# The State of Delaware

## GHIP FY19 Planning

June 25, 2018







Willis Towers Watson

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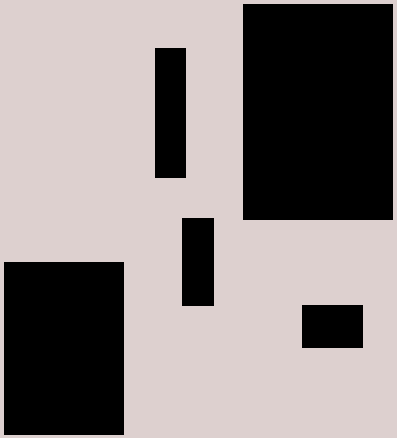
# GHIP long term health care cost projections



# GHIP long term health care cost projections

## FY18 Q3 update – with FY19 program changes[1]

| GHIP Costs ($ millions) | FY17 Actual | FY18 Projected | FY19 Projected | FY20 Projected | FY21 Projected | FY22 Projected | FY23 Projected |
|---|---|---|---|---|---|---|---|
| Average Enrolled Members | 123,132 | 125,122 | 125,122 | 125,122 | 125,122 | 125,122 | 125,122 |
| **GHIP Revenue** | | | | | | | |
| Premium Contributions (No Change)[2] | $799.0 | $815.0 | $815.0 | $815.0 | $815.0 | $815.0 | $815.0 |
| Other Revenues[3] | $81.6 | $80.3 | $82.1 | $86.2 | $90.5 | $95.0 | $99.8 |
| **Total Operating Revenues** | **$880.6** | **$895.3** | **$897.1** | **$901.2** | **$905.5** | **$910.0** | **$914.8** |
| **GHIP Expenses (Claims/Fees)** | | | | | | | |
| Operating Expenses (No Change) | $816.8 | $857.5 | $921.1 | $967.3 | $1,014.7 | $1,065.4 | $1,117.7 |
| *% Change Per Member* | | *3.3%* | *7.4%* | *5.0%* | *5.0%* | *5.0%* | *5.0%* |
| Excise Tax Liability[4] | | | | | | $9.1 | $16.3 |
| **Adjusted Net Income (Revenue less Expense)** | **$63.8** | **$37.8** | **($24.0)** | **($66.1)** | **($109.2)** | **($164.5)** | **($219.2)** |
| Balance Forward | $38.9 | $102.7 | $140.5 | $116.5 | $50.4 | ($58.8) | ($223.3) |
| Ending Balance | $102.7 | $140.5 | $116.5 | $50.4 | ($58.8) | ($223.3) | ($442.5) |
| *- Less Claims Liability[5]* | *$54.0* | *$58.9* | *$63.3* | *$66.5* | *$69.8* | *$73.9* | *$78.0* |
| *- Less Minimum Reserve[5]* | *$24.0* | *$24.0* | *$25.7* | *$27.0* | *$28.3* | *$30.0* | *$31.7* |
| **GHIP Surplus (After Reserves/Deposits)** | **$24.7** | **$57.6** | **$27.5** | **($43.1)** | **($156.9)** | **($327.2)** | **($552.2)** |

Note: FY17 Actual based on final June 2017 Fund Equity report. FY18 projections assume 13 remaining weekly invoices for Aetna/Highmark and six for ESI.

[1] Includes approved design changes for site-of-care steerage for imaging/outpatient lab and COE services and proposed design changes for $0 statin coverage and preventive 3D mammography effective 7/1/2018; assumes no additional program changes FY2020 and beyond.

[2] Includes State and employee/pensioner premium contributions and assumes no increase to premiums 7/1/2017 and beyond; premiums include 5% risk fee surcharge for participating non-State groups.

[3] Includes Rx rebates, EGWP payments, and other revenues. FY18 includes additional $5.8M due to FY16 EGWP federal reinsurance reconciliation timing.

[4] 40% excise tax on the value of employer sponsored health care coverage over specified thresholds starting CY 2022. Threshold assumed to increase at 2% annually.

[5] FY18 Claims Liability and FY19 Minimum Reserve levels updated with data through December 2017. Future years assumed to increase with overall GHIP expense growth.

*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

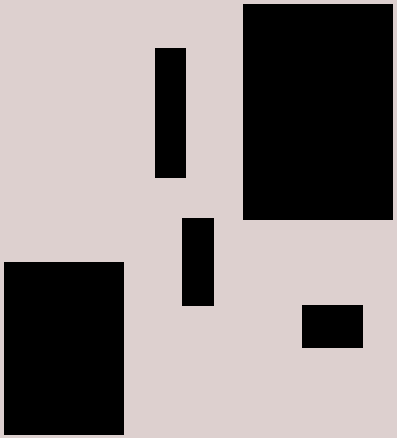
# GHIP long term health care cost projections

## Eliminating the FY20 funding deficit

- Absent program or premium changes, the GHIP is projected to have a funding deficit of $43.1m by the end of FY20
- Some combination of premium increases and program/plan design changes are required to fully address the FY20 funding deficit; examples of potential program changes, not in order of priority, are outlined below:

| Savings Opportunity | GHIP Goal | Member Impact | | FY20 Savings Potential |
|---|---|---|---|---|
| | | Requires education or engagement? | Scope of potential impact | |
| Implement Health Savings Account plan | ○ ▲ | Yes – Requires all employees to understand this plan option's impact on their total out-of-pocket costs as influencer of which option is elected. For enrollees, requires understanding of how the plan works (including the Health Savings Account) | For those enrolled in the plan, potential for higher member out-of-pocket cost sharing at point of care and ability to leverage tax-advantaged Health Savings Account to save and pay for medical expenses | Potential for moderate savings depending on final plan design, account seed and enrollment in this plan vs. other medical plan options |
| Cost transparency tools | ○ ▲ | Yes – Must be aware such tool exists in order to benefit from it. For the State, plan design changes would be a significant driver of member utilization | No negative impact to member cost if member doesn't use tool | TBD |
| Plan design changes for current plans | ○ | Yes – Employees need to be aware of plan design changes and how those would affect their out-of-pocket cost for coverage under each plan option | Potential for higher member out-of-pocket cost sharing at point of care | Potential for significant savings depending on magnitude of change |
| High-performing networks | ○ ▲ | Yes – Members must be aware of providers included in the high-performing network and benefit differential when using alternate providers | Higher member out-of-pocket cost when using out-of-network providers | TBD |
| Active benefits enrollment | ▲ | Yes – Must complete enrollment process or risk being defaulted into alternative plan option | Would affect all benefits-eligible employees/retirees who do not take action during Open Enrollment | TBD based on default option |

# Health Savings Account (HSA) plan considerations



# Advantages of a Health Savings Account plan – For current employees

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

| | |
|---|---|
| **Employee savings vehicle** | ▪ A Health Savings Account allows employees to save for future medical expenses, including but not limited to retiree medical<br>▪ Employees decide when and how to use Health Savings Account funds, or whether to save them for future qualified medical expenses, including after retirement<br>▪ Employees can start, stop, or adjust Health Savings Account contributions at any time<br>▪ Funds can be invested once the Health Savings Account balance exceeds a certain threshold |
| **No "use it or lose it" rule** | ▪ 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** | ▪ 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<br>▪ Taxes and penalties do apply if Health Savings Account funds are used to pay for anything other than qualified medical expenses |
| **Competitive position** | ▪ 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 2017[2]<br>▪ 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. In AL, pre-tax contributions are tax-free, but any post-tax employee contributions to the Health Savings Account are taxable by the state.
2 2017 Willis Towers Watson Best Practices in Health Care Employer Survey. Sample: Companies with at least 1,000 employees.

