The State of Delaware

GHIP FY23 Planning – Plan Design Considerations

October 11, 2021

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Today's discussion

- GHIP long term health care cost projections – recap
- FY23 opportunities for consideration
  - Presented to the Subcommittees in September and October
  - In progress for discussion with the Subcommittees in November
- Update on other program design considerations
- Next steps

- Appendix
  - Additional details on FY23 opportunities
  - GHIP long term health care cost projections

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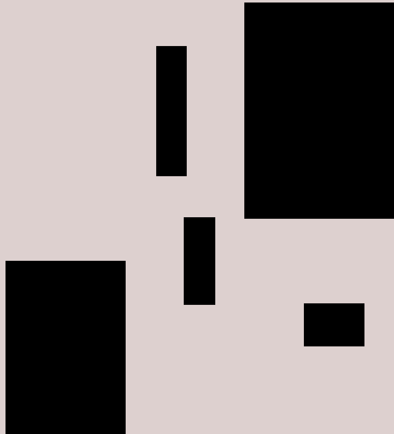
GHIP long term health care cost projections – recap



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GHIP long term health care cost projections (FY21 Q4 update)

No premium increases FY22-FY26 (***includes*** $20m supplemental bill funding in FY22)

GHIP Costs ($ millions)	FY20 Actual	FY21 Actual	FY22 Projected[1]	FY23 Projected[1]	FY24 Projected[1]	FY25 Projected[1]	FY26 Projected[1]
Average Enrolled Members	128,531	129,768	130,427	131,731	133,048	134,378	135,722
GHIP Revenue							
Premium Contributions (Increasing with Enrollment)[2]	$830.8	$839.4	$841.8	$850.2	$858.7	$867.3	$876.0
Hold premium rates flat FY21 and beyond	-	-	$0.0	$0.0	$0.0	$0.0	$0.0
Other Revenues[3]	$122.8	$128.9	$190.0	$182.0	$202.0	$219.3	$237.3
Total Operating Revenues	**$953.7**	**$968.3**	**$1,031.8**	**$1,032.2**	**$1,060.7**	**$1,086.6**	**$1,113.3**
GHIP Expenses (Claims/Fees)							
Operating Expenses[4]	$927.7	$1,005.7	$1,089.6	$1,163.1	$1,241.7	$1,325.5	$1,415.1
% Change Per Member	*0.9%*	*7.4%*	*7.8%*	*5.7%*	*5.7%*	*5.7%*	*5.7%*
Adjusted Net Income (Revenue less Expense)	**$26.0**	**($37.4)**	**($57.8)**	**($130.9)**	**($181.0)**	**($238.9)**	**($301.8)**
Balance Forward	$163.8	$189.8	$152.3	$94.6	($36.3)	($217.3)	($456.3)
Ending Balance	$189.8	$152.3	$94.6	($36.3)	($217.3)	($456.3)	($758.0)
- Less Claims Liability[5]	*$57.5*	*$57.5*	*$61.0*	*$65.1*	*$69.5*	*$74.2*	*$79.2*
- Less Minimum Reserve[5]	*$24.3*	*$24.3*	*$24.3*	*$25.9*	*$27.6*	*$29.5*	*$31.5*
- Less COVID-19 Reserve[6]	-	-	-	-	-	-	-
GHIP Surplus (After Reserves/Deposits)	**$108.0**	**$70.5**	**$9.3**	**($127.3)**	**($314.4)**	**($560.0)**	**($868.7)**

- FY21 reflects release of COVID-19 reserve and June 2021 Fund balance of $152.3m (includes $23.3m in COVID-19 reimbursement, reflected as offset to FY21 operating expenses)
  - Prior projections assumed COVID-19 reimbursement would be received in July (FY22)

It is evident that the COVID-19 pandemic will have an impact on health care costs. We have used available information and reasonable estimation techniques to develop health care cost estimates for the GHIP that reflect the impact of COVID-19. However due to the high degree of uncertainty associated with this pandemic, results may vary from the estimates provided.

