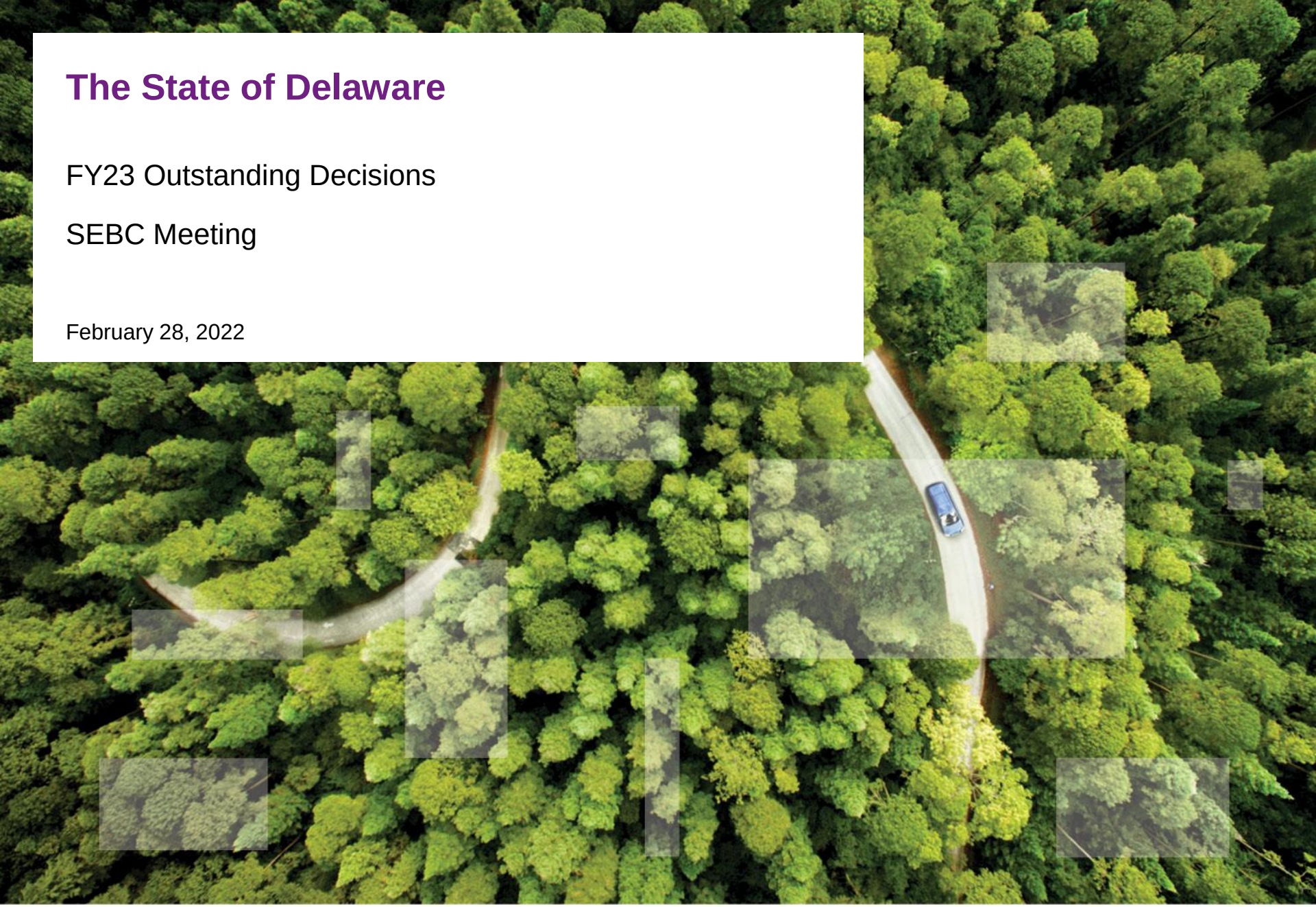
The State of Delaware

FY23 Outstanding Decisions

SEBC Meeting

February 28, 2022



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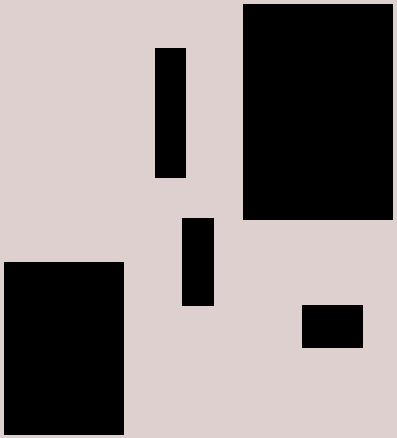
Contents

