The State of Delaware

FY24 Planning Considerations

SEBC Meeting

March 6, 2023

Disclaimer

Willis Towers Watson has prepared this information solely in our capacity as consultants under the terms of our engagement with you with knowledge and experience in the industry and not as legal advice. This information is exclusively for the State of Delaware's State Employee Benefits Committee to use in the management, oversight and administration of your state employee group health program. It may not be suitable for use in any other context or for any other purpose and we accept no responsibility for any such use.

Willis Towers Watson is not a law firm and therefore cannot provide legal or tax advice. This document was prepared for information purposes only and it should not be considered a substitute for specific professional advice. As such, we recommend that you discuss this document with your legal counsel and other relevant professional advisers before adopting or implementing its contents. This document is based on information available to Willis Towers Watson as of the date of delivery and does not account for subsequent developments after that date.

Willis Towers Watson shares available medical and pharmacy research and the views of our health management practitioners in our capacity as a benefits consultant. We do not practice medicine or provide medical, drug, or legal advice, and encourage our clients to consult with both their legal counsel and qualified health advisors as they consider implementing various health improvement and wellness initiatives.

This material was not prepared for use by any other party and may not address their needs, concerns or objectives. This document may not be reproduced, disclosed or distributed to any other party, whether in whole or in part, other than as agreed with you in writing, except as may be required by law.

We do not assume any responsibility, or accept any duty of care or liability to any other party who may obtain a copy of this material and any reliance placed by such party on it is entirely at their own risk.

Contents

- FY24 planning considerations
  - Flexible Spending Account Plan – Participant Fund Forfeitures
  - Weight loss medication coverage
  - Program and copay options to promote preferred sites of care
  - Prescription copay options
  - COVID-19 national and public health emergency period expirations
  - July 1, 2023 non-Medicare health plan premium rate scenarios

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 $140.5M FY24 deficit
  - This includes savings from adoption of the CVS PrudentRx program for the non-Medicare population effective 7/1/2023
- 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 $140.5m
  - 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

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.

Flexible spending account plan – participant fund forfeitures

- **Question from February 20, 2023 SEBC Discussion:** How much variance is there between the estimated FY24 enrollment and the forfeiture funds available for distribution?

- **SBO Response:** The FY23 year-to-date actual Flexible Spending Account (FSA) enrollment is 6,700. Using this as a baseline and setting the one-time plan contribution at $125, a 35% enrollment increase would fully deplete the $1.1M in available forfeiture funds.

- **SBO Recommendation for Approval**:

  Provide a one-time Flexible Spending Account plan year contribution of $125 for each FY24 FSA participant. Employees enrolling in the FSA plan during open enrollment and through the first quarter of FY24 would receive the full $125. New enrollments after September 30, 2023 would be prorated accordingly.

  Increase the FY24 plan year employee minimum for health care and dependent care FSA plan year elections to $125.

Weight loss medication coverage

FY24 Opportunity	Description	Estimated # Members or Services Impacted*	Est. FY24 Net $ Impact + Cost / (Savings)	Impact to required FY24 premium increase of 16.8%	Comments
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**	**+0.3% - 0.5% 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

- Several questions regarding this coverage were raised at the February 20 SEBC meeting that will be addressed today:
  - Further information about the utilization management criteria under CVS
  - Details from other East Coast states that have recently implemented this coverage for state employee health plans
  - Any additional studies that demonstrate savings associated with these types of medications

Weight loss medication coverage (continued)

Utilization management criteria under CVS

- Per CVS, the prior authorization requirements align with the FDA label for each medication and current clinical guidelines for standard of care and evidence-based clinical literature for weight loss
  - For a member newly utilizing weigh loss medications, this includes certain requirements:
    - A diagnosis of obesity or overweight with at least one weight related comorbid condition (e.g., hypertension, type 2 diabetes mellitus or dyslipidemia),
    - Previous participation in a comprehensive weight management program, and
    - Continued use with a reduced calorie diet and exercise
  - For select medications, the criteria varies for pediatric patients 12 years of age and older
- Typically for a member already utilizing weight loss medications, the requirements include the patient achieving or maintaining a positive clinical response; documentation is required for ongoing approval

Weight loss medication coverage (continued)

East Coast states and other public employee health plans that offer coverage

- State employee plans that offer coverage of weight loss medications (based on publicly available benefit information): New York, New Jersey, Massachusetts, Rhode Island, Virginia, North Carolina, Georgia
- Florida offers a pilot weight management program that includes coverage of FDA-approved weight management medications; pilot program has an application process with ongoing requirements of participants (capped at 2,500 members)
- BCBS Federal Employee benefit program includes coverage of weight loss medications effective 1/1/2023

See Appendix for links to publicly available source documents.

