and non-Medicare eligible members) – FY2020			
Age Band	Eligible members ¹	Zostavax ²	Shingrix ³
		\$0 copay	\$0 copay
50 - 59	1,006	\$232,000	\$280,000
60 - 74	705	\$163,000	\$196,000
75 and Older	14	\$3,000	\$4,000
GHIP Total	1,725	\$398,000	\$480,000
\$ Δ from Zostavax (age 50+)	-	-	\$82,000
% Δ from Zostavax (age 50+)	-	-	21%

- Current Zostavax utilization for eligible members age 50+ with \$0 copay is 1.9%
- GHIP cost for the two-dose Shingrix vaccine at the current \$28 copay level (per dose) is less than the cost for one-dose of Zostavax
- Assuming 5% of eligible members receive a shingles vaccine in FY2020 with \$0 copay, the GHIP would spend an additional \$82k on Shingrix in place of Zostavax
- For employees age 50-59 eligible to receive Shingrix with \$0 copay in FY2020, the GHIP would spend \$48k more than covering Zostavax exclusively

FY2020	Gender	Eligible Members ¹	Zostavax ²	Shingrix ³
			(\$0 copay)	(\$0 copay)
Age band 50 – 59	F	577	\$133,000	\$160,000
	M	429	\$99,000	\$120,000
GHIP Total	-	1,006	\$232,000	\$280,000
\$ Δ from Zostavax (age 50+)	-	-	-	\$48,000
% Δ from Zostavax (age 50+)	-	-	-	21%

1. Active and pre-65 retiree member counts for experience period 12/1/16 – 11/30/17 provided by Truven on 4/10/2018

2. The Advisory Committee on Immunization Practices (ACIP) recommends Zostavax for individuals age 60 years and older

3. 2 of 477 unique members who received the Zostavax vaccine from 12/1/2016 – 11/30/2017 received the Shingrix vaccine from 12/1/2017 – 3/31/2018; WTW assumes future GHIP cost for members receiving Shingrix after receiving Zostavax will be minimal (and limited to those receiving Zostavax before Shingrix became available); members receiving a vaccine for the first time likely to elect Shingrix due to its efficacy

Zostavax and Shingrix coverage

Incremental cost of Shingrix – 100% utilization (illustrative only)

GHIP Plan Cost (Active and non-Medicare eligible members) – FY2019				
Age Band	Eligible members ¹	Zostavax ²	Shingrix ³	
		\$0 copay (age 50+)	\$28 copay	\$56 copay
50 - 59	20,113	\$4,638,000	\$4,477,000	\$3,351,000
60 - 74	14,096	\$3,251,000	\$3,138,000	\$2,348,000
75 and Older	280	\$65,000	\$62,000	\$47,000
GHIP Total	34,489	\$7,954,000	\$7,677,000	\$5,746,000
\$ Δ from Zostavax (age 50+)	-	-	(\$277,000)	(\$2,208,000)
% Δ from Zostavax (age 50+)	-	-	-3%	-28%

GHIP Plan Cost (active and non-Medicare eligible members) – FY2020			
Age Band	Eligible members ¹	Zostavax ²	Shingrix ³
		\$0 copay	\$0 copay
50 - 59	20,113	\$4,638,000	\$5,604,000
60 - 74	14,096	\$3,251,000	\$3,927,000
75 and Older	280	\$65,000	\$78,000
GHIP Total	34,489	\$7,954,000	\$9,609,000
\$ Δ from Zostavax (age 50+)	-	-	\$1,655,000
% Δ from Zostavax (age 50+)	-	-	21%

