The State of Delaware

FY24 Planning Considerations

SEBC Meeting

February 20, 2023

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FY24 planning considerations

Recap of recent discussions with the Subcommittees

- Due to the FY24 deficit, the SEBC has asked the Subcommittees to review alternatives that will generate GHIP plan savings and reduce the anticipated FY24 premium increase needed to solve for the projected $138.1M FY24 deficit
- Savings opportunities reviewed with the Subcommittees were tailored to reflect:
  - Untapped short-term opportunities that would reduce plan costs for FY24 and are possible within the requirements of Delaware Code[1]
  - Consistency with approaches that other large, self-funded plan sponsors have taken to manage short-term costs
- The following slides detail the potential savings associated with these alternatives
  - Savings estimates are intended to highlight the magnitude of program changes needed to solve for the projected FY24 deficit of $138.1m
  - Also summarized is the financial impact of other changes that will result in an initial and/or ongoing cost to the GHIP, such as the addition of coverage for weight loss medications and the expiration of the COVID-19 national and public health emergency periods

- ***For further discussion at today's meeting:*** Overview of FY24 opportunities with Subcommittee members' feedback

SEBC decisions on FY24 opportunities and FY24 premium rates must be voted on by March 20, 2023 to ensure readiness to deliver on 2023 Open Enrollment for active employees and non-Medicare pensioners, which starts in May 2023

1 See Appendix for further details on the role of the Delaware Code in the ongoing management of the GHIP.

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FY24 opportunities for consideration

FY24 Opportunity	Description	Estimated # Members or Services Impacted*	Est. FY24 Net $ Impact + Cost / (Savings)	Impact to required FY24 premium increase of 16.6%	Comments
Already brought before the SEBC					
CVS PrudentRx	Program leverages manufacturer assistance with specialty medications and requires engagement from members	Approximately 1,600 members utilizing specialty drugs (excluding HIV and fertility) *Non-Medicare plans only*	Savings of: **($6.6M)** to the GHIP **($358K)** to plan participants	**0.7%** reduction to the required increase	Based on prior Subcommittee recommendation, was discussed with SEBC in January 2023 with potential vote in February 2023 ***CVS to address member experience and answer SEBC questions today***
Other opportunities reviewed with the Subcommittees					
Aetna's Gene-Based, Cellular and other Innovative Therapies (GCIT) Network	Narrow network of high quality providers that have agreed to discounted pricing for several expensive, emerging therapies Has potential to reduce total cost of care for GHIP and members	None currently (no utilizers of these therapies in any non-Medicare plan) *HMO and CDH Gold only*	N/A	N/A	**Recommended by WTW** Opportunity to mitigate future impact of these high cost therapies by implementing now. **Subcommittee feedback:** Requires further study; no recommendation at this time
Weight loss medications	Consider adding coverage of a relatively new class of drugs that have demonstrated effectiveness in achieving weight loss • Relatively recent FDA approval for drug class (as early as 2015) • Limited long-term experience with savings • Further details in appendix	N/A (not covered today) *Non-Medicare plans only* SBO has received numerous GHIP member inquires and requests for this coverage to be added	Added cost to the GHIP of: **+$1.8M with utilization management** **+$2.9M without utilization management**	**+0.2-0.4% addition** to the required increase	**Not recommended by WTW** If the SEBC wishes to add coverage of these drugs, then WTW recommends doing so with utilization management. Coverage recently added by Delaware Medicaid and City of Wilmington. **Subcommittee feedback:** Requires further study; no recommendation at this time

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FY24 opportunities for consideration