Weight loss medication coverage (continued)

Additional studies that demonstrate savings associated with these medications

Several published studies that received funding from Novo Nordisk:

1. Study of the impact of obesity on both direct and indirect costs (such as disability, workers compensation and absenteeism) on over 19.1 million covered lives from a US employer claims database with data from 2010-2017 determined the following average annual savings associated with moving an individual from:
   - Obesity Class III (BMI $\geq$40 kg/m^2) to Class II (BMI between 35.0 and 39.9 kg/m^2): $10,266
   - Class II to Class I (BMI between 30.0 and 34.9 kg/m^2) = $3,714
   - Class I to Normal Weight (BMI < 30.0 kg/m^2) = $3,216
   - Class III to Normal Weight = $17,196

   Study limitations cited by authors included potential overestimate of obesity severity in study group and underestimate in control group

(1) Ramasamy, Abhilasha MSc, MS; Laliberté, François MA; Aktavoukian, Shoghag A. PharmD, RPh; Lejeune, Dominique MSc; DerSarkissian, Maral PhD; Cavanaugh, Cristi MHS; Smolarz, B. Gabriel MD, MS; Ganguly, Rahul PhD; Duh, Mei Sheng MPH, ScD. Direct and Indirect Cost of Obesity Among the Privately Insured in the United States: A Focus on the Impact by Type of Industry. Journal of Occupational and Environmental Medicine 61(11):p 877-886, November 2019. https://journals.lww.com/joem/fulltext/2019/11000/direct_and_indirect_cost_of_obesity_among_the.3.aspx

Weight loss medication coverage (continued)

Additional studies that demonstrate savings associated with these medications

Several published studies that received funding from Novo Nordisk:

2. Retrospective cohort study among US adults with obesity using commercial insurance claims data and medical records reported nonsurgical weight loss (lifestyle interventions and weight management medications) resulting in cost savings 1 and 2 years later
   - Average savings (total cost of care): up to $157.41 ($P < 0.05$) to $185.41 (not statistically significant) per member per month among cohorts that lost weight by certain percentage of total body weight (>5% to ≤10% and >10% to ≤20%, respectively)
   - Study excluded adults with weight fluctuations (i.e., weight gain after initial loss, or vice versa)
   - Study limitations cited by the authors include:
     - Study population focused on individuals seeking care at tier 1 medical facilities (centers of excellence offering comprehensive, holistic care); results may not be generalizable to patients who seek majority of care from ambulatory and primary care settings
     - Selection bias in the data: patients with comorbidities are more likely to interact with health care system, therefore have more data and health outcomes (BMI) compared to patients with no comorbidities and/or less severe obesity diagnosis
     - Weight loss associated with specific nonsurgical weight loss treatments (such as the isolated impact of lifestyle interventions vs. weight loss medications) was not assessed due to limitations in dataset (i.e., lifestyle interventions often not captured in electronic medical records)

(2) Yuchen Ding, Xiaozhou Fan, Christopher M Blanchette, B Gabriel Smolarz, Wayne Weng, and Abhilasha Ramasamy. Economic value of nonsurgical weight loss in adults with obesity. J Manag Care Spec Pharm. 2021;27(1):37-50. https://www.jmcp.org/doi/full/10.18553/jmcp.2020.20036?role=tab

Weight loss medication coverage (continued)

Additional studies that demonstrate savings associated with these medications

Several published studies that received funding from Novo Nordisk:

3. Retrospective cohort study compared health care costs over two-year period for two groups of obese individuals (BMI > 30.0 mg/k^2): users of weight management medications vs. “never users” of those medications, from a large US commercial health care claims database
   - Key findings (at 2-year follow-up): ongoing users of these medications were more likely to lose weight than “never-users” and had declining costs (not including cost of these medications) as health care costs in the “never user” group continued to increase
     - Annual savings (total cost of care, excluding medication cost): $1,323 to $2,766, depending on severity of obesity
     - Annual savings (total cost of care, including medication cost): $3,836 to $5,252; however, a percentage of this decline in cost may be attributed to lower medication adherence rate in year 2
       - Average number of days of weight management medication use: 265 days in year 1 vs. 131 days in year 2
   - Study limitations cited by authors included:
     - Relatively low medication adherence rate for ongoing users of weight management medications (minimum adherence: ≥ 112 non-consecutive days/year)
     - Greater likelihood of the study capturing results for individuals with severe disease, due to known under-coding or misclassification of obesity diagnosis and unavailability of weight/BMI data to confirm such diagnosis
     - Greater likelihood for individuals with severe obesity to also experience more severe complications, and
     - Other differences between users of these medications vs. “never-users” including use of other lifestyle/dietary interventions

(3) Stephanie Watkins, Joshua C Toliver, Nina Kim, Sarah Whitmire, and W. Timothy Garvey. Economic outcomes of antiobesity medication use among adults in the United States: A retrospective cohort study. J Manag Care Spec Pharm. 2022;28(10):1066-1079. https://www.jmcp.org/doi/full/10.18553/jmcp.2022.22116?role=tab.

Program and copay options to promote preferred sites of care

FY24 Opportunity	Description	Estimated # Members or Services Impacted*	Est. FY24 Net $ Impact + Cost / (Savings)	Impact to required FY24 premium increase of 16.8%	Comments
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

Program and copay options to promote preferred sites of care

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

Prescription copay options

FY24 Opportunity	Description	Estimated # Members or Services Impacted*	Est. FY24 Net $ Impact + Cost / (Savings)	Impact to required FY24 premium increase of 16.8%	Comments
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	**0.1%** 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

COVID-19 national and public health emergency period expirations

FY24 Opportunity	Description	Estimated # Members or Services Impacted*	Est. FY24 Net $ Impact + Cost / (Savings)	Impact to required FY24 premium increase of 16.8%	Comments
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 16.8% premium increase for FY24 deficit **0.1%** 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.

- The following benefit enhancements previously implemented by the SEBC have an end date specified as extending "for no more than 30 days following the end of the COVID-19 national public health emergency," i.e., June 11, 2023
  - For ease of administration and communication to plan participants, consider extending these enhancements until at least June 30, 2023 (coinciding with the end of the FY23 plan year)
- Annual cost estimates for retaining these enhancements after the end of the public health emergency period is outlined below

Benefit Plan	Change	Optional / Legislation	Approval Date for Change	Start Date	Estimated annual cost for retaining this benefit enhancement
EAP	Coverage for all SOD employees	Optional	3/18/2020	3/19/2020	$67,200
Medical	No member cost share for office visits (PCP, urgent care, ER) that result in either order or administration of COVID-19 test or for treatment of COVID-19 or associated health complications	FFCRA[1]	3/18/2020	3/18/2020	n/a[2]
Medical	No member cost share for in-network, inpatient services related to treatment of COVID-19 or associated complications	Optional	4/2/2020	4/2/2020	$800,000[3]
Medical	No member cost share for any telehealth visits	Optional	3/20/2020	3/20/2020	$600,000[4]

1 FFCRA = Families First Coronavirus Response Act.
2 Not valued separately – cost included in medical estimate for expanding in-network inpatient treatment of COVID-19 shown above.
3 Based on estimated 2022 COVID-19 inpatient admits from Highmark/Aetna November 2022 reporting
4 Telehealth visit cost estimate based on 2022 utilization through Nov., provided by Aetna and Highmark, annualized; assumes cost sharing applies to all telehealth visits ($15 copay HMO, $20 copay PPO, 10% coinsurance CDH Gold and First State Basic); assumes average $90 allowed cost per telehealth visit for coinsurance amounts; reflects offsetting savings for reduced cost of virtual behavioral health visits relative to in-person behavioral health visits based on Merative reporting.