Please refer to Appendix for FY17, FY18, and FY19 actual results (slide 15) and detailed projection footnotes (slide 16)

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GHIP long term health care cost projections (FY21 Q4 update)

Recap of August 16, 2021 SEBC meeting

- In order to support the GHIP's strategic framework, Willis Towers Watson (WTW) and the State of Delaware have partnered to identify opportunities to reduce future health care expenditures while creating better health care consumers and ultimately improving the health of the GHIP population
- WTW's latest FY23 budget projection reflects a **$127.3m deficit** that must be solved through a combination of premium rate increases and other levers that can generate substantial plan savings
  - The Financial Subcommittee will be tasked with recommending the timing and level of rate increase in FY23
  - If no other program changes, a 15.0% premium increase will be needed on July 1, 2022 to solve for the projected FY23 deficit of $127.3M
  - A 15.0% premium increase yields $93m in State share revenue and $11m in employee/pensioner revenue for the active/pre-65 retiree population

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GHIP long term health care cost projections (FY21 Q4 update)

Recap of August 16, 2021 SEBC meeting

- Due to the looming FY23 deficit, WTW has been asked to review alternatives that will generate GHIP plan savings and reduce the anticipated FY23 premium increase needed to solve for the deficit
- Savings opportunities can come from, but are not limited to, the following alternatives:
  - Medical TPA RFP initiatives
  - Plan design changes for active/pre-65 and Medicfill programs
  - Adoption of proposed CVS Health pharmacy programs
  - Adoption of mandatory bariatric carve-out and incentive modifications with SurgeryPlus
- The following section details the potential savings associated with these alternatives
  - All savings estimates require additional analysis and refining; estimates are intended to highlight the magnitude of program changes needed to solve for the projected FY23 deficit of $127.3m

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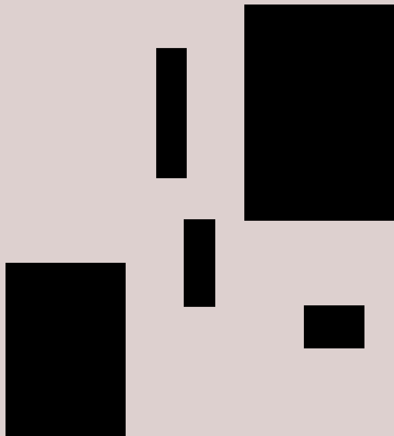
FY23 opportunities for consideration



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FY23 opportunities for consideration

Presented to the Subcommittees in September and October

FY23 Opportunity	Description	Est. # Members Impacted*	Est. FY23 Net Savings / Cost Avoided	Impact to required FY23 premium increase of 15.0%
Add deductibles to the Comprehensive PPO and HMO plans	WTW modeled deductibles for single / family coverage ranging from $50 / $100 to $500 / $1,000	89,000 *(PPO & HMO only)*	**$1.5M – $11.7M**, depending on deductible level	**0.2% – 1.4%** reduction in required increase
Deductible/copay changes to the Medicfill plan	WTW modeled deductibles of $50 and $250 as well as copays for office visits, ER visits and hospital stays	28,600 *(Medicfill only)*	Each change ranges from **$0.8M** to **$3.9M** (max: **$10.3M**)	**0.1% – 0.5%** (max: **1.2%**) reduction in required increase
Rx copay changes	WTW modeled impact of increasing Rx copays for Commercial (non-Medicare) and EGWP populations	Commercial: 102,100 EGWP: 28,000	Commercial: **$3.9M** EGWP: **$2.3M** Total: **$6.2M**	Commercial: **0.5%** EGWP: **0.3%** Total: **0.7%** reduction in required increase
Telemedicine copay changes	WTW modeled reinstatement of member cost sharing for telehealth visits with community providers	102,100 *(Commercial plans only)*	**$4.0M**, assuming future utilization mirrors pre-pandemic utilization	**0.5%** reduction in required increase
CVS Drug Savings Review	Program reviews Rx utilization to ensure that prescriptions follow evidence-based medical guidelines	Commercial: 102,100	**$1.0M – $2.8M,** assuming 7/1/22 effective date	**0.1% – 0.3%** reduction in required increase
CVS PrudentRx	Program leverages manufacturer assistance with specialty medications and requires significant engagement from members	102,100 *(Commercial plans only)*	**$6.9M**, current Exclusive Specialty formulary **$7.7M**, with enhanced Excl. Specialty formulary	**0.8%** reduction in required increase, current formulary **0.9%** with enhanced formulary
CVS Transform Diabetes Care	Engages members with diabetes on actionable steps to address gaps in care, evaluate medical needs and facilitate overall wellness	102,100 *(Commercial plans only)*	**$1.9M** *(Impact on Medicfill plans will be addressed separately today)*	**0.2%** reduction in required increase

*Based on enrollment as of August 2021.