Indicates new plan design not previously presented to SEBC

# Health Savings Account plan design – *illustrative scenarios*

| Plan Design (In-network) | CDH HRA | HSA Scenario 1 | HSA Scenario 2 | HSA Scenario 3 |
|---|---|---|---|---|
| Deductible (Ind./Fam.) | $1,500 / $3,000 | $2,000 / $4,000 | $1,500 / $3,000 | $1,500 / $3,000 |
| Account Funding (Ind./Fam.) | $1,250 / $2,500 | $1,000 / $2,000 | $1,000 / $2,000 | $1,000 / $2,000 |
| Coinsurance | 90% | 80% | 80% | 90% |
| Out-of-Pocket Max (Ind./Fam.) | $4,500 / $9,000 | $4,500 / $9,000 | $4,500 / $9,000 | $4,500 / $9,000 |
| PCP Office Visit | 90% | 80% | 80% | 90% |
| Specialist Office Visit | 90% | 80% | 80% | 90% |
| Emergency Room | 90% | 80% | 80% | 90% |
| Inpatient Care | 90% | 80% | 80% | 90% |
| **Prescription Drug[1]** | | | | |
| Out-of-Pocket Max (Ind./Fam.) | Combined with medical | Combined with medical | Combined with medical | Combined with medical |
| ▪ Retail | $8 / $28 / $50 after deductible | $8 / $28 / $50 after deductible | $8 / $28 / $50 after deductible | $8 / $28 / $50 after deductible |
| ▪ Mail Order | $16 / $56 / $100 after deductible | $16 / $56 / $100 after deductible | $16 / $56 / $100 after deductible | $16 / $56 / $100 after deductible |
| **Relative Benefit Value (RBV)[2]** | **0.96** | **0.89** | **0.91** | **0.93** |

1 Retail 30 day supply; mail order 90 day supply.
2 RBV estimate includes Health Savings Account seed.

Indicates new plan design not previously presented to SEBC

# Health Savings Account plan financial impact – 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 FY20 GHIP Savings[1] | HSA Scenario 1 | HSA Scenario 2 | HSA Scenario 3 |
|---|---|---|---|
| Per 5% Migration to HSA plan | $3.0M ($1.9M General Fund) | $2.2M ($1.4M General Fund) | $1.2M ($0.7M General Fund) |
| Full Replacement (100% enrollment in HSA plan) | $59.2M ($37.2M General Fund) | $43.1M ($27.1M General Fund) | $23.7M ($15.0M General Fund) |

- The richest Health Savings Account plan design permissible under IRS mandate includes a $1,350/$2,700 deductible (ind./family), followed by 100% plan cost-sharing
  - Relative Benefit Value: 98.7% (assumes $1,000/$2,000 Health Savings Account seed)
  - Estimated GHIP **Cost**[1]: $0.8M ($0.5M General Fund) per 5% migration, up to $16.7M ($10.5M General Fund) at 100% migration

[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. Savings based on reduction in GHIP claims due to difference in actuarial value between current plan and HSA scenarios 1, 2 and 3.

# Health Savings Account plan – member impact

## Illustrative examples for low, medium, and high utilizers (Scenario 1)

- The below exhibit shows the potential employee cost (out of pocket costs plus payroll contributions) under the Health Savings Account plan compared to other plan options
  - See Appendix for services accessed by members under each illustrative low, medium, and high utilizer
  - Assumes up front lump sum of Health Savings Account dollars at beginning of plan year, and does not reflect value of unused Health Savings Account balances that are carried over to a future plan year or employee contributions into Health Saving Account
- For low utilizer examples, employee cost is lowest under the Health Savings Account option – and employees also have Health Savings Account funds remaining to use for future qualified expenses

| Annual Member Impact | Low Utilizer | | | | Medium Utilizer | | | High Utilizer | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | EE OOP | EE Contrib | Total EE Cost | Account Rollover[1] | EE OOP | EE Contrib | Total EE Cost | EE OOP | EE Contrib | Total EE Cost |
| **Individual Coverage** | | | | | | | | | | |
| PPO | $28 | $1,262 | **$1,290** | n/a | $212 | $1,262 | **$1,474** | $532 | $1,262 | **$1,794** |
| HMO | $23 | $566 | **$589** | n/a | $187 | $566 | **$753** | $497 | $566 | **$1,063** |
| CDH Gold | $0 | $432 | **$432** | n/a | $0 | $432 | **$432** | $3,250 | $432 | **$3,682** |
| HSA | $0 | $399 | **$399** | **$855** | $88 | $399 | **$487** | $3,500 | $399 | **$3,899** |
| **Family Coverage** | | | | | | | | | | |
| PPO | $112 | $3,274 | **$3,386** | n/a | $328 | $3,274 | **$3,602** | $944 | $3,274 | **$4,218** |
| HMO | $92 | $1,489 | **$1,581** | n/a | $318 | $1,489 | **$1,807** | $862 | $1,489 | **$2,351** |
| CDH Gold | $0 | $1,137 | **$1,137** | n/a | $1,260 | $1,137 | **$2,397** | $5,912 | $1,137 | **$7,049** |
| HSA | $0 | $1,051 | **$1,051** | **$1,568** | $3,320 | $1,051 | **$4,372** | $7,000 | $1,051 | **$8,051** |

Note: Based on proposed HSA Scenario 1; payroll contributions set based on relative AV compared to CDH Gold plan and 5% cost share per Delaware Code. Assumes employees are accessing lower cost services where possible ("Good Consumers" as outlined in the examples in the Appendix)

[1] Year-end Health Savings Account balance that would rollover to the next plan year. There is no Health Savings Account balance remaining for "medium" or "high" utilizer examples







**Blue font indicates lowest total cost**

# Health Savings Account plan – employer seed considerations

- The GHIP has flexibility in the amount and timing of Health Savings Account seed money

| Seed timing | Pros | Cons |
|---|---|---|
| Up-front lump sum | ▪ Employees have immediate protection against high claims early in plan year<br>▪ Administrative ease | ▪ Employer seed vests immediately and money is portable; employees leaving employer during the year receive full value of the benefit<br>▪ The GHIP could forfeit $100k in annual seed money for employees terminating during the year[1] |
| Fixed per-pay contribution | ▪ Employer protection against employee turnover<br>▪ Employees "earn" seed money over course of plan year<br>▪ Minimizes budget impact | ▪ Employees may have to pay for early claims with personal funds<br>▪ Administrative complexity for employer and employee |
| Periodic payments (quarterly, semi-annually, etc.) | ▪ Employer protection against employee turnover<br>▪ Employees "earn" seed money over course of plan year, with more money available initially<br>▪ Less complex than per-pay deposits | ▪ Employees may have to pay for early claims with personal funds<br>▪ Administrative complexity for employer and employee |

- Additional considerations:
  - Determination of the amount and timing of Health Savings Account seed money must be made as part of plan design and could impact overall plan costs/savings
  - Total deposits (employer + pre-tax employee contributions) are treated as employer contributions, and are subject to nondiscrimination testing
  - How to treat new hires during course of the year (i.e., make "whole" on date of hire, prorate, etc.)?

[1] Per 5% migration to Health Savings Account plan; assumes 5% annual turnover with uniform distribution throughout year, $1,000/$2,000 ind./family seed, and 40%/60% ind./family enrollment split

# Health Savings Account – member access to funds

- Health Savings Account funds are available for use as soon as they appear in the account, similar to a checking account
  - Timing of the availability of funds following deposit varies by account administrator
- Health Savings Account administrator determines how account holder can access funds
  - Most administrators provide access via a Health Savings Account debit card
  - Paper checks and online bill payment options are also common
- Members have complete discretion over how to use their Health Savings Account
  - Account holder is responsible for determining whether use is for "qualified medical expense"[1]
  - No claim substantiation requirement, but must save receipts for all Health Savings Account distributions (in the event of an IRS audit)
  - Employers and Health Savings Account administrators ***are not required*** to determine whether Health Savings Account distributions are used exclusively for qualified medical expenses

1 Term generally means "medical care" including medical, Rx, dental, vision and long-term care services. IRS Publications 502 (https://www.irs.gov/publications/p502) and 969 (https://www.irs.gov/publications/p969) provide guidance on IRC §213(d) qualified medical expenses. Withdrawals for any other expenses (prior to account holder reaching age 65) are subject to a tax penalty.