Medicare Plan Options

Overview



Medicare pensioner plan options

Overview of medical TPA RFP scoring decision for Medicare

- On November 2, 2021, the Proposal Review Committee (PRC) voted affirmatively on the following recommendations related to the Medicare plan options:
  - Both Highmark Delaware and Aetna are qualified to administer both a Special Medicfill Medicare Supplement plan as well as a Group Medicare Advantage (Group MA) product to the Medicare pensioner population, with Highmark Delaware's Medicare Advantage product being slightly more favorable than Aetna's product based on the results of the scoring
  - Of a total of 125 points, the scores by plan were as follows:
    - Special Medicfill Medicare Supplement: Highmark Delaware scored 80.4, Aetna scored 78.2
    - Medicare Advantage: Highmark Delaware scored 83.0, Aetna scored 80.2
  - The PRC recommended continued evaluation of these Medicare plan options in accordance with the recommendations from the Retirement Benefits Study Committee (released on November 1, 2021), with no immediate contract award of a Medicare product at that time
  - **The PRC also recommended that the State Employee Benefits Committee (SEBC) should reach a decision on the administration of a Medicare plan for calendar year 2023 no later than March 31, 2022, in order to provide sufficient time for implementation of that plan option before the current Special Medicfill Medicare Supplement plan contract terminates on December 31, 2022**
  - Should the SEBC wish to offer the Special Medicfill Medicare Supplement plan beyond December 31, 2022, then the SEBC could potentially do so through an award to Highmark Delaware based on the scoring results by the PRC
  - Subcommittee members discussed the Medicare plan options for FY23 and formulated recommendations that will be discussed at today's meeting

Medicare pensioner plan options

Industry perspective – Medicare Supplement vs Group Medicare Advantage

Plan type	Description	Current state	Future state
Medicare Supplement* and Coordination of Benefit (COB) plans	▪ Employer-sponsored plans that provide benefits secondary to Medicare ▪ No federal funding for medical claims ▪ Federal funding available for Rx claims (usually not sufficient to fully offset cost) ▪ Generally self insured for larger employers ▪ Employer sets plan design	▪ Shrinking enrollment in recent years due to advent of Medicare marketplace approach driving enrollment in individual coverage	▪ Continued shrinkage as employers continue shift to marketplace plans or convert to group MA plans ▪ Enrollment will decline as older members of closed groups pass away
Group Medicare Advantage (Group MA)	▪ Private group plans that replace Medicare Parts A and B ▪ Always fully insured ▪ Part D Rx coverage can be included or excluded from group MA plan ▪ Significant federal funding covers lion's share of cost ▪ Minimum design standards set by Centers for Medicare and Medicaid (CMS) ▪ Wide latitude for employer custom design	▪ Enrollment over 3m as group MA plans can often match current benefits at lower cost ▪ Many employers offer group MA plans as a full replacement passive Preferred Provider Organization (PPO) that minimizes network disruption ▪ Major group MA insurers: UHC, Humana, Aetna	▪ Good fit for employers with substantial post-65 groups where movement to a Medicare marketplace is not feasible ▪ Stability and growth predicated on continuing favorable federal funding

*GHIP Medicfill plan is a Medicare Supplement plan.

- Per Delaware statute, the State Employee Benefits Committee (SEBC) is tasked with deciding the types of Medicare options available to Delaware retirees

Medicare pensioner plan options

GHIP-specific considerations related to Group MA with Part D Rx coverage

Considerations for including Part D Rx coverage (MAPD)	Considerations for excluding Part D Rx coverage (MA only)
▪ Simplified administration under one carrier ▪ Short term financial predictability with known fixed premiums covering both medical and prescription drug spend ▪ 2020 Pharmacy Benefits Manager (PBM) RFP included flexibility for the State to discontinue Employer Group Waiver Plan (EGWP) for Rx coverage through CVS ▪ More advantageous than MA only to GHIP cash position in year of implementation due to payment timing lag for rebate and EGWP revenues under existing Rx plan	▪ The State is already benefiting from significant federal and PBM subsidies via the EGWP ▪ The State recently concluded negotiation of highly competitive financial terms for the EGWP contract under CVS ▪ Cost volatility is low for the portion of Rx drug spend not covered by Part D ▪ Additional PBM disruption for members including potential change in pharmacy network, formulary, etc. for 1/1/2023, following the change in PBMs from Express Scripts to CVS effective 1/1/2022