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FY23 opportunities for consideration

In progress for discussion with the Subcommittees in November

Potential program changes for the SurgeryPlus benefit:

- Mandating use of SurgeryPlus for selected types of surgery:
  - Updates to the prior analysis of the cost and estimated savings associated with bariatric surgery is ongoing
    - Prior analysis estimated the potential cost avoidance of this approach could range from $355,000 to $1.4m, depending upon number of procedures performed during the plan year
  - Opportunities to consider mandating use for other types of surgeries (e.g., joint replacements) will be explored as well
  - Recent feedback from members who used the SurgeryPlus benefit will be shared as part of this discussion

- Incentive modifications:
  - Impact of mandating use of the SurgeryPlus benefit on incentives paid to members will also be presented at the November Subcommittee meeting
    - Potential cost avoided by removing the incentive for bariatric surgery was factored into the prior estimates above
    - Potential cost avoided through further changes to remaining incentives for optional use of this benefit is highly dependent upon member utilization; based on FY21 experience, the State paid members approximately $412,000 in incentives (reflects the maximum potential cost avoided if incentive changes were made for FY21)
  - Opportunities to modify incentive levels for other surgeries will be explored as well

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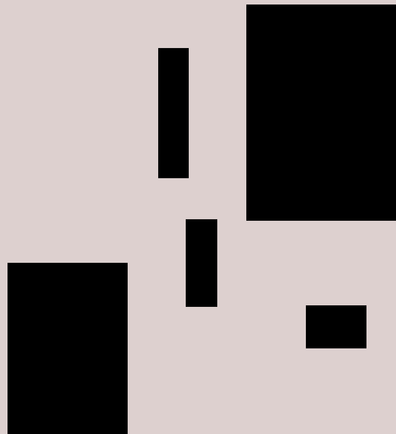
Update on other program design considerations



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Program design considerations

- The SEBC has previously adopted a variety of initiatives that improve health outcomes and support management of cost for members and the GHIP
- WTW has periodically updated the Subcommittees on the utilization and outcomes of these initiatives (most recently in November-December 2020 for site of care steerage and clinical management programs)
- An update on the utilization and outcomes associated with prior copay changes on site of care steerage and with GHIP clinical management programs (including SurgeryPlus) was presented at last week's Subcommittee meeting

	FY17 *(Effective 7/1/16)*	FY18 *(Effective 7/1/17)*	FY19 *(Effective 7/1/18)*	FY20 *(Effective 7/1/19)*	FY21 *(Effective 7/1/20)*	FY22 *(Effective 7/1/21)*
Site of Care Steerage	▪ ***Already in place***: Aetna infusion therapy site-of-care steerage ▪ Copay changes for urgent care, high-tech imaging ▪ Third-party telemedicine programs added	(no changes)	▪ Copay changes for basic imagining, high-tech imaging, outpatient labs	▪ Copay changes for basic imaging, high-tech imaging, outpatient labs, emergency room, and telemedicine ▪ Implemented Highmark infusion therapy site-of-care steerage program	(no changes)	(no changes)
Clinical Management Programs	(no changes)	▪ Implemented Aetna/Carelink and Highmark CCMU care management programs	▪ Implemented diabetes prevention programs (Retrofit, YMCA)	▪ Implemented Livongo for diabetes management	(no changes)	(no changes)
Other Initiatives and Changes	(no changes)	• Implemented Aetna Enhanced Clinical Review program for select high tech imaging services	▪ HB203 Diabetes monitoring and prevention	▪ Implemented SurgeryPlus surgeons of excellence program ▪ ***Effective 8/1/19:*** Implemented enhanced fertility benefits	(no changes)	(no changes)

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Update on utilization of services with variable copays by site of care

- IBM Watson Health and Willis Towers Watson compared the most recent 12 months of incurred claims experience (April 2020 – March 2021) to the prior two years to evaluate changes that occurred during the initial year of the pandemic
- Consistent with earlier utilization analyses[1] presented to the Financial Subcommittee, there continues to be a reduction in utilization of most services with variable copays by site of care, except for outpatient labs, which have increased at both hospitals and preferred labs (driven by COVID-19 testing)
- Likely stems from the combined impact of the COVID-19 pandemic and changes in behavior driven by copay differentials
- Prior to COVID-19, GHIP experience would show reduction in utilization of non-preferred sites of care in the plan years coinciding with copay changes, but in years with no changes, utilization of non-preferred sites of care would revert back to higher levels
- With the pandemic playing a significant role in changing utilization patterns across virtually all types of care, it is necessary to establish a new baseline for GHIP experience with site of care utilization and continue to monitor to determine whether these behavior changes are sustainable
- At this time, no changes to these copay differentials are recommended for FY23