# Health Savings Account – member access to funds (continued)

- Members are also responsible for ensuring they do not have "other health coverage" (as defined by the IRS[1]) that could disqualify them from making or receiving Health Savings Account contributions

| Other Health Coverage |
|---|
| ✘ **Health care FSA** – general purpose, even if only covered by the grace period from the prior plan year, or if covered under a spouse's FSA |
| ✘ **Medicare** |
| ✘ **Dual coverage under a spouse's plan** |
| ✘ **First dollar coverage** for any non-preventive medical services or prescription drugs |

- State employees who want to take full advantage of the Health Savings Account will need to plan ahead, particularly if they are enrolled in a health care FSA

***Assuming no changes to the State's benefits plan year, if an employee:***

Enrolls in, or is covered by spouse's, health care FSA for CY2019 plan year (1/1/19 – 12/31/19)

**AND**

Enrolls in Health Savings Account plan for FY2019 plan year (7/1/19 – 6/30/20)

***…then the earliest date that employee is eligible to make or receive Health Savings Account contributions depends on their FSA balance as of 12/31/19:***

| FSA balance as of 12/31/19 | HSA-eligible as of: |
|---|---|
| Equal to $0 | 1/1/2020 |
| Greater than $0 | 4/1/2020 |

i.e., 9 months after beginning of 2019 medical plan year, due to FSA grace period (ends 3/31/2020)





1 See IRS Publication 969 (https://www.irs.gov/publications/p969).

# Health Savings Account – member access to funds (continued)

- Examples of "permitted coverage"[1] that ***would not*** disqualify an individual from eligibility to make or receive Health Savings Account contributions

| Permitted Coverage | |
|---|---|
| ✓ **Dental insurance**, if stand-alone plan | ✓ **Insured supplemental health benefits**, such as workers' comp or critical illness, as long as principle health coverage is provided by the Health Savings Account plan |
| ✓ **Vision insurance**, if stand-alone plan | ✓ **Discount card** for health care services or products |
| ✓ **Accident insurance** | ✓ First-dollar coverage for **preventive medical and prescription drugs** |
| ✓ **Disability insurance** | |
| ✓ **Long-term care** | |
| ✓ **Dependent care FSA** | |

**Permitted Coverage (with limits)**

- ✓ **Limited purpose health care FSA or HRA** – limited to dental and vision expenses
- ✓ **Post-deductible health care FSA or HRA** – only provides benefits after the minimum annual deductible under an IRS-qualified Health Savings Account plan has been satisfied
- ✓ **EAP, disease management and wellness programs** – as long as the program doesn't provide "significant" medical care or treatment benefits
- ✓ **Onsite/Near-site clinic** – limited to first aid, unless member is charged fair market value for services





1 See IRS Publication 969 (https://www.irs.gov/publications/p969).

# New hire enrollment patterns

- The below exhibit summarizes the distribution of plan elections made by new hires or rehired employees, at time of hire/rehire eligibility date
- New hires/rehires were more likely to waive coverage or elect First State Basic and CDH Gold options compared to the current GHIP State eligible population overall
  - In more recent years, new hires are increasingly likely to elect the lowest cost plan (FSB) or waive coverage; fewer new employees elected HMO and the CDH Gold options, though proportion in CDH Gold remains higher than GHIP overall

| | % Original Election by Plan[1] | | | | |
|---|---|---|---|---|---|
| **Hire Year** | **PPO** | **Aetna/Highmark HMO** | **Aetna/Highmark CDH** | **FSB** | **Waive** |
| CY 2014 | 37.8% | 26.8% | 7.6% | 5.4% | 22.3% |
| CY 2015 | 36.0% | 28.2% | 7.5% | 6.1% | 22.3% |
| CY 2016 | 32.6% | 25.6% | 8.4% | 10.9% | 22.5% |
| CY 2017 | 34.1% | 20.8% | 6.9% | 13.9% | 24.3% |
| CY 2018 | 32.7% | 14.4% | 5.1% | 17.3% | 30.4% |
| Overall GHIP[2] (current election) | 55.2% | 24.6% | 4.5% | 5.6% | 10.1% |

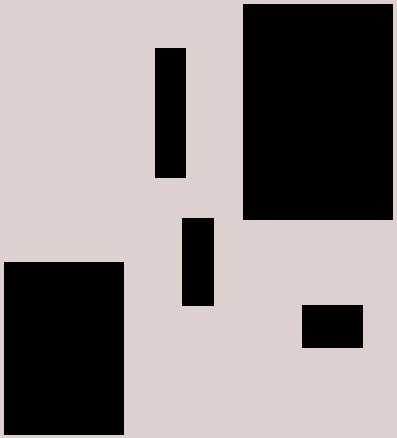
[1] Based on all full-time benefits eligible employees of the State hired or rehired between 2014 and 2018 per 'PHRST_Hires_Rehires_ConHires_FY15-18_medical election_6.20.2018' provided to WTW by OMB on June 20, 2018

[2] Based on all full-time benefits eligible employees of the State per 'Ben Elig Ees April2018 wEarnings thru 041518' report provided to WTW by OMB on May 14, 2018. Includes 31,107 active State employees enrolled in GHIP. Excludes participating groups (waiver data not available)

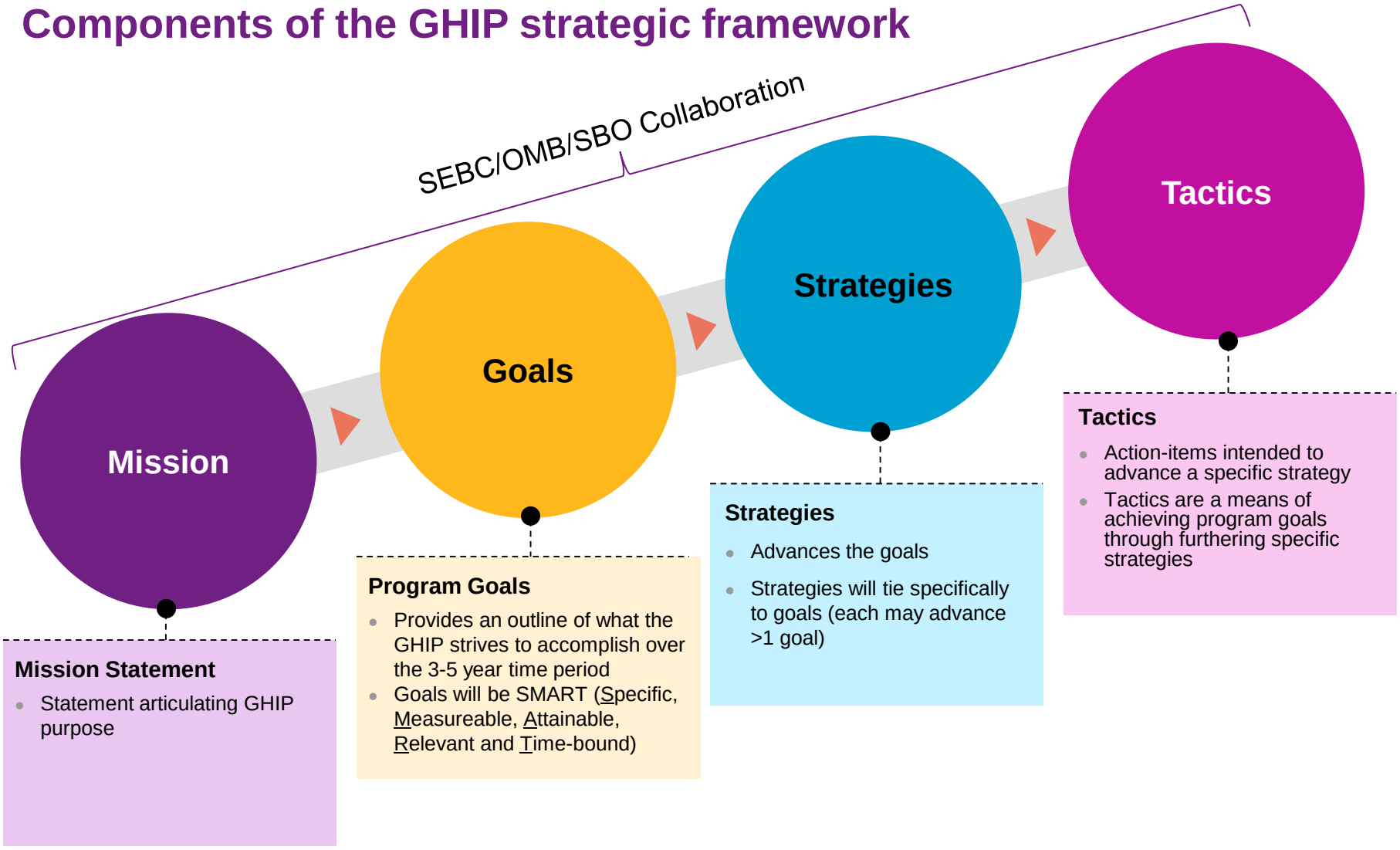
# Health Savings Account plan – value to employees