Medicare pensioner plan options

Overview of proposed options – Medicfill vs Group MA

Plan feature	Medicfill (current)	Proposed Group MA (Aetna)	Proposed Group MA (Highmark)
Plan type	▪ Self-funded medical/EGWP	▪ Fully-insured MA (medical only) or MAPD	▪ Fully-insured MA (medical only) or MAPD
Federal funding	▪ Retained by GHIP (EGWP only)	▪ Retained by Aetna	▪ Retained by Highmark
Medical plan design[1]	▪ Member responsible for Part B premium only ($170.10/month for 2022)	▪ Same as Medicfill	▪ Same as Medicfill
Rx plan design[2]	▪ Generic copay: $8 / $16 retail/mail ▪ Brand formulary: $28 / $56 ▪ Brand non-formulary: $50 / $100 ▪ Out-of-pocket max: None[3]	▪ Same as Medicfill	▪ Same as Medicfill
Provider network	▪ Passive PPO (members may seek care from any medical provider that accepts Medicare assignment) ▪ See appendix for more details	▪ Same as Medicfill ▪ Mirrors access to providers available today	▪ Same as Medicfill ▪ Mirrors access to providers available today
CY 2023 premium rate (per retiree per month)[4]	▪ $459.38 total ▪ $260.44 medical ▪ $198.94 Rx	▪ Redacted	▪ $162 total (MAPD) ▪ $0 medical (MA medical only) ▪ $162 Rx
Group MA transition credit	▪ N/A	▪ $	▪ $$$

1. Plan fully covers medical out-of-pocket costs not covered by Medicare Part B, other than the Part B premium
2. Prescription drug copays and 5% premium cost share applies for pensioners retiring on or after 7/1/2012; State share is 100% for pensioners retiring before 7/1/2012; State pays 100% of State Share for pensioners with 20+ years of service
3. Catastrophic Coverage: After yearly out-of-pocket drug costs reach $7,050, retirees pay the greater of 5% coinsurance or from $3.95 to $9.85 copayment per script based on drug tier
4. Assumes no change in rates effective 7/1/2022; Medicfill rates represent funding revenue only; actual cost of Medicfill program differs from the current funding rates

Considerations for Medicare plan options

- Balance short term financial impact to the GHIP of Medicare Supplement vs. Medicare Advantage plan options with the longer-term impact of change in terms of OPEB liability
- Another option discussed by the Retirement Benefits Study Committee (RBSC) – the Medicare marketplace – is outside the scope of this RFP and was not considered in this analysis
- Changes in Medicfill program design that reduce the State's unfunded OPEB liability can be recognized once the changes have been announced, regardless of effective date
- Important for SEBC to thoroughly evaluate all options and make the best decision for the GHIP, for pensioners and for the State’s retiree liability obligations
- Any change from the current Medicfill plan will require extensive outreach and communication in advance of the plan effective date
- If moving from Medicfill to Group MA, Medicare rates will reset to the fully-insured rate (with or without Rx), and will reduce overall subsidy for active and pre-65 rates

SEBC Decision Points:

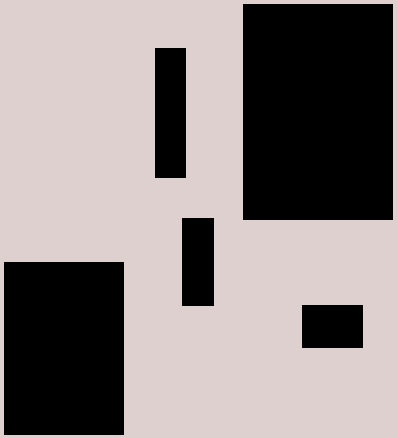
- **Maintain Medicfill plan or move to Group MA product, effective 1/1/23 (or later)**
- **Aetna or Highmark**
- **Including/Excluding Part D drug coverage as part of Group MA product**

Medicare pensioner plan options

Decisions requiring vote by SEBC

- The joint Subcommittees provide recommendations for the following with regards to a Medicare plan:
  - Effective January 1, 2023, move to Group Medicare Advantage Plan
  - Award administration of the Group MA plan to Highmark
  - Maintain existing self-funded EGWP coverage

Active/Non-Medicare Plan Considerations



Active Non-Medicare Plan Considerations

Overview of outstanding decisions for 2/28 SEBC vote

- Subcommittee members discussed the following programs for FY23 and formulated recommendations that will be discussed at today's meeting:
  - Care management program option for each medical vendor
  - Aetna HMO plan's PCP election/referral requirement
  - Other FY23 opportunities for consideration
- At the conclusion of today's discussion, the SEBC will be asked to take a vote on Subcommittee recommendations

Outstanding decisions from the Medical RFP

Care management programs – Aetna

Outstanding decision	Effective date of decision	Estimated FY23 Admin Cost / (Savings)
Aetna HMO and CDH Gold plans: Choose which care management program to implement: ▪ Option 1 (“One Advisor”): Targets more people, engages with them earlier, uses more advanced technology, is more integrated with other Aetna services ▪ Option 2 (“One Flex”): Targets fewer people, uses less advanced technology/integration, is lower cost than Option 1 Both programs are new to the State Group Health plan and both offer performance guarantees.	7/1/2022 (SEBC must vote by 2/28)	**($0.6M)** – Option 1 **($1.7M)** – Option 2 Savings are based on administrative costs only and do not factor in any potential savings from the performance guarantee.