FY24 Opportunity	Description	Estimated # Members or Services Impacted*	Est. FY24 Net $ Impact + Cost / (Savings)	Impact to required FY24 premium increase of 16.6%	Comments
Other opportunities reviewed with the Subcommittees					
Site-of-care steerage: ER copay changes	Increase ER visit copay to encourage use of alternate sites of care for non-emergency use Modeled incremental increases of $25 - $75	Varies by year; in FY22, only 6% of about 33K ER visits were for non-emergency use *Non-Medicare plans only*	Cost avoidance to GHIP of: **($264K)** to **($792K)** based on range of copay options modeled	**0.1% - 0.2%** reduction to the required increase	**Not recommended by WTW** Any increases to ER copay (currently $200) would exceed the max copay per inpatient stay ($200) **Subcommittee feedback:** Limited support / Not recommended
Site-of-care steerage: Hospital outpatient surgery copay changes	Increase hospital outpatient surgery copay to encourage use of alternate sites of care Modeled incremental increases of $25 - $75	Varies by year; in FY22, about 30% of top 10 types of outpatient surgeries (2,300 total) were conducted at an outpatient hospital *Non-Medicare plans only*	Cost avoidance to GHIP of: **($52K)** to **($156K)** based on range of copay options modeled	**0.0% - 0.1%** reduction to the required increase	**Recommended by WTW** These copays have not been increased in multiple years despite increases to other site-of-care copays. Outpatient facility was the most expensive medical service category in both FY21 and FY22. **Subcommittee feedback:** Support was split in favor vs. opposition
Site-of-care steerage: High-tech imaging copay changes	Increase high-tech imaging copay to encourage use of alternate sites of care Modeled incremental increases of $5 - $25	Varies by year; in FY22, about 54% of 13,500 high-tech imaging services were conducted at non-preferred sites of care *Non-Medicare plans only*	Cost avoidance to GHIP of: **($37K)** to **($183K)** based on range of copay options modeled	**0.0% - 0.1%** reduction to the required increase	**Recommended by WTW** Opportunity to continue managing future use of non-preferred sites of care for these high cost procedures. **Subcommittee feedback:** Strong support for this change

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FY24 opportunities for consideration

Site-of-care steerage (continued)

- Subcommittee members were generally in support of continuing to steer members to preferred sites of care, though differing opinions on how to achieve this (i.e., through plan design vs. communications)
- Discussed the following additional considerations:
  - ***ER copays:*** Instead of considering additional increases to ER copays, consider requiring the medical carriers to assist in supporting a focused ER utilization and education campaign that includes a target reduction over FY22 by the end of FY24
  - ***Either in addition to or in lieu of any copay changes for FY24:*** Consider negotiating actual utilization performance guarantees with Highmark/Aetna as part of the GHIP's care management programs for FY24

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FY24 opportunities for consideration

FY24 Opportunity	Description	Estimated # Members or Services Impacted*	Est. FY24 Net $ Impact + Cost / (Savings)	Impact to required FY24 premium increase of 16.6%	Comments
Other opportunities reviewed with the Subcommittees					
Rx copay changes	WTW modeled impact of increasing Rx copays by following increments: *Up to 30-day supply*: Generic: +$2 Formulary: +$4 Non-Formulary: +$10 *Up to 90-day supply:* Generic: +$4 Formulary: +$8 Non-Formulary: +$20 *Specialty:* +$100 ($0 if PrudentRx adopted and member doesn't opt out)	Approximately 102,000 members enrolled in non-Medicare plans (as of 12/2022) *Non-Medicare plans only*	Cost avoidance to GHIP of: **($565K)** total **($530K)** if PrudentRx is also implemented	**0.2%** reduction to the required increase (same impact if PrudentRx is also implemented)	**Recommended by WTW** Rx copays have not been increased in multiple years and have not kept pace with Rx unit cost trends. **Subcommittee feedback:** Support was split in favor vs. opposition
Regulatory changes – no vote required by the SEBC					
Expiration of COVID-19 national and public health emergency (PHE) periods	Expiration of the COVID-19 national and PHE periods will end federal funding of COVID-19 vaccine ingredient costs and oral antivirals. Will also end GHIP benefit enhancements (extended EAP eligibility, waived member cost share for COVID-19 testing/treatment, waived telehealth cost share) *Non-Medicare plans only*		**+$2.4M** to **+$8.3M** for COVID-19 vaccine and oral antiviral costs **($1.4M)** for ending benefit enhancements	Expiration of PHE already included in 16.6% premium increase for FY24 deficit **0.2%** reduction to the required increase for ending benefit enhancements	Biden Administration has announced that the COVID-19 national and PHE periods will end on May 11, 2023.