1 See materials from the January 2021 Subcommittee meeting for further details: https://dhr.delaware.gov/benefits/sebc/documents/sub-comm-2021/0121-covid-cost-reporting.pdf

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Update on clinical management programs

- Willis Towers Watson conducted a “current state analysis” of the following clinical management programs that have been previously implemented for the GHIP:
  - Diabetes prevention (“DPP”) and management programs (Livongo, YMCA DPP, Solera)
  - SurgeryPlus surgical centers of excellence (COE)
  - Care management programs (CareVio, Aetna case/disease management, Highmark CCMU)
- Key considerations regarding this analysis:
  - Care and utilization trends based on the most recent data available coincide with peak periods of the COVID-19 pandemic, therefore observed data trends may not be indicative of true program performance
  - Program variations and associated reporting among similar programs such as the diabetes prevention programs do not support an “apples-to-apples comparison” of program outcomes
    - SBO and WTW continue to work with vendor partners to define and standardize metrics across programs where possible
  - Available data reflects varied and disparate reporting periods among similar programs, and in some cases had limited detailed reporting to support further analysis, which impacted the ability to conclusively evaluate the effectiveness of some programs (such as the diabetes prevention programs)
  - For consistent and detailed evaluation between similar programs, recommend continued efforts to define and standardize plan year metrics across programs and an analysis based on defined metrics and outcomes from the vendor partners for purposes of comparison
  - A key challenge with these programs is the administrative effort of the SBO and the GHIP vendor partners in administering, reporting, assessing and determining which vendor takes credit for health improvements/risk reduction/savings
    - Examples: coordination of care management between SurgeryPlus and other care management programs; impact of care management programs vs. Livongo in improving diabetic member health outcomes

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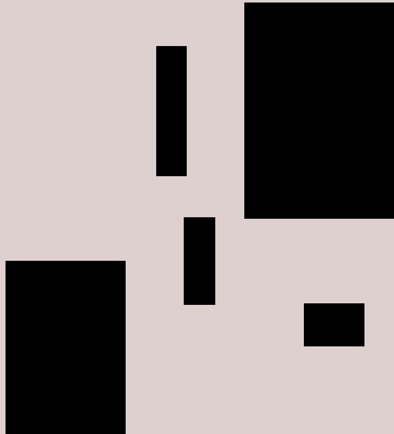
Next steps



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Next steps

- Further discussion of FY23 savings opportunities will occur at the November Subcommittee meeting
  - Recommendations from the Subcommittee will be shared with the SEBC at the December meeting
- Continue to monitor emerging utilization and cost savings for the GHIP initiatives adopted to date
- Continue to discuss timing and level of future rate action

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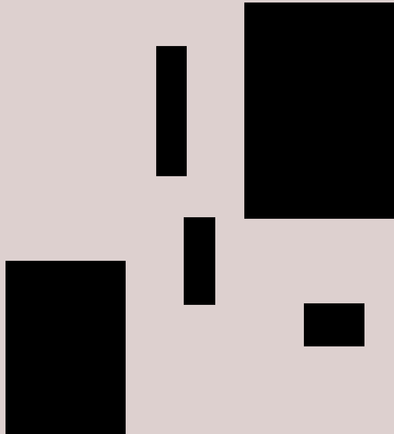
Appendix

Additional details on FY23 opportunities



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Plan design considerations

Deductible modeling – HMO and Comprehensive PPO plans

- The table below highlights savings attributable to adding various deductibles to the Comprehensive PPO and HMO plans effective 7/1/22

FY23 Deductible (single / family)	$50 / $100	$100 / $200	$150 / $300	$200 / $400	$250 / $500	$500 / $1000
HMO	$0.3 M	$0.7 M	$0.9 M	$1.3 M	$1.5 M	$2.7 M
Comprehensive PPO	$1.1 M	$2.0 M	$3.1 M	$4.2 M	$5.1 M	$9.0 M
Total	**$1.5 M**	**$2.6 M**	**$4.0 M**	**$5.5 M**	**$6.6 M**	**$11.7 M**