- Aetna appeared before the Combined Subcommittees in January to present on key differences between these programs, using several member scenarios to illustrate how the member’s experience would be different under each option, and answered questions from Subcommittee members, who were briefed on both options prior to this meeting
  - This briefing focused on information Aetna submitted in its response to the 2021 Medical RFP including descriptions of each program, fees, performance guarantees, outcomes achieved and case studies

- At the February Subcommittee meeting, follow-ups from Aetna’s presentation were discussed; this included clarification of the engagement rates produced by each option, further description of how both care management programs address components of the member experience such as members’ social determinants of health, early identification of members with pre-diabetes, and care coordination with members’ PCPs and other community providers

Outstanding decisions from the Medical RFP

Care management programs – Aetna (continued)

- The Subcommittees saw value in a program that identifies more plan participants for engagement, at earlier points in their health care journey, and how doing so could lead to a better member experience, improved health outcomes and reduced cost
- Subcommittee members also felt that Aetna's presentation in January effectively outlined key differences in the degree of care advocacy and navigation support available to members through each option
- The availability of performance guarantees addressing member engagement and clinical outcomes, in addition to financial outcomes, was viewed favorably by Subcommittee members
- Based on the above, Subcommittee members agreed that the **Aetna One Advisor program ("Option 1")** would be better suited to identify, engage and support the health care needs of plan participants

Outstanding decisions from the Medical RFP (continued)

Care management programs – Highmark

Outstanding decision	Effective date of decision	Estimated FY23 Admin Cost / (Savings)
Highmark PPO and First State Basic plans: Choose which care management program to implement: ▪ Option 1 ("Well360 Clarity"): New program, targets more people, delivered in conjunction with partner, more steerage to high quality providers ▪ Option 2 ("CCMU"): In place today, targets fewer people, Highmark alone delivers program, WTW* provides clinical oversight on behalf of all mutual customers served by the CCMU Both programs offer performance guarantees.	7/1/2022 (SEBC must vote by 2/28)	**($0.6M)** – Option 1 **$0.1M** – Option 2 Savings are based on administrative costs only and do not factor in any potential savings from the performance guarantee.

- Highmark appeared before the Combined Subcommittees in January to present on key differences between these programs, using several member scenarios to illustrate how the member's experience would be different under each option, and answered questions from Subcommittee members, who were briefed on both options prior to this meeting
  - This briefing focused on information Highmark submitted in its response to the 2021 Medical RFP including descriptions of each program, fees, performance guarantees, outcomes achieved and case studies

- At the February Subcommittee meeting, follow-ups from Highmark's presentation were discussed; this included clarification of which functions of the Option 1 "Well360 Clarity" program would be managed by Highmark vs. its care management partner and further description of how both care management programs address components of the member experience such as members' social determinants of health, early identification of members with pre-diabetes, and care coordination with members' PCPs and other community providers

* WTW oversight consists of clinical audits, ongoing calls to discuss CCMU operations and review of outcomes reports and is provided by WTW's CCMU operations team, which includes WTW clinicians and is separate from the WTW team supporting the State of Delaware.

Outstanding decisions from the Medical RFP

Care management programs – Highmark (continued)

- Subcommittee members discussed key differences between each program's operations, mechanisms for engaging members and ability to influence members' site-of-care choices
- There was hesitation from Subcommittee members around adopting a program for which Highmark is using a new care management provider to deliver services to members
- Subcommittee members expressed concerns about an insufficient level of transparency into Highmark's broader relationship with its care management provider, despite multiple inquiries requesting further details
- There was deliberation about the fact that, in general, care management programs are not "locked in" throughout the life of a TPA contract and can be changed, unlike most core administrative components of the State's contracts with the TPAs
- Based on the above, Subcommittee members agreed that the **Highmark CCMU ("Option 2")** would be better suited to continue supporting plan participants for FY23. There was a willingness to consider reevaluating this decision throughout the subsequent years of the State's contract with Highmark

Outstanding decisions from the Medical RFP (continued)

Outstanding decision	Effective date of decision	Estimated FY23 Admin Cost / (Savings)
Aetna HMO plan: Maintain or waive current requirement for participants to select a primary care physician and obtain referrals	7/1/2022 (SEBC must vote by 2/28)	**$2.0M** if waived (though within margin of error of estimated discounts)