- Health Savings Account plans can deliver added value to employees – especially new hires and millennials – in a number of ways, including:
  - New hires who already have a Health Savings Account from a prior employer could start contributing to the account again
  - In-network preventive care is always 100% covered with no member cost sharing – even if the member hasn't met their annual deductible
    - This may also include preventive prescription drugs (based on the preventive drug list maintained by the pharmacy benefits manager, i.e., Express Scripts)
  - Employees who don't require much health care now can save for future medical expenses, including those incurred in retirement
  - Employees can contribute to a Health Savings Account on a pre-tax basis
  - Health Savings Account funds can be invested, after reaching a certain threshold (which varies by account administrator), and any interest earned is tax-free
  - Health Savings Account funds are fully portable, if employee were to retire or change jobs
  - While not recommended, the Health Savings Account can be used for non-qualified medical expenses (subject to a tax penalty for account holders under age 65, which needs to be reported to the IRS on account holder's annual tax filing)

# GHIP Strategic Framework Update



# Components of the GHIP strategic framework




**Final strategic framework including all four components above was approved by the SEBC in December 2016**


# GHIP mission statement

Approved by the SEBC in December 2016

***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.***

# GHIP mission statement

## *Core concepts* defined

***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 Concept | Definition | Benchmarking Metric | Benchmarking Example |
|---|---|---|---|
| Adequate access | Access to various types of healthcare providers that meets generally accepted industry standards (e.g., *x* number of *y* PCPs, specialists, hospitals within *z* miles of GHIP participant's home zip code). | Vendor-provided GeoAccess reporting indicating average distance to provider based on industry-standard access parameters | Vendor XYZ's network yields 99.8% access to in-network primary care providers. |
| 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 (e.g., AHRQ, NCQA, The Leapfrog Group).[1] | Metrics as provided by GHIP's TPAs which measure the effectiveness and quality of providers and care delivery within their given networks | Vendor XYZ's chronic disease management program is NCQA certified. |
| Affordable cost | Annual health care cost trend that is lower than national average for both GHIP participants and the State. For GHIP participants, at minimum, medical plans meet the minimum value and affordability requirements under PPACA; cost reflects both out-of-pocket cost sharing via plan features and employee payroll contributions. For the State, program costs are monitored and budgeted to promote greater fiscal certainty. | Participants: Plan actuarial value (AV) and affordability requirements under ACA<br><br>State: Annual trend rate for GHIP program | All of the GHIP's plans meet the 60% AV and 9.5% affordability metrics set forth under the ACA.<br><br>The GHIP's medical plan will achieve annual trend rate that is 2% less than the national average trend rate after plan design changes. |
| Healthy lifestyles | Combination of behaviors that reduce health risk factors, including regular exercise, proper nutrition, avoidance of tobacco, moderation of alcohol use, preventive care, and active management of chronic conditions. | Vendor-provided risk score, which measures the relative health status of the GHIP. A higher score indicates a sicker population. | The GHIP's risk score of actives is 1.41 (according to Truven-provided data: 1/15 – 12/15) |
| Engaged consumers | GHIP members who have taken ownership of their health by using all available resources provided by the State (e.g., provider cost/quality data, SBO consumerism website and online training course) to make informed decisions on how, where and when they seek care. | Emergency room visits per 1,000 and allowed amount ($) per visit | The GHIP's ER visits/1,000 is 239 (according to Truven). The Allowed amount per visit is $XYZ. |

[1] AHRQ = Agency for Healthcare Research and Quality, a Federal agency within the U.S. Department of Health and Human Services (HHS).
NCQA = National Committee for Quality Assurance, a 501(c)(3) not-for-profit organization.
The Leapfrog Group is a nonprofit watchdog organization and a national advocate of hospital transparency in cost, quality and safety data to support informed decision-making among healthcare consumers.


# GHIP goals – approved by SEBC

## Tied to the GHIP mission statement

***Mission Statement:***

*Offer State of Delaware employees, retirees and their dependents* ***adequate access*** *to* ***high quality healthcare that produces good outcomes…***

***Goals:***

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

***New Proposed:***

- Reduction of GHIP diabetic cost per-member-per-month (PMPM) by 5% by the end of FY2021

*at an* ***affordable cost****…*

- Reduction of gross GHIP medical and prescription drug trend by 2% by end of FY2020[1]

*promotes* ***healthy lifestyles,*** *and helps them be* ***engaged consumers.***

- GHIP membership enrollment in a consumer-driven or value-based plan exceeding 25% of total population by end of FY2020[2]

***New Proposed:***

- Incremental increase to unique users engaged in a specific consumerism tool by at least 5% annually

[1] Gross trend is inclusive of total increase to GHIP medical plan costs (both "employer" and "employee") and will be measured from a baseline average trend of 6% (based on a blend of the State's actual experience and Willis Towers Watson market data).

[2] Note: To drive enrollment at this level, the State will need to make plan design and employee contribution changes that may require changes to the Delaware Code.

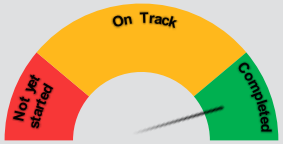
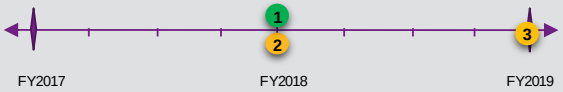
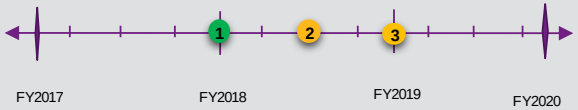
# GHIP goals

## Tracking the progress

### Strategic Framework Scorecard

**Progress review date:** June 25, 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** |  |  | 1 Introduction of AIM HMO model via Aetna/CareLink partnership, effective 7/1/2017<br>2 Continue to work with Highmark and the State's other carriers to identify opportunities to implement other VBCD models<br>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** |  |  | 1 Adoption of cost reduction programs, i.e., CCMU, Diabetes Prevention Program, AIM HMO<br>2 Additional changes to promote use of high quality/efficient providers are under consideration<br>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** |  |  | 1 5% of employees enrolled in the CDH Gold plan[1]<br>2 27% of employees enrolled in the Aetna HMO AIM Model[1]<br>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.

# GHIP strategies – linked to GHIP goals

## Framework for the health care marketplace

| | Health Care Services | Health Status of the Population |
|---|---|---|
| **Providers** | **Provider Care Delivery**<br>■ Continue to support medical TPAs' efforts to contract with providers on a "pay-for-value" basis<br>■ Continue to support the DHIN, including encouraging medical TPAs' participation, and other data-driven approaches to provider care delivery<br>○ Continue managing medical TPA(s)<br>▲ Evaluate emerging vendor tools and capabilities | **Provider-led Health and Wellness Initiatives**<br>■ Leverage community-based diabetes prevention programs and hospital-based health & wellness classes<br>○ Continue managing medical TPA(s) |
| **Participants** | **Participant Care Consumption**<br>○ Implement changes to GHIP medical plan options and price tags<br>▲ Ensure members understand benefit offerings and value provided<br>▲ Promote price and quality transparency tools<br>▲ Offer meaningfully different medical plan options to meet the diverse needs of GHIP participants, and targeted programs to support special needs<br>■ Ensure members are aware of how to find high quality, high value providers | **Participant Engagement in Health and Wellness**<br>○ Offer and promote resources that will support member efforts to improve and maintain their health<br>▲ Drive GHIP members' engagement in their health<br>■ Encourage member awareness and usage of diabetes self-care resources and lifestyle risk reduction programs |

**Group Health Insurance Program**

***Goals:***

***New Proposed:***

■ Reduction of GHIP diabetic cost per-member-per-month (PMPM) by 5% by the end of FY2021

○ 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]

***New Proposed:***

▲ Incremental increase to unique users engaged in a specific consumerism tool by at least 5% annually