- The 15.0% premium increase modeled in August results in the following increase in annual employee/pensioner contributions:
  - HMO: $85 – $223
  - Comprehensive PPO: $189 – $491
- Adding deductibles will have minimal impact on the overall deficit and only generate savings through cost shifting
  - If the State decided to add deductibles to these plans, a premium increase will still be needed to solve for the remaining deficit, creating two layers of member disruption

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Plan design considerations

Deductible/copay modeling – Medicfill plan

- Medicare retirees have minimal cost sharing for medical under the current Medicfill plan
- The State can achieve savings through increased cost sharing for the Medicfill plan in the form of deductibles and/or copays on specific services
  - Adding deductibles to the Medicfill plan would generate savings while creating significant member disruption
  - Adding copays for office, emergency department and/or inpatient visits can more effectively achieve savings while mitigating member disruption
- The table below highlights savings attributable to adding various deductibles and copays to the Medicfill plan (savings reflect 12-month plan year)
  - Note: utilization data on Medicare office visits is currently unavailable

Plan design change	Gross savings
$50 Deductible[1]	$0.8 M
$250 Deductible[1]	$3.9 M
$10 OV Copay	$3.4 M
$150 ER Copay	$2.1 M
$100 IP Copay[2]	$0.9 M

[1] Deductibles apply to hospital benefits only (Part A)
[2] $100 copay per day to a maximum of $200

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Plan design considerations

Rx copay modeling

- To evaluate potential copay changes to Rx plan design, WTW reviewed benchmarking information from its Benefit Data Source database
- Benchmarking reflects 272 organizations with 10,000+ employees
- Majority of organizations offer copays for generic drugs (retail and mail-order), and coinsurance for brand drugs (preferred and non-preferred, retail and mail-order)
- The illustrative design changes below target copay amounts aligned with the copays offered by the majority of organizations in BDS for each category of drug

	Current Design	Benchmark Design
Prescription Drug[2] – (Retail / Mail-Order)		
Generic	$8 / $16	$12 / $24
Brand Formulary	$28 / $56	$42 / $84
Brand Non-Formulary	$50 / $100	$75 / $150

- Illustrative savings[1]:
  - Commercial plans: $3.9m
  - Medicfill plan: $2.3m

[1] Savings estimates utilize Rx copay data provided by IBM Watson Health; reflects Rx scripts and copays paid in FY21 separately for generics, preferred brands and non-preferred brands for retail and mail-order drugs; applies ratio of average paid copay per script relative to maximum current copay to the illustrative benchmark copays for each drug category; actual savings may vary

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Plan design considerations

COVID-19 benefit enhancements

- Since the onset of COVID-19, the GHIP has continued to evaluate and extend certain benefit enhancements related to the pandemic, including:
  - EAP coverage for all SOD employees (annual GHIP cost ~$70k)
  - No member cost sharing for any telehealth visit
    - GHIP cost impact varies, and has grown with the substantial increase in telehealth utilization with "other" telehealth providers, including PCP's and specialists
  - Benefit enhancements currently extended for no more than thirty days following the end of the public health emergency
- In the 12-months ended in July 2021, the GHIP paid approx. $19m in telehealth claims associated with these "other" providers with essentially no member cost sharing
  - Based on cost sharing for pre-pandemic telehealth claims[1], the GHIP could save up to $4m by waiving the extension of no member cost sharing for any telehealth visit[2]
    - Assumes future utilization mirrors pre-pandemic utilization

[1] 10% coinsurance for CDH and FSB plans, $0 copay for PPO/HMO visits with select telehealth providers (i.e., Teladoc, Doctor on Demand, Amwell), and office visit copays for appointments with community-based providers (i.e., PCPs, specialists) and for behavioral health counseling services through certain telehealth providers (MDLive, Array AtHome Care, Bright Heart Health)
[2] Savings estimates based on IBM Watson reporting of telehealth utilization with other providers (excludes Doctor on Demand, Teladoc and Amwell) for the periods August 2020 – July 2021 and November 2018 – October 2019; savings based on % member cost share for pre-pandemic telehealth visits applied to most recent 12 months of paid telehealth claims

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Proposed CVS Health pharmacy programs