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Appendix

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Role of the Delaware Code in the ongoing management of the GHIP

Following chart provides examples of potential tactics to address GHIP plan management and possible requirements for legislative changes in order to implement such tactics (not an exhaustive list of potential tactics or requirements of Delaware Code)

Potential tactic to address GHIP plan management	Illustrative example(s)	Requires legislative change?
Traditional plan design changes	Increase deductible by $100	No
Non-traditional plan design changes	1. Implement reference-based pricing 2. Add a third coverage tier for a narrow network	No
Adding a new medical plan	Adding CDHP/HSA or adding a PPO option that has a narrow network	Possibly*
Removing a plan option specified by the Delaware Code	Removing the First State Basic plan	Yes**
Freezing enrollment in a medical plan	1. Freeze to new entrants (i.e., from qualifying events) 2. Freeze to new hires	Yes
Adding a vendor	Wellness vendor or engagement vendor	No*
Adjustments in employee cost share	Increasing the payroll contribution for an employee from 12% to 15%	Yes
Adjustments in dependent cost share	Increasing the dependent cost sharing by 10%	Yes
Addition of surcharges	1. Add a tobacco and/or spousal surcharge 2. Wellness “dis-incentive” for non-participation	Possibly
Addition of an incentive program or a percentage of savings achieved by using a COE	1. Paying an employee $100 to get their biometric screening from their PCP 2. Paying an employee $100 for using a COE	No
Modify and/or implement a more aggressive medical or Rx utilization management program	1. Implement high-cost radiology management program 2. Discontinue coverage of certain high-cost specialty drugs and/or compound drugs	No

*Procurement would be involved in reviewing any amendments to vendor contracts for the new plan(s). Additionally, cost share would have to fit within one of the existing plans to avoid legislative change. Any plans to implement a narrower network within an existing medical plan may require legislative change.
**May require legal input regarding Delaware Code.

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PrudentRx

- Program has been previously discussed with the SEBC and Subcommittees at several recent meetings; further details can be found in the following meeting materials
  - SEBC: January 23, 2023
  - Subcommittees: October 20, November 17 and December 15, 2022

- CVS will present an overview of the member experience at today's meeting, and will also address SEBC questions from the January 2023 meeting

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Weight loss medications

Overview

- Trends in obesity prevalence among U.S. adults and youth continue to rise
  - 42% of U.S. adults reported undesired weight gain since the start of the pandemic, with an average of 29 pounds[1]
  - Over 30% of adults in the U.S. have obesity[2]
- Until recently, medical therapy for obesity has been far less successful than surgery
- A relatively new class of drugs, initially marketed for diabetes, is associated with weight loss that rivals bariatric surgery, although this weight is regained if the drugs are stopped; includes:
  - Liraglutide (approved in 2010 as Victoza for diabetes and in 2015 as Saxenda for weight loss)
  - Semaglutide (approved in 2017 as Ozempic and in 2019 Rybelsus for diabetes, and approved in 2021 as Wegovy for weight loss)
  - Tirzepatide (Mounjaro) was approved earlier this year and is on the market for type-2 diabetes and is likely expected to be approved for obesity by April 2023
- This class of drugs are very expensive, with some drugs carrying an average wholesale price of $15,000 annually (after rebates, range is $8,000 - $9,000 per year)

Sources: [1]https://www.apa.org/monitor/2021/07/extra-weight-covid, [2]https://www.cdc.gov/obesity/data/obesity-and-covid-19.html,

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Weight loss medications

GHIP member inquiries

- Over the past 12-18 months, SBO has received numerous requests from plan participants and other stakeholders to add coverage of weight loss medications to the State Group Health Plan

- Between 7/1/2021 and 2/14/2023, SBO received 20 calls into its customer service number that may have been about weight loss medications:
  - 7 general questions about weight loss medications
  - 5 questions about a specific weight loss medication
  - 8 general questions about categories of drugs that may be excluded from coverage entirely (“plan level exclusions”); specific medications were not indicated in discussion with these members, so those inquires may or may not have been about weight loss medications