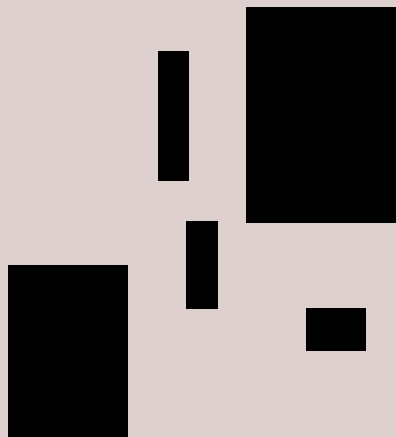
FY2020	Gender	Eligible Members ¹	Zostavax ²	Shingrix ³
			(\$0 copay)	(\$0 copay)
Age band 50 – 59	F	11,539	\$2,661,000	\$3,215,000
	M	8,574	\$1,977,000	\$2,389,000
GHIP Total	-	20,113	\$4,638,000	\$5,604,000
\$ Δ from Zostavax (age 50+)	-	-	-	\$966,000
% Δ from Zostavax (age 50+)	-	-	-	21%

1. Active and pre-65 retiree member counts for experience period 12/1/16 – 11/30/17 provided by Truven on 4/10/2018

2. The Advisory Committee on Immunization Practices (ACIP) recommends Zostavax for individuals age 60 years and older

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Engagement strategy update



Engagement strategies

Willis Towers Watson survey data

- Willis Towers Watson utilizes several tools and surveys to identify marketplace best practices and assess program competitiveness
- When available, Willis Towers Watson will include industry cuts (i.e., Government and Public Sector) or utilize publicly-available information from surrounding States for the purpose of benchmarking
- Selected findings from the 2017 Willis Towers Watson’s Best Practices in Health Care Survey were presented at the last SEBC meeting
 - Participants in this survey included a mix of local municipalities and state governments, but none of the states immediately surrounding Delaware

Survey/Tool	Description	Participants – Overall*	Participants – Industry Cut
Best Practices in Health Care Survey	<ul style="list-style-type: none"> ■ Now in its 21st year, this survey provides insights into the actions and plans of employers to control health care costs and achieve optimal outcomes for active employees ■ Length of time survey/database in place: 22 years 	555	48 gov’t/public sector/education

* Companies with at least 1,000 employees, based on 2017 survey respondents

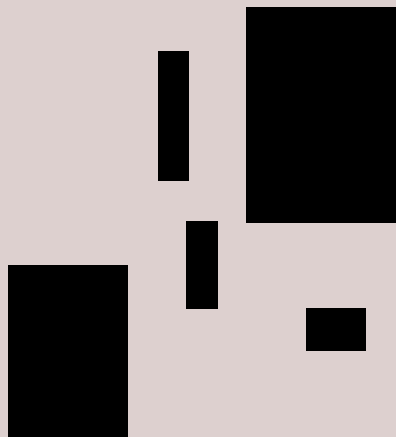
Engagement strategies

Next steps

- During the March 26 SEBC meeting, an option was discussed to establish different premiums for GHIP members who do not comply with engagement initiatives
- While utilization of financial incentives to influence desired behaviors (“incentives”) is declining in prevalence in the marketplace, current best-in-class engagement strategies include multiple member “touch-points” throughout the plan year:
 - **Prior to enrollment (*targeted education*),**
 - **During enrollment (*robust decision support*), and**
 - **At the point of care (*steerage mechanism to high quality providers, etc.*)**
- Epilogue language would require modification to include engagement surcharges as a tactic for the SEBC to utilize this approach. An example is illustrated below:

Per § 9602 of the Delaware Code, the SEBC has the authority “to establish different premiums, plan designs, plan options to apply to [employees] [employees and pensioners] [individuals covered by the State employees group health insurance program] based upon compliance with engagement initiatives established by the State Employee Benefits Committee.”

Health Savings Account plan considerations



Health Savings Account plan – defined

Definitions	
Consumer Directed Health Plan (CDHP)	<p>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.</p> <p>Also called a High Deductible Health Plan (HDHP).</p>
Health Savings Account (HSA)	<p>A tax-advantaged medical savings account available to taxpayers in the United States who are enrolled in an IRS-qualified HDHP.</p>
Health Reimbursement Arrangement (HRA)	<p>Employer-funded account that reimburses employees for out-of-pocket medical expenses. Currently in place today with the State’s Consumer Directed Health Plan.</p>