- Today, the State's HMO requires members to select a PCP upon enrollment and also requires referrals for members seeking specialty care
- Prompted by feedback from plan participants about the difficulty of finding a PCP or accessing primary care, the medical RFP included a request for alternative HMO designs that would remove this PCP selection/referral requirement
- The Subcommittees discussed the possible implications of removing this requirement on plan costs and on GHIP revenue through enrollment migration from the PPO to the HMO (i.e., lost contribution revenue for similar plan design, potential impact on Highmark performance guarantees and other elements of Highmark's financial proposal)
- Based on the above, Subcommittee members agreed that **maintaining the requirement for PCP selection and referrals** is preferable to waiting this requirement

Other FY23 opportunities for consideration

Recommended by Subcommittees for SEBC

- Combined Subcommittees revisited the FY23 opportunities that were previously recommended to the SEBC by Subcommittee members in December 2021, since no vote was taken at the 12/13 SEBC meeting
- There was a discussion several updates on these potential opportunities since December, with the exception of the CVS Drug Savings Review program, did not make them feasible for vote in February or March and in time to apply as savings against the FY23 deficit
  - There was agreement that telemedicine utilization would continue to be monitored with the feasibility of plan design changes reevaluated in the future
  - Further discussion of the CVS Transform Diabetes Care program will coincide with additional discussion of other condition-specific program opportunities available through the Medical RFP at the March Subcommittee meetings

FY23 Opportunity	Description	Est. # Members Impacted*	Est. FY23 Net Savings / Cost Avoided
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
CVS Drug Savings Review	Program reviews Rx utilization to ensure that prescriptions follow evidence-based medical guidelines	102,100 *(Commercial plans only)*	**$1.0M** – **$2.8M,** assuming 7/1/22 effective date
CVS Transform Diabetes Care	Engages members with diabetes on actionable steps to address gaps in care, evaluate medical needs and facilitate overall wellness	Approximately 6,400 Commercial plan members who are currently participating in the Livongo diabetes management program	**$1.9M** *(impact on Medicfill plans addressed separately)*

*Based on enrollment as of August 2021.

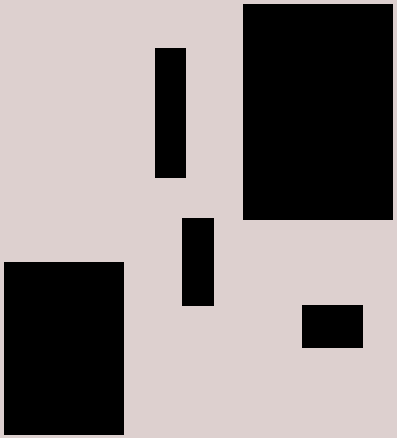
CVS Drug Savings Review

- There was discussion to gauge Subcommittee members' interest maintaining their earlier recommendation for the Drug Savings Review program to the SEBC
- Key elements of the program were discussed (see sidebar)
- Some Subcommittee members were concerned about whether this program was truly voluntary for providers and recalled requirements to change prescriptions with earlier PBM transition to CVS; clarification was provided about the differences between those situations and this program
- Discussed the State's ability to turn this program "On" / "Off" throughout the duration of the CVS contract
- Notwithstanding the above, the Subcommittees remain in support of the SEBC considering this program for FY23, but with continued monitoring of the member experience, physician engagement and program results throughout the first year of the program for reconsideration of continuing the program past FY23

CVS Drug Savings Review

- Identifies opportunities for improved prescribing and utilization based on evidence-based medical guidelines
- Program savings highly dependent on responsiveness and engagement of the medical provider community
  - CVS outreach to physicians with patient safety and savings opportunities; would request physician considers changing member's prescription therapy
  - Provider retains discretion over making any changes; if provider declines to change member's prescription, CVS will honor provider's 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
  - Est. annual net savings range (after member cost sharing): $1.0M – $2.8M

Updated long-term projections



GHIP long term health care cost projections (updated through Jan' 22)

Overview

- GHIP long-term projections have been updated to reflect all legislation signed into law and initiatives voted on by the SEBC as of February 24th, 2022 (see slide 21)
- Projections include assumed $24m in COVID-19 reimbursement funds based on COVID claims incurred in 2021; payment expected to be received during FY23
  - No additional COVID-19 funding relief reflected in projections as funding relief would offset COVID-19 related expenses
- EGWP revenue projections (direct subsidy, coverage gap discount payment and federal reinsurance) for CY23 based on estimates previously provided by ESI; CVS will provide revised projections by 2/25 and any material deviation from current projections will be updated for 2/28 SEBC meeting
- Rate action required to solve for FY23 deficit, and annual rate action in FY23, FY24 and FY25 required to target $0 deficit by end of FY25 are also provided
  - Member impact slides for various rate actions included beginning on slide 24
- On February 28th, 2022, the SEBC will vote on a Medicare plan option for 1/1/23
- On February 28th, 2022, the SEBC will also vote on a premium rate increase for FY23, based on a recommendation to be provided by the Financial Subcommittee