Supply Demand

# GHIP tactics

## To prepare for 2019 and beyond (7/1/2017 – 6/30/2018)

| Addition of at least net 1 VBCD model by end of FY2018 | *New Proposed:* Reduction of GHIP diabetic cost per-member-per-month (PMPM) by 5% by the end of FY2021 | Reduction of gross GHIP trend by 2% by end of FY2020 | Enrollment in a CDHP or value-based plan >25% by end of FY2020 | *New Proposed:* Incremental increase in users engaged in consumerism tool by ≥ 5% annually |
|---|---|---|---|---|
| ▪ Implementation of VBCD models from RFP (including COEs)<br>▪ Look for leveraging opportunities with the DCHI and DHIN to partner on promotion of value based networks (including APCD initiative)<br>▪ Identify opportunities to partner and encourage participation in VBCD models using outside vendors, TPAs and DelaWELL<br>▪ Educate GHIP population on other provider quality tools from CMS, Health Grades, Leapfrog, etc. | ▪ Educate GHIP members on health care consumerism topics related to diabetes, including:<br>▪ Importance of preventive care, wellness and lifestyle risk reduction (e.g., tobacco cessation, physical activity, healthy diet)<br>▪ Availability of Diabetes Prevention Programs<br>▪ Management of chronic diseases and availability of enhanced care management programs (e.g., Aetna/CareLink CareNow, Highmark's CCMU)<br>▪ Benefits available to diabetics (e.g., diabetic supplies available at no cost through the prescription drug plan and scripts for multiple diabetic medications filled at the same time available for just 1 copay)<br>▪ Availability of local health and wellness events led by Delaware hospitals<br>▪ Provider quality and cost transparency tools | ▪ 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<br>▪ Explore avenues for building "culture of health" statewide<br>▪ Continuation of education of GHIP members on the importance of preventive care and the State's preventive care benefits (covered at 100% in-network)<br>▪ 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)<br>▪ Continuation of the evaluation of feasibility of reducing plan options and/or replacing copays with coinsurance—based on emerging market and value-based design* | ▪ Offer a medical plan selection decision support tool (e.g., Truven's "My Benefits Mentor" tool)<br>▪ Promote cost transparency tools available through medical TPA(s)<br>▪ Evaluate feasibility of offering incentives for engaging in wellness activities | ▪ Promote medical plan selection decision support tool (e.g., Truven's "My Benefits Mentor" tool)<br>▪ Communicate the importance of actively participating in open enrollment |







*May require changes to the Delaware Code


# GHIP tactics

## To prepare for 2020 and beyond (7/1/2018 – 6/30/2019)

| Addition of at least net 1 VBCD model by end of FY2018 | ***New Proposed:*** Reduction of GHIP diabetic cost per-member-per-month (PMPM) by 5% by the end of FY2021 | Reduction of gross GHIP trend by 2% by end of FY2020 | Enrollment in a CDHP or value-based plan >25% by end of FY2020 | ***New Proposed:*** Incremental increase in users engaged in consumerism tool by ≥ 5% annually |
|---|---|---|---|---|
| ▪ Continue to monitor and evaluate VBCD opportunities | ▪ Measure baseline diabetes prevalence and cost<br>▪ Explore and implement ways to further promote cost transparency tools to support member decisions about the providers they choose<br>▪ Continue to promote health care consumerism and member education<br>▪ Explore opportunities to expand access to primary care for GHIP participants (e.g., employer-sponsored health care, more intensive telehealth care)<br>▪ Continue to hold medical TPAs accountable for expanding their pay-for-value contracts with providers<br>▪ Continue to require medical TPAs to submit GHIP claim data to the DHIN and other value-based contracts (e.g., ACOs) where applicable | ▪ Explore and implement medical TPA programs, such as tiered pricing for lab services, high cost radiology utilization management (UM) and other medical and Rx UM programs, where necessary<br>▪ Continuation of education of GHIP members on the importance of preventive care and the State's preventive care benefits (covered at 100% in-network)<br>▪ 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)<br>▪ Continuation of the evaluation of feasibility of reducing plan options and/or replacing copays with coinsurance—based on emerging market and value-based design* | ▪ Change medical plan designs and employee/retiree contributions to further differentiate plan options*<br>▪ Change the number of medical plans offered* | ▪ Continue promoting cost and quality transparency tools<br>▪ Consider incentives to drive additional utilization of cost and quality transparency tools<br>▪ Consider requiring an active enrollment for the FY20 open enrollment period for active employees and non-Medicare eligible retirees |







*May require changes to the Delaware Code

# GHIP tactics

## To prepare for 2021 and beyond (7/1/2019 – 6/30/2020)

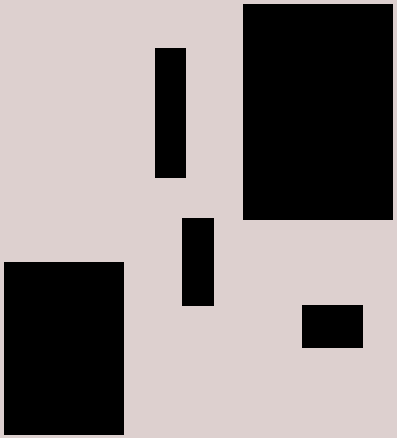
| | *New Proposed:* | | | *New Proposed:* |
|---|---|---|---|---|
| **Addition of at least net 1 VBCD model by end of FY2018** | **Reduction of GHIP diabetic cost per-member-per-month (PMPM) by 5% by the end of FY2021** | **Reduction of gross GHIP trend by 2% by end of FY2020** | **Enrollment in a CDHP or value-based plan >25% by end of FY2020** | **Incremental increase in users engaged in consumerism tool by ≥ 5% annually** |
| ▪ Continue to monitor and evaluate VBCD opportunities | ▪ Explore opportunities to further reduce barriers to accessing care for diabetes (e.g., additional reduction in diabetes medication copays; waived copays for high quality, high value PCPs and/or select specialist physicians)<br>▪ Further leverage and promote use of centers of excellence for treatment of comorbid conditions prevalent among diabetics (e.g., bariatric, orthopedic, spine, cardiac COEs) | ▪ Continue to educate GHIP members on:<br>  ▪ Importance of preventive care and the State's preventive care benefits (covered at 100% in-network)<br>  ▪ Lower cost alternatives to seek care outside of the emergency room (i.e., telemedicine, urgent care centers, retail clinics)<br>▪ Continue to evaluate feasibility of reducing plan options and/or replacing copays with coinsurance—based on emerging market and value-based design* | ▪ Continue to evaluate medical plan designs and employee/retiree contributions to maintain meaningful differences between medical plan options* | ▪ Continue promoting cost and quality transparency tools<br>▪ Consider reviewing plan design provisions that could promote additional utilization of cost and quality transparency tools |





*May require changes to the Delaware Code

# Next steps



# Prospective SEBC meeting discussion topics
## Through Fall 2018

- The below represents a high-level outline of agenda topics for upcoming SEBC meetings
- The plan does not include normally scheduled activities (i.e., fund equity, quarterly cost reporting)
- Additional opportunities may exist, not included below (i.e., exploration of pilot-based programs)

| July (23rd) | August (20th) | September (24th) | October (22nd) |
|---|---|---|---|
| **Discussion Topic(s):**<br>1. Aetna/Highmark update on VBC[1]<br>2. Clinical mgmt. programs – update on member engagement<br>3. FY19 GHIP monthly budget<br>4. HSA plan – options for plan design & rates/contributions<br>5. COE RFP final update | **Discussion Topic(s):**<br>1. Healthcare Benchmark next steps<br>2. COE RFP results*<br>3. Options for FY20 medical plan design & rates/contributions (including HSA plan) | **Discussion Topic(s):**<br>1. Options for FY20 medical plan design & rates/contributions (including HSA plan)<br>2. Other options to address future budget deficit – for FY20 and later<br>3. Eligibility rules | **Discussion Topic(s):**<br>1. Final FY20 plan designs, rates and contributions*<br>2. HSA plan "go/no-go" decision (includes plan design and rates / contributions)*<br>3. Other options to address future budget deficit – for FY20 and later<br>4. DIP RFP final update (vote in Nov or Dec)<br>5. Eligibility rules |

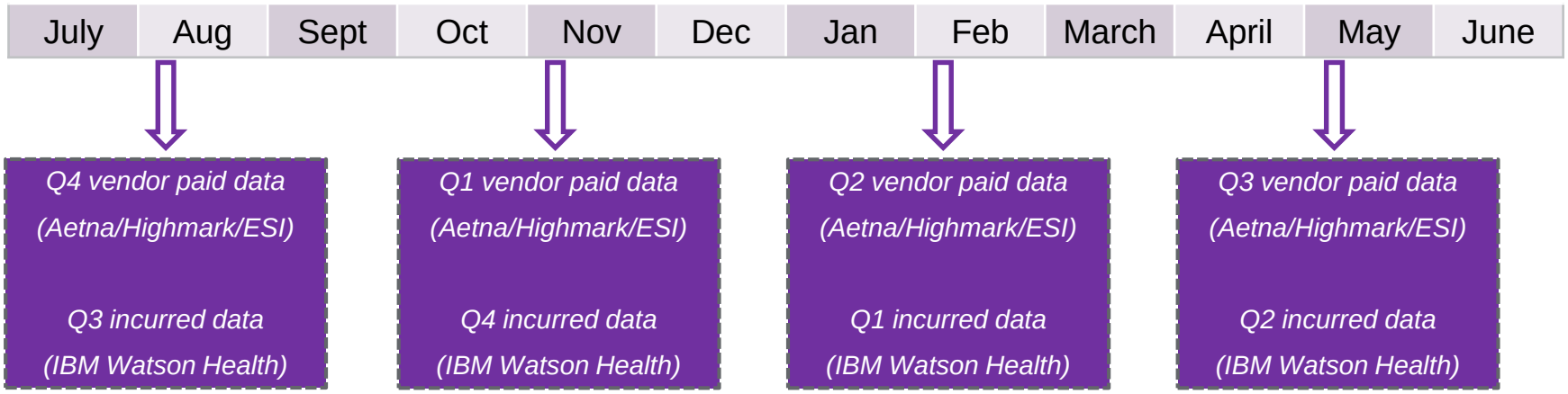
*Denotes potential vote by the Committee.
[1]VBC = Value-based care and high performing providers.