- In addition and in the last 6 months, there have been 6 emails into the SEBC mailbox:
  - 4 from members requesting coverage for weight loss medications
  - 1 from a member wanting to understand how coverage can be added
  - 1 from a members who shared information on obesity

Sources: [1]https://www.apa.org/monitor/2021/07/extra-weight-covid, [2]https://www.cdc.gov/obesity/data/obesity-and-covid-19.html,

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Weight loss medications

Other state/government entity experience and estimated savings

- According to CVS, 59% of their employer client book of business covers weight loss medications
  - State and other government entities only: about 70% cover this drug class
  - Majority of those with coverage also have utilization management (i.e., prior authorization) in place

- Long term experience with this class of drugs is very limited
  - Savings specific to states and other government employers with this coverage is not available
  - FDA approval for weight loss indication is too new (initially for Saxenda in 2015) to produce results

- Several longer-term studies support the benefits of weight loss medications in concept; however, these are studies that modeled the impact of weight loss on the health care cost of a population and do not reflect actual experience with savings from weight loss that is directly attributed to these medications
  - *J Med Econ*: Modeled expanded Medicare coverage of anti-obesity interventions; estimated savings of $6,842 to $7,155 per Medicare beneficiary over 10-year period[1]
  - *Health Econ Rev*: Modeled estimated impact of 10% to 15% weight loss in Medicare participants on Medicare spending; estimated gross savings per capita of $8,287 to $9,826, even when accounting for a weight rebound among most patients[2]

1 Chen F, Su W, Ramasamy A, et al. Ten-year Medicare budget impact of increased coverage for anti-obesity intervention. J Med Econ. 2019;22(10):1096-1104. https://pubmed.ncbi.nlm.nih.gov/31378108/
2 Thorpe KE, Yang Z, Long KM, Garvey WT. The impact of weight loss among seniors on Medicare spending. Health Econ Rev. 2013;3(1):7. https://pubmed.ncbi.nlm.nih.gov/23514437/

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Weight loss medications

Impact on Delaware's Health Care Spending Benchmark

- A Subcommittee member questioned whether there is any information captured in the data reported for Delaware's Health Care Spending Benchmark that could support the rationale for the SEBC to consider adding coverage for weight loss medications
- As part of the Delaware Health Care Commission's benchmark initiative, data is collected on 6 quality measures, one of which is adult obesity (source: CDC Behavioral Risk Factor Surveillance System)
- Recent results[1] indicate that the adult obesity rate for Delaware's statewide population is not meeting the benchmark and is actually getting worse

	CY 2019	CY 2020
Delaware Health Care Spending Benchmark	30.0%	29.4%
Delaware Actual Results[1]	34.4%	36.5%

- Next Health Care Spending Benchmark report (for CY 2021) will be released in early April 2023

1 Data provided by the Delaware Health Care Commission.

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Weight loss medications

Estimated GHIP cost for adding coverage

- CVS-estimated annual gross cost (before member cost sharing) to the GHIP for adding coverage of weight loss medications:
  - With no utilization management: $2,873,600
  - With utilization management: $1,778,800 (recommended if coverage is added)

- Cost estimates are based on CVS employer book of business utilization experience from April – June 2022
- Estimates do not account for any additional rebate value that may be earned on these medications

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Site-of-care steerage

Current copay differentials and member communications/educational materials

Highlights copay change

- The GHIP PPO and HMO plans include variable copays for the same type of service depending on where the service is provided ("site of care" or "site of service")
- Chart reflects current site of care copay differentials, which have been in place since July 1, 2019
  - Exception: telemedicine copay was lowered to $0 in March 2020
- For the past several years, the SBO, Highmark and Aetna have implemented multiple communications (i.e., emails, letters, flyers, postcards, posters, and online training courses) to educate members[1] throughout each fiscal year about selecting the most appropriate site of care for members' individual needs
  - See October 2022 Subcommittee meeting materials for more details