Financial Subcommittee recommendations to SEBC must consider:

- **Recommended Medicare plan option for 1/1/23**
- **Signed/pending legislation impacting future GHIP costs**
- **Impact of any proposed rate action on FY23 and beyond (i.e., one-time rate action for FY23, or target 3-year smoothed rate increase)**

GHIP long term health care cost projections (updated through Jan' 22)

FY23 legislation impacting the GHIP

- The following bills have either been signed or are anticipated to be signed with an effective date on or before the end of FY23; future cost estimates are not reflected in the updated long-term projections but are included below:

Bill	Effective Date	Description	Fiscal Year Cost (Savings)
Bills signed and/or enacted without signature from the Governor:			
SB 25	January 1, 2022	Chiropractor reimbursement not less than Medicare	**$0.5M-$1.0M***
SS 1 for SB 120	January 1, 2023; or as early as March/April 2022	Sustaining primary care through increased reimbursements	**$4.6M – $29.9M;** reflects cost estimate for Highmark population only
HB 219	Immediately	Provides enhanced oversight and transparency as it relates to PBMs	**$1.8M**
Bills anticipated to be passed during the 151st General Assembly:			
150th General Assembly HB 307	As early as January 1, 2023	Requires coverage of annual behavioral health well visits with a non-physician behavioral health provider	**$2.0M-$3.1M**
TBD	As early as January 1, 2023	Sponsored bill will require all insurers, including the GHIP, to provide supportive/maintenance chiropractic care	**>$1M**

- Potential FY23 Cost / (Savings): $9.9m - $36.8m

*Reflected in updated long-term projections due to 1/1/2022 effective date.

GHIP long term health care cost projections (updated through Jan' 22)

No premium increases FY22-FY26 (***move to Group MA, medical only, eff. 1/1/23***)

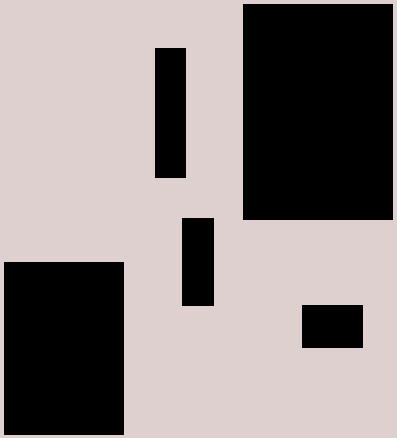
GHIP Costs ($ millions)	FY20 Actual	FY21 Actual	FY22 Projected[1]	FY23 Projected[1]	FY24 Projected[1]	FY25 Projected[1]	FY26 Projected[1]
Average Enrolled Members	128,531	129,768	130,158	131,460	132,775	134,103	135,444
GHIP Revenue							
Premium Contributions (Increasing with Enrollment)[2]	$830.8	$839.4	$839.4	$802.5	$764.8	$772.4	$781.1
Hold premium rates flat FY23 and beyond	-	-	$0.0	$0.0	$0.0	$0.0	$0.0
Other Revenues[3]	$122.8	$128.9	$188.3	$186.1	$219.7	$238.2	$258.2
Total Operating Revenues	**$953.7**	**$968.3**	**$1,027.7**	**$988.6**	**$984.5**	**$1,010.6**	**$1,039.3**
GHIP Expenses (Claims/Fees)							
Operating Expenses[4]	$927.7	$1,005.7	$1,064.6	$1,080.2	$1,136.7	$1,214.1	$1,299.1
% Change Per Member	*0.9%*	*7.4%*	*5.5%*	*0.5%*	*4.2%*	*5.8%*	*5.9%*
Adjusted Net Income (Revenue less Expense)	**$26.0**	**($37.4)**	**($36.9)**	**($91.6)**	**($152.2)**	**($203.5)**	**($259.8)**
Balance Forward	$163.8	$189.8	$152.3	$115.5	$23.9	($128.2)	($331.7)
Ending Balance	$189.8	$152.3	$115.5	$23.9	($128.2)	($331.7)	($591.5)
- Less Claims Liability[5]	*$57.5*	*$57.5*	*$61.0*	*$61.9*	*$65.1*	*$69.5*	*$74.4*
- Less Minimum Reserve[5]	*$24.3*	*$24.3*	*$24.3*	*$24.7*	*$26.0*	*$27.8*	*$29.7*
- Less COVID-19 Reserve[6]	-	-	-	-	-	-	-
GHIP Surplus (After Reserves/Deposits)	**$108.0**	**$70.5**	**$30.2**	**($62.7)**	**($219.3)**	**($429.0)**	**($695.6)**