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

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 medical Employees decide when and how to use Health Savings Account funds, or whether to save them for future qualified medical expenses, including after retirement Employees can start, stop, or adjust Health Savings Account contributions at any time Funds 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 expenses Taxes 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 2017² New hires may have open Health Savings Accounts from a prior employer

1. 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. Effective 1/1/18 in AL, individuals may take a state income tax deduction for post-tax contributions to a Health Savings Account.
 2. 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
Relative Benefit Value (RBV)²	0.89	0.91

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

2. RBV estimate includes Health Savings Account seed (seed dollars are \$1,000 Individual/\$2,000 Family)

Financial impact of a Health Savings Account plan on the GHIP

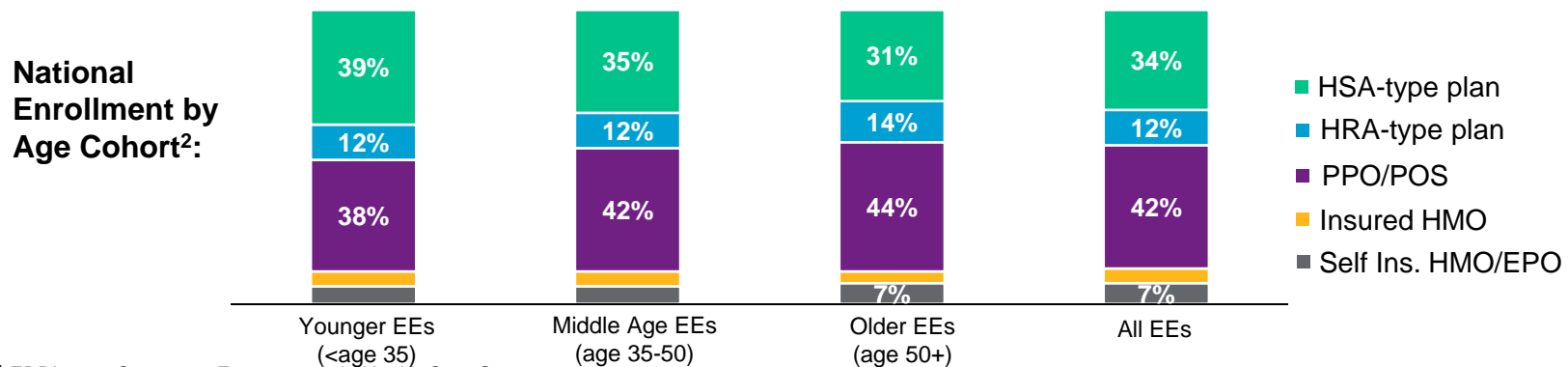
- Financial impact of a Health Savings Account plan will vary based on:
 - Which participant groups are offered this plan
 - Availability of other plan options and/or changes to existing plan options
 - Final plan design and employer Health Savings Account contribution (“seed”)
 - Employee contributions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

Estimated GHIP Savings ¹	HSA Scenario 1	HSA 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.

Demographic considerations

- Millennials are more cost-conscious decision makers than other generations when consuming healthcare
- According to the Employee Benefit Research Institute (EBRI)¹, millennials are more likely than other generations to:
 - Engage in researching health care options
 - Check whether a health plan would cover care or medication
 - Check the quality rating of a doctor or hospital before receiving care
 - Talk to a doctor about treatment/prescription options and costs
 - Try to find the cost of health care services before getting care (and use an online cost tracking tool provided by a health plan to manage expenses)
- Among employees with Health Savings Account plans, millennials are more interested in the tax-advantages and investment features of their Health Savings Account than other generations¹
- Additionally, HSA plans are particularly attractive when preparing for retirement—the monies saved before age 65 can be used for medical expenses (tax free), or withdrawn during retirement and spent on non-medical expenses similar to an IRA (subject to taxation)



¹ EBRI 2017 Consumer Engagement in Health Care Survey

² Willis Towers Watson 2018 Financial Benchmarks Survey. Reflects enrollment by medical plan type and by age band across all employers in database.