Drug Savings Review

- Identifies opportunities for improved prescribing and utilization based on evidence-based medical guidelines
- Program savings are highly dependent on the responsiveness and engagement of the medical provider community, as CVS would be reaching out to physicians with patient safety and savings opportunities
  - CVS outreach consists of a request to the provider to consider making a change in a member's prescription therapy
  - Provider retains discretion over the member's prescription therapy; if the provider does not wish to make a change, CVS will honor their clinical opinion
- Minimal impact to member outside of possible change in prescription(s)
- Program has a 3:1 minimum Return on Investment (ROI) guarantee
  - Monthly administrative fee applies
  - Estimated annual net savings range (after member cost sharing): $1.0M – $2.8M
- Program can only be implemented at the beginning of a quarter; for a 1/1/2022 effective date, CVS must be notified by October 15, 2021

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Proposed CVS Health pharmacy programs

PrudentRx specialty copay card program

- PrudentRx is an independent third-party organization that CVS Health has partnered with to offer this program
- Program leverages changes to member cost sharing for specialty drugs to optimize savings from manufacturer copay cards and reduce plan and member costs
  - Applies to all specialty medications on the CVS Caremark® specialty drug list, including highly utilized classes such as autoimmune, hepatitis C, multiple sclerosis and oncology
  - Would be applicable for Commercial (non-Medicare) plan participants only; not applicable to EGWP
- All members on a specialty medication that is exclusively filled by the CVS specialty pharmacy would be contacted by PrudentRx to enroll in this program
  - Enrollment would allow members to pay $0 out-of-pocket for all specialty medications on the State of Delaware's exclusive specialty drug list dispensed by CVS Specialty®, regardless of whether a copay card is available
  - If copay card is available, then copay assistance provided by the drug manufacturer will be used to offset the plan sponsor's share of the specialty drug cost
  - According to PrudentRx, 96% of specialty brand drug scripts have copay assistance

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Proposed CVS Health pharmacy programs

PrudentRx specialty copay card program (continued)

- Program would require significant engagement from members and would increase member out-of-pocket costs for individuals who do not enroll in the program
  - Members must take action to enroll in PrudentRx once contacted by the program
  - Any member who does not take action to enroll in PrudentRx would be subject to a 30% coinsurance on specialty medications dispensed by the CVS specialty pharmacy
  - Currently, members with new specialty medications are allowed one “grace fill” of their specialty medication outside of the CVS Specialty pharmacy; this would be removed if PrudentRx is implemented, requiring members to utilize the CVS Specialty pharmacy exclusively for these Rx
- All specialty medications on the CVS exclusive specialty list would be included; a list of the most common conditions for GHIP members who use specialty drugs that would be affected by PrudentRx are noted to the right
  - Can be expanded to also include specialty drugs for other conditions noted below that are not currently included on the CVS exclusive specialty list
- Program is also dependent upon the continuation of drug manufacturer copay assistance programs
- CVS-estimated annual net savings to the GHIP: $6.9M
  - Savings increases to $7.7M with specialty drugs for expanded list of conditions
  - Highly dependent upon members’ enrollment in PrudentRx
  - May vary based on actual specialty drug utilization and spend
- No upfront administrative fees but savings is shared with PrudentRx

Most common conditions for GHIP members using specialty drugs that would be affected by PrudentRx

- Atopic Dermatitis
- Autoimmune
- Multiple Sclerosis
- Oncology

Other conditions that could be included in PrudentRx

- Hepatitis B
- HIV
- Transplants

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Proposed CVS Health pharmacy programs

Next Generation Transform Diabetes Care (ngTDC)

- Potential replacement for the Livongo diabetes care management program for Medicfill plan participants, who will lose access to Livongo on 12/31/2021 when the State's contract with Express Scripts terminates
- Several key differences between the Livongo and ngTDC programs, including the glucose meters used by both programs
  - Livongo provides all enrolled participants with a "connected meter" that uses wireless technology to transmit blood glucose test results to Livongo coaches, who will contact members with abnormally high or low glucose levels
  - ngTDC uses a different connected meter for members at high risk of abnormal glucose values; all other enrolled participants will be offered another meter available from the CVS formulary
  - While lower-risk members will still be required to change their glucose meter, there are additional benefits for those members under the ngTDC
    - Formulary meter uses testing supplies that are covered at no cost under the Rx plan, and can connect to the CVS mobile app to synch readings, provide additional wellness support and send results to external providers
    - These participants are also eligible for diabetes coaching from nurses, nutrition counseling and in-person support at CVS pharmacies, which are all enhancements from the Livongo program
- While the estimated annual cost of ngTDC is about $115,000 more than Livongo (based on Medicfill population only), there is a guaranteed ROI of at least 2:1