Copays by type of service	HMO & PPO plans (effective since July 1, 2019)
Basic Imaging (X-rays, ultrasounds) ▪ In-network non-hospital affiliated freestanding facility (preferred) ▪ Hospital-based facility	 ▪ $0 copay ▪ $50 copay *(+$15 from FY19)*
High Tech Imaging (MRI, CT, PET scan) ▪ In-network non-hospital affiliated freestanding facility (preferred) ▪ Hospital-based facility	 ▪ $0 copay ▪ $75 copay *(+$25 from FY19)*
Outpatient Lab ▪ In-network non-hospital affiliated preferred lab ▪ Other lab	 ▪ $10 copay ▪ $50 copay *(+$30 from FY19)*
Emergency / Urgent Care ▪ Urgent Care ▪ Emergency Room	 ▪ $15 HMO / $20 PPO ▪ $200 copay *(+$50 from FY19)*
Outpatient Surgeries (through medical carrier network provider) ▪ Ambulatory Surgery Center ▪ Hospital	 ▪ $50 copay ▪ $100 copay
In-network telemedicine provider through third-party vendors	▪ $0 copay[2] *(-$15 HMO / -$20 PPO from FY19)*

1 Includes employees, non-Medicare eligible pensioners and their covered dependents.
2 Effective March 2020, $0 copay temporarily applied to CDH Gold and First State Basic plans and virtual telemedicine services provided by a primary care or other physician.

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Site-of-care steerage

Current GHIP plan designs vs. benchmarks: Comprehensive PPO and HMO

	Comprehensive PPO	PPO Benchmark[1]	HMO	HMO Benchmark[1]
Medical				
Deductible (Single/Family)	$0/$0	$625/$1,500	$0/$0	$750/$1,600
Office Visit - PCP	$20	$25	$15	$25
Office Visit - SPC	$30	$40	$25	$35
Hospital outpatient surgery (non-preferred site of care)	$100	$150	$100	$150
High-tech imaging (non-preferred site of care)	$75	$300	$75	$300
Emergency Room	$200	$150	$200	$125
Inpatient Admission	$100/day, max $200	$275	$100/day, max $200	$275
Out-Of-Pocket Max (Single/Family)	$4500/$9000	$3250/$6500	$4500/$9000	$3500/$7500

Observations

- Except for emergency room copays and out-of-pocket maximums, most other GHIP PPO and HMO plan provisions are less than benchmark
- GHIP ER utilization for non-emergent/primary care treatable conditions was consistently about 6% of total visits during FY20-FY22
- Hospital outpatient surgery copays have not been increased in multiple years. Outpatient facility was the most expensive medical service category in both FY21 and FY22[2]
- Member access to ambulatory surgery centers (ASC) throughout Delaware is comparable to inpatient hospital access, with at least 1 ASC in each Delaware county
- From FY20 to FY22, there was a modest reduction in use of non-preferred site of care relative to overall use of outpatient high-tech imaging services

1 Calculated from 2022 WTW Financial Benchmarks Survey, Government/Public Sector/Education industry cut.
2 Source: Merative Incurred Claims Reporting through FY22 Q4.

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Highlights copay change

Summary of site-of-care steerage copay changes and next steps

Copays by type of service	HMO & PPO plans (effective since July 1, 2019)	WTW-modeled copay changes	Potential range of cost avoidance (annual, first year following change)[1]
Emergency / Urgent Care ▪ Urgent Care ▪ Emergency Room	▪ $15 HMO / $20 PPO ▪ $200 copay *(+$50 from FY19)*	▪ $15 HMO / $20 PPO ▪ $225 - $275 copay (not recommended – see below)	$264,000 to $792,000
Outpatient Surgeries (through medical carrier network provider) ▪ Ambulatory Surgery Center ▪ Hospital	▪ $50 copay ▪ $100 copay	▪ $50 copay ▪ $150 - $250 copay (*)	$52,000 to $156,000[2]
High Tech Imaging (MRI, CT, PET scan) ▪ In-network non-hospital affiliated freestanding facility (preferred) ▪ Hospital-based facility	▪ $0 copay ▪ $75 copay *(+$25 from FY19)*	▪ $0 copay ▪ $100 - $150 copay (*)	$37,000 to $183,000