- 8.67% rate increase needed to solve for FY23 deficit
- 8.98% annual increase in FY23, FY24, FY25 needed to target $0 deficit by end of FY25

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 30) and detailed projection footnotes (slide 31)

Member Impact Scenarios



FY23 monthly rates and employee/retiree contributions

Illustrative: 8.67% increase effective 7/1/2022

FY23 reflects employee contribution increases of $2.41 - $23.66 per employee per month ($28.92 - $283.92 per year) and State subsidy increases of $57.88 - $156.14 per employee per month ($694.56 - $1,873.68 per year) effective 7/1/2022

	Current Rates			FY 2023 with 8.67% 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	$755.65	$30.25	$725.40	$2.41	$28.92	$57.88	$694.56
Employee + Spouse	$1,438.68	$57.52	$1,381.16	$1,563.41	$62.51	$1,500.90	$4.99	$59.88	$119.74	$1,436.88
Employee + Child	$1,057.02	$42.26	$1,014.76	$1,148.66	$45.92	$1,102.74	$3.66	$43.92	$87.98	$1,055.76
Family	$1,798.42	$71.92	$1,726.50	$1,954.34	$78.16	$1,876.18	$6.24	$74.88	$149.68	$1,796.16
CDH Gold										
Employee	$719.68	$35.98	$683.70	$782.08	$39.10	$742.98	$3.12	$37.44	$59.28	$711.36
Employee + Spouse	$1,492.22	$74.58	$1,417.64	$1,621.60	$81.05	$1,540.55	$6.47	$77.64	$122.91	$1,474.92
Employee + Child	$1,099.56	$54.96	$1,044.60	$1,194.89	$59.73	$1,135.16	$4.77	$57.24	$90.56	$1,086.72
Family	$1,895.74	$94.78	$1,800.96	$2,060.10	$103.00	$1,957.10	$8.22	$98.64	$156.14	$1,873.68
Aetna HMO										
Employee	$725.94	$47.16	$678.78	$788.88	$51.25	$737.63	$4.09	$49.08	$58.85	$706.20
Employee + Spouse	$1,530.58	$99.50	$1,431.08	$1,663.28	$108.13	$1,555.15	$8.63	$103.56	$124.07	$1,488.84
Employee + Child	$1,110.52	$72.18	$1,038.34	$1,206.80	$78.44	$1,128.36	$6.26	$75.12	$90.02	$1,080.24
Family	$1,909.82	$124.12	$1,785.70	$2,075.40	$134.88	$1,940.52	$10.76	$129.12	$154.82	$1,857.84
Comprehensive PPO										
Employee	$793.86	$105.18	$688.68	$862.69	$114.30	$748.39	$9.12	$109.44	$59.71	$716.52
Employee + Spouse	$1,647.34	$218.26	$1,429.08	$1,790.16	$237.18	$1,552.98	$18.92	$227.04	$123.90	$1,486.80
Employee + Child	$1,223.46	$162.08	$1,061.38	$1,329.53	$176.13	$1,153.40	$14.05	$168.60	$92.02	$1,104.24
Family	$2,059.40	$272.86	$1,786.54	$2,237.95	$296.52	$1,941.43	$23.66	$283.92	$154.89	$1,858.68

Medicare Supplement – Special Medicfill

Rates effective January 1, 2022 – December 31, 2022

	Total Monthly Rate	State Share	Pensioner Pays
Highmark Delaware Medicare Supplement for Pensioners Retired On or Prior to July 1, 2012			
Special Medicfill with Prescription	$459.38	$459.38	$0.00
Special Medicfill without Prescription	$260.44	$260.44	$0.00
Highmark Delaware Medicare Supplement for Pensioners Retired After July 1, 2012			
Special Medicfill with Prescription	$459.38	$436.42	$22.96
Special Medicfill without Prescription	$260.44	$247.44	$13.00

- If you have less than 20 years of service and were first hired on or after July 1, 1991, the State does not pay the full state share but will pay a percentage of the state share of the cost of your coverage as explained in the charts below.