Maximizing success of a Health Savings Account plan roll-out

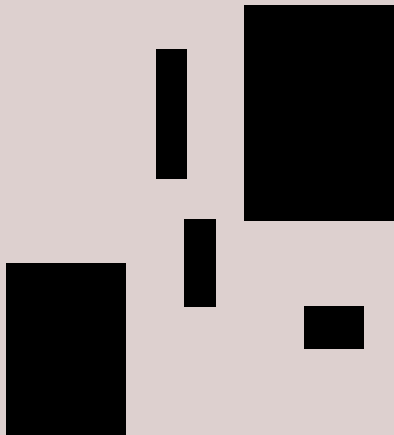
- Help plan participants understand the differences between “traditional” plans (i.e., PPO, HMO) and Health Savings Account plans
- Help plan participants understand the differences between Flexible Spending Accounts (FSAs), Health Reimbursement Arrangements (HRAs) and Health Savings Accounts (HSAs)
- Provide plan participants with tools to assist their decision-making and educate them on how to use available resources
- Provide ongoing communication and education to help plan participants navigate the complexities of the plan and the health care system
- Consider a January 1 effective date
 - Due to the tax benefits associated with the Health Savings Account
 - For optimal member experience, consider aligning the benefits plan year for all other benefits to the Health Savings Account plan year (i.e., from July 1 to January 1)

Considerations and next steps

- Advantages to the GHIP/State of Delaware to offering a Health Savings Account plan
 - Attractive plan offering for recruitment/retention as well as portability for those close to retirement
 - 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 for discussion at the May SEBC meeting
 - Financial impact of HSA plan on GHIP members
 - Detailed implementation timeline for consideration
 - HSA plan consideration – opportunity to change benefits plan year to calendar year

Health Savings Account plan implementation for a 1/1/20 effective date requires SEBC approval no later than October 2018

Revisiting the GHIP strategic framework



Revisiting the GHIP strategic framework

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

- Through vendor value-based care delivery models (AIM, True Performance) and steerage of members to high quality, cost effective sites of care, the GHIP has achieved the VBCD goal established in 2016 (*additional detail on goal status on next page*)
 - As FY18 comes to a close, the SEBC should consider new strategic framework goal to better align with current GHIP environment and Statewide Health Care Spending Benchmark
- Employers are putting more emphasis on specific clinical areas – notably diabetes, musculoskeletal and mental health – to improve member health and reduce costs
 - Target diabetes, a highly prevalent and costly chronic condition for GHIP members
 - Promote better health for GHIP members while reducing GHIP gross trend
 - Aligns with part of the focus on chronic disease within the Statewide Health Care Spending Benchmark
- While WTW and SBO are currently reviewing potential metrics for a Diabetes-specific goal, examples of focus-areas that the SEBC could strive to impact include:
 - Reduction of Diabetic risk score
 - Increase in compliance of ongoing Diabetes testing
 - Reduction in PEPM Diabetic cost

Tracking the progress: GHIP strategic framework goals

Strategic Framework Scorecard

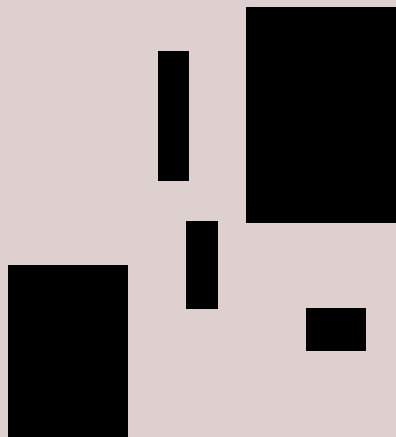
Progress review date: April 23, 2018

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			<ol style="list-style-type: none"> 1 Introduction of AIMHMO 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 3 COE steerage design, effective 7/1/2018
Goal 2: Reduction of gross GHIP medical and prescription drug trend by 2% by end of FY2020			<ol style="list-style-type: none"> 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 3 Site of care steerage design differentials, effective 7/1/2018
Goal 3: GHIP membership enrollment in a consumer-driven or value-based plan exceeding 25% of total population by end of FY2020			<ol style="list-style-type: none"> 1 5% of employees enrolled in the CDH Gold plan¹ 2 27% of employees enrolled in the Aetna HMO AIM Model¹ 3 Introduction of Health Savings Account, under consideration for 7/1/19 or 1/1/2020