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Proposed CVS Health pharmacy programs

Next Generation Transform Diabetes Care (ngTDC) (continued)

- In order to have ngTDC in place by 1/1/2022 to avoid a gap in diabetes care management for Medicfill plan participants, CVS required notification of intent to implement by October 1, 2021
- SBO obtained conditional approval from the SEBC co-chairs to begin implementation of this program with CVS but will be seeking final approval from the SEBC at the October 11, 2021 meeting
  - If the SEBC does not provide final approval to implement this program at the October 11 meeting, CVS has agreed to terminate the implementation process at no cost to the State and with no impact to members
- Subcommittee members will still need to determine whether this program should be adopted for active employees and non-Medicare pensioners and assess the value of this program against other diabetes offerings available through the medical TPAs
  - Estimated annual net savings to the GHIP: $1.9M on medical and pharmacy costs for active employees and non-Medicare pensioners

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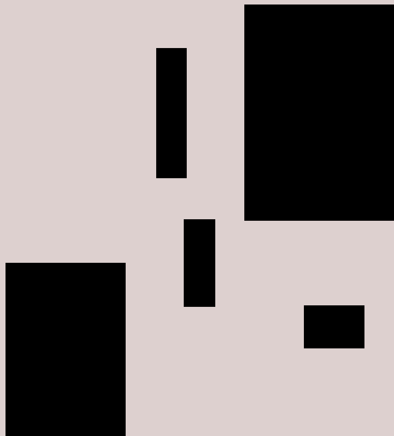
Appendix



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FY23 monthly rates and employee/retiree contributions

Illustrative: 15.0% increase effective 7/1/2022

FY22 reflects employee contribution increases of $4.18 - $40.93 per employee per month ($50.16 - $491.16 per year) and State subsidy increases of $100.12 - $270.14 per employee per month ($1,201.44 - $3,241.68 per year) effective 7/1/2022

	Current Rates			FY 2023 with 15.0% Increase (effective 7/1/2022)			$ Change Employee/ Pensioner Contribution		$ Change State Subsidy	
	Rate	Employee Contribution	State Subsidy	Rate	Employee Contribution	State Subsidy	Monthly	Annual	Monthly	Annual
First State Basic										
Employee	$695.36	$27.84	$667.52	$799.66	$32.02	$767.64	$4.18	$50.16	$100.12	$1,201.44
Employee + Spouse	$1,438.68	$57.52	$1,381.16	$1,654.48	$66.15	$1,588.33	$8.63	$103.56	$207.17	$2,486.04
Employee + Child	$1,057.02	$42.26	$1,014.76	$1,215.57	$48.60	$1,166.97	$6.34	$76.08	$152.21	$1,826.52
Family	$1,798.42	$71.92	$1,726.50	$2,068.18	$82.71	$1,985.47	$10.79	$129.48	$258.97	$3,107.64
CDH Gold										
Employee	$719.68	$35.98	$683.70	$827.63	$41.38	$786.25	$5.40	$64.80	$102.55	$1,230.60
Employee + Spouse	$1,492.22	$74.58	$1,417.64	$1,716.05	$85.77	$1,630.28	$11.19	$134.28	$212.64	$2,551.68
Employee + Child	$1,099.56	$54.96	$1,044.60	$1,264.49	$63.20	$1,201.29	$8.24	$98.88	$156.69	$1,880.28
Family	$1,895.74	$94.78	$1,800.96	$2,180.10	$109.00	$2,071.10	$14.22	$170.64	$270.14	$3,241.68
Aetna HMO										
Employee	$725.94	$47.16	$678.78	$834.83	$54.23	$780.60	$7.07	$84.84	$101.82	$1,221.84
Employee + Spouse	$1,530.58	$99.50	$1,431.08	$1,760.17	$114.43	$1,645.74	$14.93	$179.16	$214.66	$2,575.92
Employee + Child	$1,110.52	$72.18	$1,038.34	$1,277.10	$83.01	$1,194.09	$10.83	$129.96	$155.75	$1,869.00
Family	$1,909.82	$124.12	$1,785.70	$2,196.29	$142.74	$2,053.55	$18.62	$223.44	$267.85	$3,214.20
Comprehensive PPO										
Employee	$793.86	$105.18	$688.68	$912.94	$120.96	$791.98	$15.78	$189.36	$103.30	$1,239.60
Employee + Spouse	$1,647.34	$218.26	$1,429.08	$1,894.44	$251.00	$1,643.44	$32.74	$392.88	$214.36	$2,572.32
Employee + Child	$1,223.46	$162.08	$1,061.38	$1,406.98	$186.39	$1,220.59	$24.31	$291.72	$159.21	$1,910.52
Family	$2,059.40	$272.86	$1,786.54	$2,368.31	$313.79	$2,054.52	$40.93	$491.16	$267.98	$3,215.76