Eligible Pensioners Hired By The State On Or After July 1, 1991 Through December 31, 2006 *(The following portion of the State Share will be paid by the State)* **(Except those receiving a disability pension or receiving an LTD benefit)**		
Less than 10 years service	0%	state share paid by state
10 years - less than 15 years service	50%	state share paid by state
15 years - less than 20 years service	75%	state share paid by state
20 years or more service	100%	state share paid by state
Eligible Pensioners Hired By The State On Or After January 1, 2007 *(The following portion of the State Share will be paid by the State)* **(Except those receiving a disability pension or receiving an LTD benefit)**		
Less than 15 years service	0%	state share paid by state
15 years - less than 17.5 years service	50%	state share paid by state
17.5 years - less than 20 years service	75%	state share paid by state
20 years or more service	100%	state share paid by state

Medicare Advantage

Rates effective January 1, 2023 – December 31, 2023

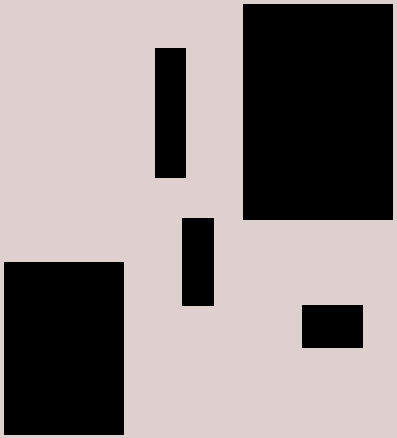
	Total Monthly Rate	State Share	Pensioner Pays
Highmark Delaware Medicare Supplement for Pensioners Retired On or Prior to July 1, 2012			
Special Medicfill with Prescription*	$216.19	$216.19	$0.00
Special Medicfill without Prescription*	$0.00	$0.00	$0.00
Highmark Delaware Medicare Supplement for Pensioners Retired After July 1, 2012			
Special Medicfill with Prescription**	$216.19	$205.38	$10.81
Special Medicfill without Prescription	$0.00	$0.00	$0.00

*Rates reflect Medicare Advantage plan recommended by Combined Subcommittee on 2/24/2022, which are pending SEBC vote on 2/28/2022

- If you have less than 20 years of service and were first hired on or after July 1, 1991, the State does not pay the full state share but will pay a percentage of the state share of the cost of your coverage as explained in the charts below.

Eligible Pensioners Hired By The State On Or After July 1, 1991 Through December 31, 2006 *(The following portion of the State Share will be paid by the State)* **(Except those receiving a disability pension or receiving an LTD benefit)**		
Less than 10 years service	0%	state share paid by state
10 years - less than 15 years service	50%	state share paid by state
15 years - less than 20 years service	75%	state share paid by state
20 years or more service	100%	state share paid by state
Eligible Pensioners Hired By The State On Or After January 1, 2007 *(The following portion of the State Share will be paid by the State)* **(Except those receiving a disability pension or receiving an LTD benefit)**		
Less than 15 years service	0%	state share paid by state
15 years - less than 17.5 years service	50%	state share paid by state
17.5 years - less than 20 years service	75%	state share paid by state
20 years or more service	100%	state share paid by state

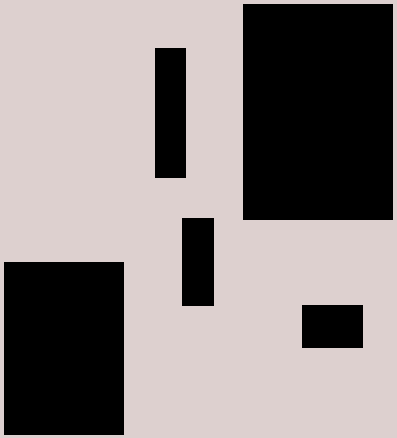
Next Steps



Outstanding decisions for 2/28 SEBC vote

- The SEBC must vote on the Subcommittee recommendations from the February 24th, 2022 Combined and Financial Subcommittee meetings; Subcommittee recommendations are summarized below:
  - Medicare plan option:
    - Subcommittees recommend moving to Group Medicare Advantage plan (medical only), effective 1/1/2023, administered by Highmark, and to continue offering drug coverage through CVS EGWP
  - Care Management program decisions:
    - HMO and CDH Gold plans: Subcommittees recommend Aetna One Advisor
    - PPO and First State Basic plans: Subcommittees recommend Highmark CCMU
  - Aetna HMO:
    - Subcommittees recommend retaining requirement for PCP selection and referrals
  - CVS Drug Savings Review Program:
    - Subcommittees remain in support of the SEBC considering this program for FY23, but with continued monitoring of the member experience, physician engagement and program results throughout the first year of the program for reconsideration of continuing the program past FY23
  - FY23 rate action:
    - Financial Subcommittee recommends an 8.67% rate increase effective 7/1/2022 to solve for the projected FY23 deficit of $62.7M

Appendix



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**

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 October 2021 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.