# Next steps

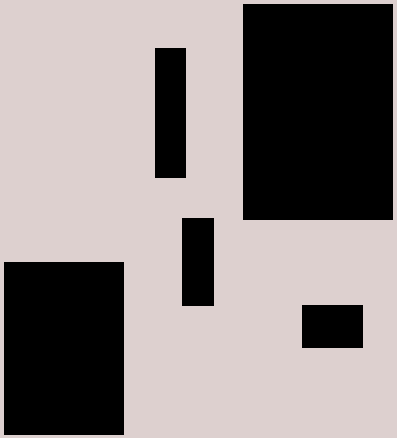
- July 23 SEBC meeting:
  - Value based contracting update from Aetna and Highmark
  - Clinical management programs – update on member engagement
  - June fund equity report
  - FY19 GHIP monthly budget
  - COE RFP final update – vote at August SEBC meeting
  - Next round of financial analysis:
    - Q4 paid data (Aetna/Highmark/ESI) available early August
    - Q3 incurred data (IBM Watson Health) available in early August

# Paid and incurred claim data availability

**Fiscal Year**



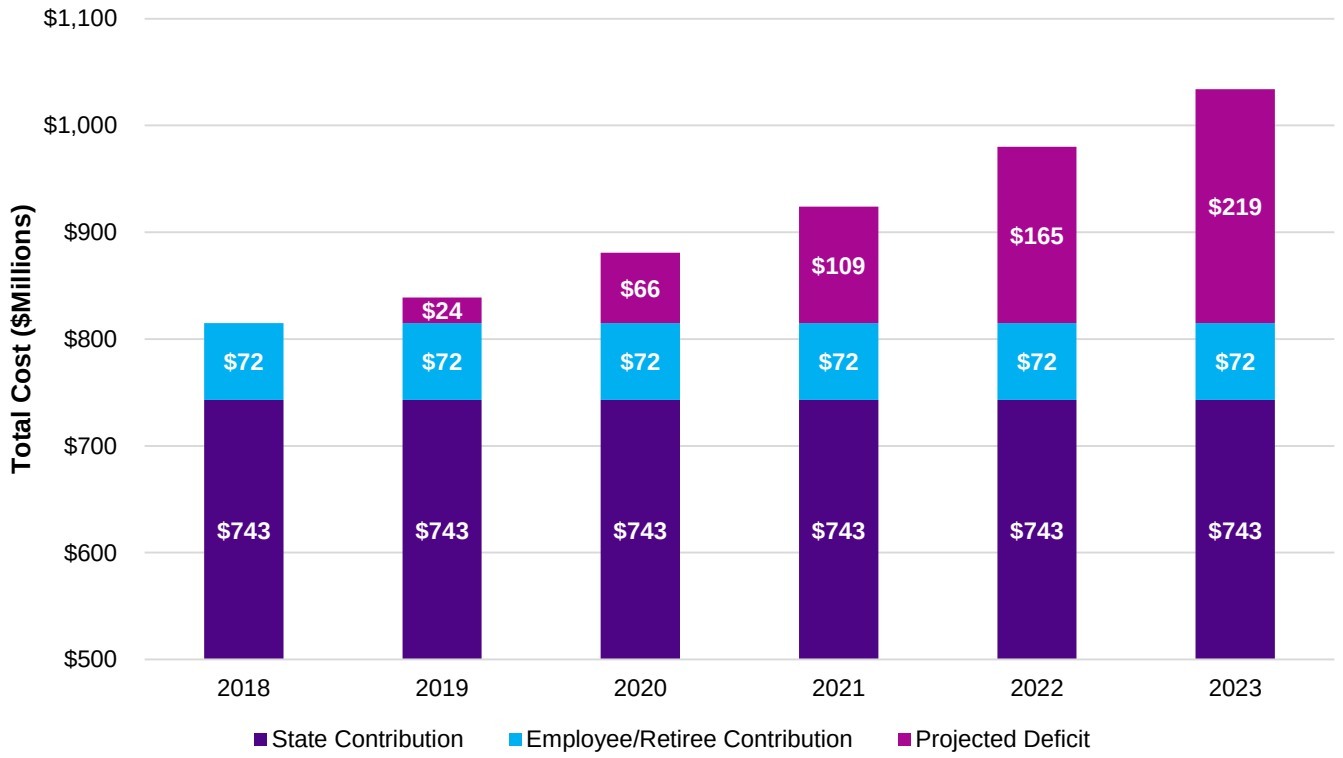
# Appendix



# GHIP long term health care cost projections

## FY18 Q3 update – with FY19 program changes

Long-term cost projections of the Group Health Insurance Plan, at intermediate trend value of 5%




Every 1% of GHIP budget growth (trend) increases the FY20 projected budget by an additional $8.4M. This would require an additional $7.7M in State Contributions ($5.1M from the General Fund), and an additional $0.7M in employee/pensioner contributions.

Notes

- FY18 total projected cost based on FY18 budget rates, FY18 employee/retiree contributions, and enrollment as of December 2017
- FY19 total projected cost based on claims data for the period 4/1/2016-3/31/2018 weighted 35% earlier / 65% later period, estimated savings from expanded COE and site-of-care steerage implemented for 7/1/2018, 7.4% composite health care trend assumption, and enrollment as of March 2018. FY2020-FY2023 projected assuming 5% annual increase (6% long term health care trend less 1% reduction). Assumes no program changes beyond FY19 and includes estimated excise tax liability starting calendar year 2022

# Health Savings Account member out-of-pocket examples

## Low Utilizer - Individual Coverage *(Illustrative)*

| Step 1 | | |
|---|---|---|
| **Services** | **Bad Consumer** | **Good Consumer** |
| 1 Preventive Exam (OV only) | $167 (covered at 100%) | $112 (covered at 100%) |
| 1 Sick Office Visit (PCP) | $176 | $86 |
| 1 X-Ray of hand | $41 [hospital] | $29 [freestanding] |
| 1 Prescription | $335 [brand drug] | $30 [generic drug] |
| **Total Claims** | **$719** | **$257** |
| **Step 2** | | |
| Deductible (excl. preventive) | $552 | $145 |
| Total Paid from HSA | $552 | $145 |
| Net Deductible | $0 | $0 |
| **Step 3** | | |
| Medical Coverage Begins (20% coinsurance up to $2,500) | $0 | $0 |
| **At the end of the year:** | | |
| HSA Fund Balance | $448 | $855 |
| Annual Deductible Remaining | $1,448 | $1,855 |
| Total Plan Paid (Claims + HSA) | $719 | $257 |
| Employee Costs | $399 | $399 |
| - *Out-of-Pocket Costs* | $0 | $0 |
| - *Premium Contributions* | $399 | $399 |

Services
- 1 Preventive Exam
- 1 Sick Visit
- 1 'Regular' X-Ray
- 1 Prescription

Assumes $1,000 seed and no employee contributions to HSA. 2018 IRS rules allow an additional pre-tax contribution of up to $2,500 by employee. Employee can also save HSA funding for future medical expenses.

Source: Department of Human Resources. Represents estimated claim costs under an illustrative high cost scenario ("bad consumer") and low cost scenario ("good consumer"). Average cost of $30 per generic drug Rx and $335 per brand drug Rx based on Willis Towers Watson 2017 HealthMaps database.