● Not yet started
 ● On track
 ● Completed

1. Based on enrollment reported in Aetna enrollment reports as of 12/31/2017)

Next steps

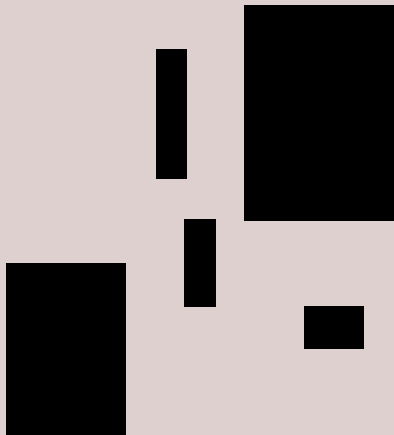


Next steps

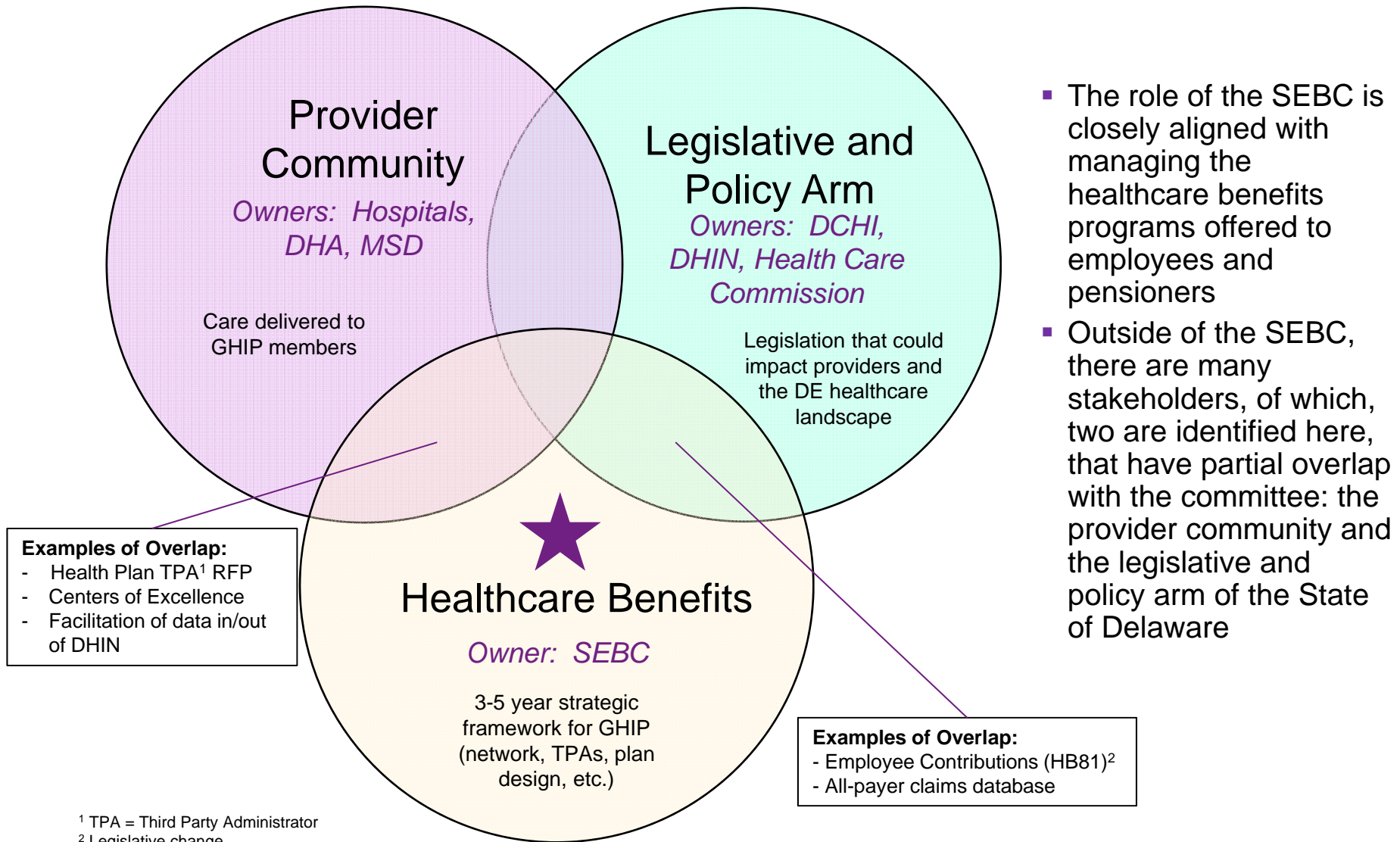
- May SEBC meeting:
 - FY17 & FY18 utilization review
 - April Fund Equity report
 - HSA plan discussion – continued dialogue
 - GHIP strategic framework – ongoing discussion