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GHIP historical health care fund information

FY17-FY19

GHIP Costs ($ millions)	FY17 Actual	FY18 Actual	FY19 Actual
Average Enrolled Members	123,132	125,488	126,360
GHIP Revenue			
Premium Contributions (Increasing with Enrollment)[2]	$799.0	$810.9	$817.4
Hold premium rates flat FY21+)	-	-	-
Other Revenues[3]	$81.6	$92.1	$98.5
Total Operating Revenues	**$880.6**	**$903.0**	**$915.9**
GHIP Expenses (Claims/Fees)			
Operating Expenses[4]	$816.8	$853.9	$904.0
% Change Per Member		*2.6%*	*5.1%*
Excise Tax Liability[5]			
Adjusted Net Income (Revenue less Expense)	**$63.8**	**$49.1**	**$11.9**
Balance Forward	$38.9	$102.7	$151.8
Ending Balance	$102.7	$151.8	$163.8
- Less Claims Liability[6]	*$54.0*	*$58.9*	*$58.8*
- Less Minimum Reserve[6]	*$24.0*	*$24.0*	*$24.3*
GHIP Surplus (After Reserves/Deposits)	**$24.7**	**$68.9**	**$80.7**

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GHIP long term health care cost projection footnotes

Note: FY17-FY21 actuals based on final June Fund Equity reports for respective fiscal year; FY22+ projected operating expenses and enrollment based on experience through FY21 Q4 with adjustments due to COVID-19 financial impact; assumed 1% annual enrollment growth; numbers in table may not add up due to rounding

1. Includes approved design changes effective 7/1/2019 including implementation of SurgeryPlus COE ($0.5m annual savings), site-of-care steerage ($6.9m), Highmark infusion therapy program ($2.0m) and implementation of Livongo ($0.7m); FY21 reflects implementation of Highmark radiation therapy authorization program ($633k annual savings per Highmark); FY22-FY26 projections based on 5% medical, 8% pharmacy baseline trend; assumes 1% annual growth in GHIP membership; FY22 projection reflects impact of COVID-19; assumes no other program changes in FY22 and beyond.
2. Includes State and employee/pensioner premium contributions; assumes 1% annual enrollment growth for FY22-FY26
3. Includes Rx rebates, EGWP payments, other revenues based on when revenues will be received; FY22 and beyond includes estimated improvements in Rx rebates based on result of PBM award to CVS Health; rebates assumed to be paid 60 days after the quarter adjudicated; includes fees for participating non-State groups (assumed to increase proportionally with membership and premium growth); FY22 includes projected $8.4m CY2020 CMS financial reconciliation payment to be received Jan. 2022.
4. FY22 and beyond includes estimated reduction in pharmacy claims as a result of PBM award to CVS Health
5. FY20 Minimum Reserve levels updated with data through June 2019; FY20 Claim Liability updated with lag factors as of Dec 2019 and claims data through December 2019; FY21 reserves assumed to remain at FY20 levels; FY22 claim liability and future years assumed to increase with overall GHIP claims growth; FY22 minimum reserve assumed to remain at FY21 level.
6. One-time COVID-19 reserve as approved by SEBC on July 27th, 2020; released at the end of FY21

It is evident that the COVID-19 pandemic will have an impact on health care costs. We have used available information and reasonable estimation techniques to develop health care cost estimates for the GHIP that reflect the impact of COVID-19. However due to the high degree of uncertainty associated with this pandemic, results may vary from the estimates provided.

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