# Health Savings Account member out-of-pocket examples

## Low Utilizer – Family Coverage *(Illustrative)*

| Step 1 | | |
|---|---|---|
| **Services** | **Bad Consumer** | **Good Consumer** |
| 3 Preventive Exam (OV only) | $501 (covered at 100%) | $329 (covered at 100%) |
| 4 Sick Office Visit (PCP) | $704 | $344 |
| 2 X-Rays of hand | $256 [hospital] | $58 [freestanding] |
| 4 Prescription | $1,340 [brand drug] | $120 [generic drug] |
| **Total Claims** | **$2,801** | **$851** |
| **Step 2** | | |
| Deductible (excl. preventive) | $2,300 | $522 |
| Total Paid from HAS | $2,000 | $522 |
| Net Deductible | $0 | $0 |
| **Step 3** | | |
| Medical Coverage Begins (20% coinsurance up to $5,000) | $0 | $0 |
| **At the end of the year** | | |
| HSA Fund Balance | $0 | $1,478 |
| Annual Deductible Remaining | $1,700 | $3,478 |
| Total Plan Paid (claims and HSA) | $2,501 | $851 |
| Employee Costs | $1,351 | $1,051 |
| - *Out-of-Pocket Costs* | $300 | $0 |
| - *Premium Contributions* | $1,051 | $1,051 |

Services
- 3 Preventive Exams
- 4 Sick Visits
- 2 'Regular' X-Rays
- 4 Prescriptions

Assumes $2,000 seed and no employee contributions to HSA. 2018 IRS rules allow an additional pre-tax contribution of up to $5,000 by employee. Employee can also save HSA funding for future medical expenses.

Source: Department of Human Resources. Represents estimated claim costs under an illustrative high cost scenario ("bad consumer") and low cost scenario ("good consumer"). Average cost of $30 per generic drug Rx and $335 per brand drug Rx based on Willis Towers Watson 2017 HealthMaps database.

# Health Savings Account member out-of-pocket examples

## Medium Utilizer – Individual Coverage *(Illustrative)*

| Step 1 | | |
|---|---|---|
| **Services** | **Bad Consumer** | **Good Consumer** |
| 1 Preventive Exam (OV only) | $167 (covered at 100%) | $112 (covered at 100%) |
| 4 Sick Visits (PCP) | $704 | $344 |
| 4 X-rays (2-high tech, 2-regular) | $562 [hospital] | $376 [freestanding] |
| 8 Lab Tests | $528 [hospital] | $128 [freestanding] |
| 1 ER Visit | $2,010 [ER] | $120 [urgent care] |
| 4 Prescriptions | $1,340 [brand drug] | $120 [generic drug] |
| **Total Claims** | **$5,311** | **$1,200** |
| **Step 2** | | |
| Deductible (excl. preventive) | $2,000 | $1,088 |
| Total Paid from HSA | $1,000 | $1,000 |
| Net Deductible | $1,000 | $0 |
| **Step 3** | | |
| Medical Coverage Begins (20% coinsurance up to $2,500) | $2,515 plan / $629 employee | $0 |
| **At the end of the year** | | |
| HSA Fund Balance | $0 ($1,000 used) | $0 |
| Annual Deductible Remaining | $0 ($2,000 met) | $912 |
| Total Plan Paid (claims and HSA) | $3,682 | $1,112 |
| Employee Costs | $2,028 | $487 |
| - *Out-of-Pocket Costs* | $1,629 | $88 |
| - *Premium Contributions* | $399 | $399 |

Services

- 1 Adult Preventive Exam
- 4 Sick Visits
- 2 High Tech X-Rays
- 2 'Regular' X-Rays
- 8 Lab Tests
- 1 ER Visit
- 4 Prescriptions

Assumes $1,000 seed and no employee contributions to HSA. 2018 IRS rules allow an additional pre-tax contribution of up to $2,500 by employee. Employee can also save HSA funding for future medical expenses.

Source: Department of Human Resources. Represents estimated claim costs under an illustrative high cost scenario ("bad consumer") and low cost scenario ("good consumer"). Average cost of $30 per generic drug Rx and $335 per brand drug Rx based on Willis Towers Watson 2017 HealthMaps database.

# Health Savings Account member out-of-pocket examples

## Medium Utilizer – Family Coverage *(Illustrative)*

| Step 1 | | |
|---|---|---|
| **Services** | **Bad Consumer** | **Good Consumer** |
| 2 Preventive Exams (OV only) | $334 (covered at 100%) | $224 (covered at 100%) |
| 2 Well Child Visits with Immunization | $442 | $302 |
| Maternity and Delivery (2 day stay) | $14,310 | $9,100 |
| 1 Sick Child Visit (PCP) | $138 | $86 |
| 4 X-rays (2-high tech, 2-regular) | $1,966 [hospital] | $750 [freestanding] |
| 4 Lab Tests | $264 [hospital] | $64 [freestanding] |
| 1 ER Visit | $2,010 [ER] | $120 [urgent care] |
| 6 Prescriptions | $2,010 [brand drug] | $180 [generic drug] |
| **Total Claims** | **$21,504** | **$10,826** |
| **Step 2** | | |
| Deductible (excl. preventive) | $4,000 | $4,000 |
| Total Paid from HSA | $2,000 | $2,000 |
| Net Deductible | $2,000 | $2,000 |
| **Step 3** | | |
| Medical Coverage Begins (20% coinsurance up to $5,000) | $13,736 plan / $3,434 employee | $5,282 plan / $1,320 employee |
| **At the end of the year** | | |
| HSA Fund Balance | $0 ($2,000 used) | $0 ($2,000 used) |
| Annual Deductible Remaining | $0 ($4,000 met) | $0 ($4,000 met) |
| Total Plan Paid (claims and HSA) | $16,070 | $7,506 |
| Employee Costs | $6,485 | $4,371 |
| - *Out-of-Pocket Costs* | $5,434 | $3,320 |
| - *Premium Contributions* | $1,051 | $1,051 |

Services

- 2 Adult Preventive Exams
- 2 Well Child Visits with Immunization
- Maternity and Delivery
- 1 Sick Child Visit
- 2 High Tech X-Rays
- 2 'Regular' X-Rays
- 4 Lab Tests
- 1 ER Visit
- 6 Prescriptions

Assumes $2,000 seed and no employee contributions to HSA. 2018 IRS rules allow an additional pre-tax contribution of up to $5,000 by employee. Employee can also save HSA funding for future medical expenses.

Source: Department of Human Resources. Represents estimated claim costs under an illustrative high cost scenario ("bad consumer") and low cost scenario ("good consumer"). Average cost of $30 per generic drug Rx and $335 per brand drug Rx based on Willis Towers Watson 2017 HealthMaps database.

# Health Savings Account member out-of-pocket examples

## High Utilizer – Individual Coverage *(Illustrative)*

| Step 1 | | |
|---|---|---|
| **Services** | **Bad Consumer** | **Good Consumer** |
| 1 Preventive Exam (OV only) | $167 (covered at 100%) | $112 (covered at 100%) |
| 6 Sick Visits (4 PCP, 2 SPV) | $1,550 | $820 |
| 2 X-rays (2-regular) | $400 [hospital] | $80 [freestanding] |
| 4 Lab Tests | $264 [hospital] | $64 [freestanding] |
| 1 ER Visit | $2,010 [ER] | $120 [urgent care] |
| 1 Cardiac catheterization – Outpatient Hospital | $15,000 | $6,000 |
| 1 Inpatient – Open Heart Surgery | $76,453 | $39,286 |
| 4 Prescriptions | $1,340 [brand drug] | $120 [generic drug] |
| **Total Claims** | **$97,184** | **$46,602** |
| **Step 2** | | |
| Deductible (excl. preventive) | $2,000 | $2,000 |
| Total Paid from HSA | $1,000 | $1,000 |
| Net Deductible | $1,000 | $1,000 |
| **Step 3** | | |
| Medical Coverage Begins (20% coinsurance up to $2,500) | $92,517 plan / $2,500 employee | $41,990 plan / $2,500 employee |
| **At the end of the year** | | |
| HSA Fund Balance | $0 ($1,000 used) | $0 ($1,000 used) |
| Annual Deductible Remaining | $0 ($2,000 met) | $0 ($2,000 met) |
| Total Plan Paid (claims and HSA) | $93,684 | $43,102 |
| Employee Costs | $3,899 | $3,899 |
| - *Out-of-Pocket Costs* | $3,500 | $3,500 |
| - *Premium Contributions* | $399 | $399 |

Services

- 1 Adult Preventive Exam
- 6 Sick Office Visits
- 2 'Regular' X-Rays
- 4 Lab Tests
- 1 ER Visit
- 1 Cardiac Catheterization
- 1 Inpatient – Open Heart Surgery
- 4 Prescriptions

Assumes $1,000 seed and no employee contributions to HSA. 2018 IRS rules allow an additional pre-tax contribution of up to $2,500 by employee. Employee can also save HSA funding for future medical expenses.