- June SEBC meeting:
 - Review Q3 FY18 financials
 - May fund equity report
 - Value based contracting update from Aetna and Highmark
 - Clinical management programs – update on member engagement

Appendix



Key influencers on GHIP

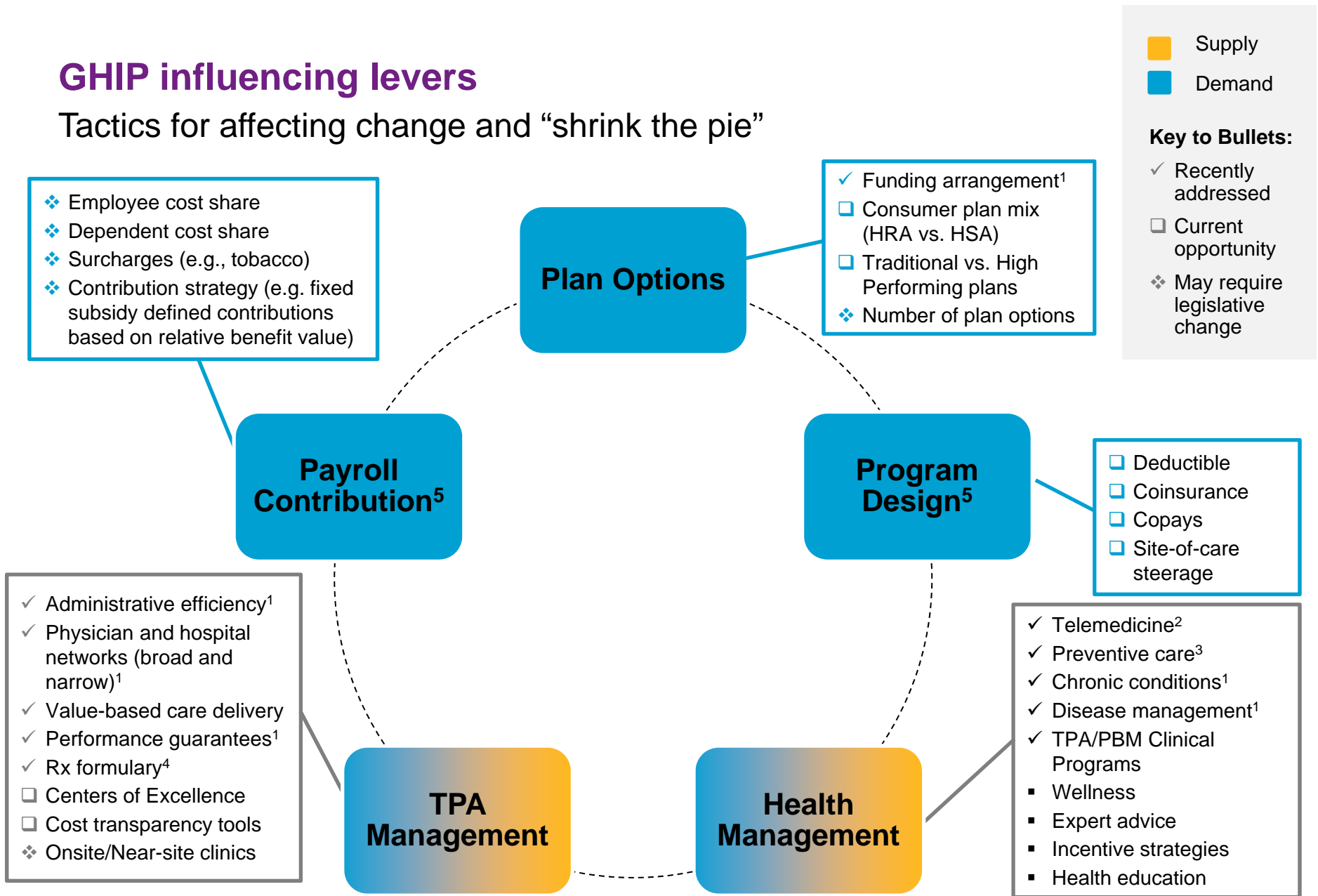


- The role of the SEBC is closely aligned with managing the healthcare benefits programs offered to employees and pensioners
- Outside of the SEBC, there are many stakeholders, of which, two are identified here, that have partial overlap with the committee: the provider community and the legislative and policy arm of the State of Delaware

¹ TPA = Third Party Administrator
² Legislative change

GHIP influencing levers

Tactics for affecting change and “shrink the pie”



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