Total cost avoidance (annual, first year following changes): $0.4M - $1.1M

(*) WTW-recommended changes only: $0.1M - $0.3M

- Without additional communications to plan participants, level of cost avoidance may diminish in the subsequent years based on similar pattern observed previously among GHIP participants
- ***ER copays:*** Instead of considering additional increases to ER copays, consider requiring the medical carriers to assist in supporting a focused ER utilization and education campaign that includes a target reduction over FY22 by the end of FY24
- ***Either in addition to or in lieu of any copay changes for FY24:*** Consider negotiating actual utilization performance guarantees with Highmark/Aetna as part of the GHIP's care management programs for FY24

1 Assumes future utilization is consistent with FY22 experience. See February 13, 2023 HP&P Subcommittee meeting materials for further details on assumptions built into estimated cost avoidance.
2 Does not reflect any change in utilization to a preferred site of care, but would expect some utilization to shift to ambulatory surgery centers.

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Prescription copay options

Rx cost and utilization trends continue to increase for the GHIP and other plans nationwide

GHIP Experience

Non-Medicare plans only

Prescription Drug Detail[1]

Previous Period: Sep 2020 - Aug 2021 (Incurred)
Current Period: Sep 2021 - Aug 2022 (Incurred)
Paid Through: Nov 2022

Annual Trend

	Previous	Current	% Change
Total			
Allowed Amt PMPY Rx	$1,841	$1,991	8.1%
Net Pay PMPY Rx	$1,727	$1,805	4.5%
Out of Pocket PMPY Rx	$99	$104	4.5%
Pats Per 1000 Rx	751.9	780.7	3.8%
Allowed Amt Per Day Supply Rx	$4.04	$4.15	2.8%
Days Supply PMPY Rx	456.0	479.5	5.1%

Specialty drugs comprised **42.4%** of FY22 total pharmacy cost (before rebates) but were only **1.3%** of all prescriptions filled[1]

Generic drugs comprised **14.9%** of FY22 total pharmacy cost (before rebates)[1]

Specialty Drug Detail	Allowed Amount Med and Rx			Patients Med or Rx			Allowed Amount Per Pat		
	Previous	Current	% Change	Previous	Current	% Change	Previous	Current	% Change
Medical Specialty	$58,415,744	$59,392,318	1.7%	3,687	3,620	-1.8%	$15,844	$16,407	3.6%
Pharmacy Specialty	$93,195,958	$109,658,151	17.7%	5,474	6,566	19.9%	$17,025	$16,701	-1.9%

National Trends

94% of employers indicate **managing healthcare costs** is a key priority over the next two years[3]

1% to 2% of Rx's are for specialty drugs, yet account for **over 50%** of pharmacy spending

Specialty spend could reach **$373 billion** by **2025**[4]

1 Source: CVS Health Annual Review, FY22.
2 Source: Merative Key Trends Report.
3 WTW 2022 Emerging Trends Survey.
4 CVS Health 2022 Marketplace Outlook
https://payorsolutions.cvshealth.com/updates/consultant-briefing-december-2021 . Accessed 2.7.2023.

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Prescription copay options

- GHIP prescription drug copays have not been updated since at least 2016
- WTW modeled the cost impact of increasing prescription drug copays for the four non-Medicare medical plans using an alternative design based on the Governmental Benchmark from WTW 2022 Financial Benchmark Survey
- Estimated GHIP savings does not factor in the potential addition of PrudentRx
  - If PrudentRx is adopted, estimated savings would be about $35K less (total: $0.5M)

Rx Plan Design	Current	Alternative
Up to 30-day supply		
Generic	$8	$10
Formulary	$28	$32
Non-Formulary	$50	$60
Up to 90-day supply		
Generic	$16	$20
Formulary	$56	$64
Non-Formulary	$100	$120
Specialty	n/a	$100
Estimated savings to GHIP		**$0.6M**

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