Source: Department of Human Resources. Represents estimated claim costs under an illustrative high cost scenario ("bad consumer") and low cost scenario ("good consumer"). Average cost of $30 per generic drug Rx and $335 per brand drug Rx based on Willis Towers Watson 2017 HealthMaps database.

# Health Savings Account member out-of-pocket examples

## High Utilizer – Family Coverage *(Illustrative)*

| Step 1 | | |
|---|---|---|
| **Services** | **Bad Consumer** | **Good Consumer** |
| 4 Preventive Exams (OV only) | $668 (covered at 100%) | $448 (covered at 100%) |
| 16 Sick Child Office Visits (PCP) | $2,600 | $2,240 |
| 6 X-rays | $7,200 [hospital] | $3,150 [freestanding] |
| 8 Physical Therapy Visits | $320 | $160 |
| 2 ER Visit | $4,020 [ER] | $480 [urgent care] |
| 1 Cardiac Catheterization | $15,000 | $6,000 |
| 1 Inpatient – Open Heart Surgery | $76,453 | $39,286 |
| 1 Outpatient – Knee Surgery | $11,000 | $2,000 |
| 10 Prescriptions | $3,350 [brand drug] | $300 [generic drug] |
| **Total Claims** | **$120,611** | **$54,064** |
| **Step 2** | | |
| Deductible (excl. preventive) | $4,000 | $4,000 |
| Total Paid from HSA | $2,000 | $2,000 |
| Net Deductible | $2,000 | $2,000 |
| **Step 3** | | |
| Medical Coverage Begins (20% coinsurance up to $5,000) | $110,943 plan / $5,000 employee | $44,616 plan / $5,000 employee |
| **At the end of the year** | | |
| HSA Fund Balance | $0 ($2,000 used) | $0 ($2,000 used) |
| Annual Deductible Remaining | $0 ($4,000 met) | $0 ($4,000 met) |
| Total Plan Paid (claims and HSA) | $113,611 | $47,064 |
| Employee Costs | $8,051 | $8,051 |
| - *Out-of-Pocket Costs* | $7,000 | $7,000 |
| - *Premium Contributions* | $1,051 | $1,051 |

Services

- 4 Preventive Exams
- 16 Sick Office Visits
- 6 X-Rays
- 8 Physical Therapy Visits
- 2 ER visit
- 1 Cardiac Catheterization
- 1 Inpatient – Open Heart Surgery
- 1 Outpatient – Knee Surgery
- 10 Prescriptions

Assumes $2,000 seed and no employee contributions to HSA. 2018 IRS rules allow an additional pre-tax contribution of up to $5,000 by employee. Employee can also save HSA funding for future medical expenses.

Source: Department of Human Resources. Represents estimated claim costs under an illustrative high cost scenario ("bad consumer") and low cost scenario ("good consumer"). Average cost of $30 per generic drug Rx and $335 per brand drug Rx based on Willis Towers Watson 2017 HealthMaps database.

# New hire enrollment patterns

## Distribution by age

- Average age for new hires/rehires is typically in the mid to late 30s
- Difference in age of new hires/rehires who enroll in a medical plan compared to those who waive coverage is minimal (on average, less than 1 year)
- Largest proportion of new hires/rehires is consistently from the 26-34 age band

| Hire Year | Average Age by Plan | | | | | |
|---|---|---|---|---|---|---|
| | PPO | HMO | CDH | FSB | All Plans | Waive |
| CY 2014 | 38.2 | 38.1 | 39.0 | 35.6 | 38.1 | 37.6 |
| CY 2015 | 41.2 | 38.9 | 41.1 | 36.9 | 40.0 | 38.8 |
| CY 2016 | 39.4 | 37.8 | 38.2 | 36.0 | 38.3 | 37.5 |
| CY 2017 | 38.5 | 37.7 | 39.3 | 35.3 | 37.8 | 36.6 |
| CY 2018 | 39.3 | 39.1 | 38.2 | 36.6 | 38.5 | 38.2 |
| **Average** | **39.3** | **38.3** | **39.1** | **36.1** | **38.5** | **37.7** |

| Hire Year | % of New Hires/Rehires by Age Band | | | | | | |
|---|---|---|---|---|---|---|---|
| | Less than 26 | 26-34 | 35-44 | 45-54 | 55-64 | 65+ | Total |
| CY 2014 | 3% | 45% | 25% | 17% | 9% | 0% | 100% |
| CY 2015 | 8% | 36% | 23% | 18% | 12% | 2% | 100% |
| CY 2016 | 13% | 37% | 22% | 18% | 9% | 1% | 100% |
| CY 2017 | 18% | 33% | 22% | 17% | 9% | 1% | 100% |
| CY 2018 | 17% | 29% | 22% | 19% | 11% | 1% | 100% |
| **Average** | **12%** | **36%** | **23%** | **18%** | **10%** | **1%** | **100%** |

[1] Based on all full-time benefits eligible employees of the State hired or rehired between 2014 and 2018 per 'PHRST_Hires_Rehires_ConHires_FY15-18_medical election_6.20.2018.xls' provided to WTW by OMB on June 20, 2018

# New hire enrollment patterns

## Enrollment by age and by plan

- Nearly half of new hires/rehires under age 26 waive coverage
- Of those who enroll in coverage, new hires/rehires under age 35 are more likely to enroll in FBS compared to older new hires, and less likely to enroll in PPO and HMO plans

| | % Original Election by Plan | | | | |
|---|---|---|---|---|---|
| **Hire Year** | **PPO** | **HMO** | **CDH** | **FSB** | **Waive** |
| **Under Age 26** | | | | | |
| CY 2014 | 33.3% | 7.4% | 3.7% | 7.4% | 48.1% |
| CY 2015 | 19.6% | 25.6% | 5.4% | 7.1% | 42.3% |
| CY 2016 | 23.8% | 19.5% | 5.4% | 9.0% | 42.2% |
| CY 2017 | 27.7% | 12.5% | 4.2% | 13.2% | 42.4% |
| CY 2018 | 23.3% | 10.3% | 3.9% | 16.4% | 46.1% |
| **Age 26-34** | | | | | |
| CY 2014 | 37.8% | 26.1% | 8.0% | 6.3% | 21.9% |
| CY 2015 | 34.9% | 29.3% | 7.3% | 7.6% | 21.0% |
| CY 2016 | 29.6% | 27.6% | 10.2% | 15.1% | 17.5% |
| CY 2017 | 32.7% | 23.5% | 6.4% | 18.7% | 18.6% |
| CY 2018 | 34.6% | 15.1% | 5.6% | 23.3% | 21.3% |
| **Age 35+** | | | | | |
| CY 2014 | 38.1% | 28.8% | 7.6% | 4.5% | 21.0% |
| CY 2015 | 39.2% | 27.8% | 7.9% | 4.9% | 20.3% |
| CY 2016 | 37.0% | 25.7% | 7.9% | 8.3% | 21.1% |
| CY 2017 | 37.5% | 22.1% | 8.2% | 10.8% | 21.4% |
| CY 2018 | 34.8% | 15.4% | 5.2% | 14.4% | 30.3% |

[1] Based on all full-time benefits eligible employees of the State hired or rehired between 2014 and 2018 per 'PHRST_Hires_Rehires_ConHires_FY15-18_medical election_6.20.2018.xls' provided to WTW by OMB on June 20, 2018

# Importance of diabetes management for the GHIP

- Recent reporting from the GHIP's data warehouse shows prevalence of diabetes within the GHIP is increasing and far exceeds IBM Watson Health benchmarks

| Diabetic Patients/1,000 (rolling 12 months) | GHIP (paid through 3/2018) | IBC Watson Health Benchmark[1] |
|---|---|---|
| Active employees & dependents | 76 | 49 |
| Non-Medicare retirees & dependents | 165 | 116 |
| Medicare retirees & dependents | 264 | 62 |

- Enhanced focus on managing diabetes within the GHIP links to broader Statewide initiative to evaluate the disease burden of this condition throughout the state
  - House Bill 203 ("HB203") proposal for a comprehensive joint report to the General Assembly on diabetes prevalence, cost and risk mitigation initiatives in Delaware
    - To be completed by the Division of Medicaid and Medical Assistance, Division of Public Health, and Human Resources Management division of the Office of Management and Budget every 2 years, with the first report due by June 30, 2019

1 Represents the U.S. Total MarketScan norm.