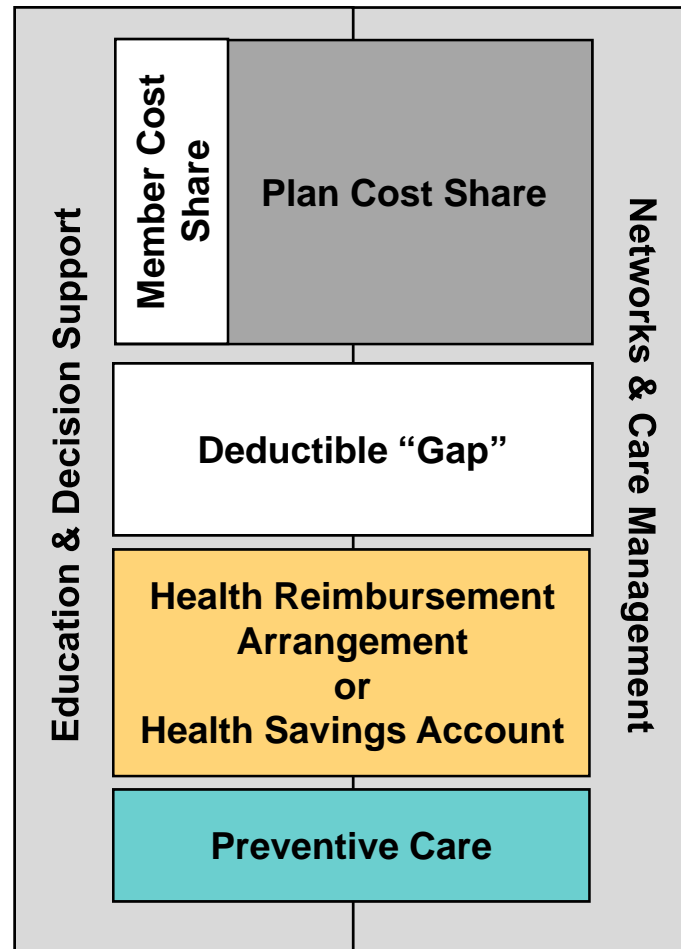
- Communication campaign in Q1 CY18 to outreach to members without a current PCP
- Member home mailings on “Choosing the Right Care” (ER, Urgent Care, Telemedicine, PCP, 24/7 Nurse Line); “Diabetes Prevention and Management”; “Cancer”; and “Musculoskeletal Pain - Prevention and Management”
- Custom Care 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.

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

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
- Seeding the Health Savings Account to offset member OOP expenses
- 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.

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 / \$6,850
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)