July 1, 2023 non-Medicare health plan premium rate scenarios

GHIP long term health care cost projections

FY23 Q2 update – Hold premium rates flat FY24+

GHIP Costs ($ millions)[1]	FY22 Actual	FY23 Projected	FY24 Projected	FY25 Projected	FY26 Projected	FY27 Projected
Average Enrolled Members	130,141	131,442	132,756	134,084	135,425	136,779
GHIP Revenues						
Premium Contributions[2]	$839.7	$906.2	$915.3	$924.4	$933.6	$942.9
Hold premium rates flat FY24+						
Other Revenues[3]	$194.7	$182.6	$215.2	$220.2	$236.7	$256.3
Total Operating Revenues	**$1,034.4**	**$1,088.8**	**$1,130.5**	**$1,144.6**	**$1,170.3**	**$1,199.2**
GHIP Expenses						
Operating Expenses[4]	$1,029.6	$1,177.4	$1,237.1	$1,302.5	$1,390.3	$1,484.5
% Change Per Member	*2.1%*	*13.2%*	*4.0%*	*4.2%*	*5.7%*	*5.7%*
Adjusted Net Income	**$4.8**	**($88.6)**	**($106.6)**	**($157.9)**	**($220.0)**	**($285.3)**
Balance Forward	$152.3	$157.2	$68.6	($38.0)	($195.9)	($415.9)
Ending Balance	$157.2	$68.6	($38.0)	($195.9)	($415.9)	($701.2)
- Less Claims Liability[5]	$61.0	*$69.8*	*$73.3*	*$77.2*	*$82.4*	*$88.0*
- Less Minimum Reserve[5]	*$24.3*	*$27.8*	*$29.2*	*$30.7*	*$32.8*	*$35.0*
GHIP Surplus (After Reserves/Deposits)	**$71.9**	**($29.0)**	**($140.5)**	**($303.8)**	**($531.1)**	**($824.2)**

- Projections reflect claims through February 2023 and all items voted on by SEBC as of February 20th, 2023 SEBC meeting and assume no additional program or legislative changes impacting GHIP spend
- Excludes potential impact of Primary Care Law (Senate Bill 120), unknown if bill will impact GHIP
- Every 1% increase in healthcare trend (medical + Rx) will increase FY24 claims by $11.3M

GHIP long term health care cost projections (FY23 Q2 update)

Premium rate increase scenarios

- Projected **$140.5** FY24 deficit driven by:
  - GHIP surplus fully depleted by end of FY23
  - Health care trend (5% medical, 8% pharmacy)
    - Economic environment (i.e., inflation) may warrant an increase to trend assumptions
  - Unfavorable claims experience in FY23 Q1 and Q2, partly driven by downstream COVID-19 impacts
- Absent any additional program changes, a **16.8% rate increase effective 7/1/2023** is required to solve for the **$140.5M projected FY24 deficit**
  - Loss of available surplus to offset premium increases by end of FY23 results in larger rate action needed to solve for FY24 deficit
  - If solving FY24 deficit with one-time rate action, future rate actions needed to solve for deficits in FY25 and beyond likely to be more closely tied to health care trend
- Smoothing the rate increase over three years to solve for FY26 deficit requires approximate 9.4% annual rate increases per year in FY24, FY25 and FY26
- ***Impact of Delaware legislative activity and upward pressures on health care trend may drive projected deficits higher absent additional program changes***

GHIP long term health care cost projections

FY23 Q2 update – 16.8% rate increase FY24

GHIP Costs ($ millions)[1]	FY22 Actual	FY23 Projected	FY24 Projected	FY25 Projected	FY26 Projected	FY27 Projected
Average Enrolled Members	130,141	131,442	132,756	134,084	135,425	136,779
GHIP Revenues						
Premium Contributions[2]	$839.7	$906.2	$915.3	$1,079.7	$1,090.4	$1,101.4
16.8% rate increase FY24			*$140.2*			
Other Revenues[3]	$194.7	$182.6	$215.2	$220.2	$236.7	$256.3
Total Operating Revenues	**$1,034.4**	**$1,088.8**	**$1,270.7**	**$1,299.9**	**$1,327.1**	**$1,357.7**
GHIP Expenses						
Operating Expenses[4]	$1,029.6	$1,177.4	$1,237.1	$1,302.5	$1,390.3	$1,484.5
% Change Per Member	*2.1%*	*13.2%*	*4.0%*	*4.2%*	*5.7%*	*5.7%*
Adjusted Net Income	**$4.8**	**($88.6)**	**$33.6**	**($2.6)**	**($63.2)**	**($126.8)**
Balance Forward	$152.3	$157.2	$68.6	$102.2	$99.6	$36.4
Ending Balance	$157.2	$68.6	$102.2	$99.6	$36.4	($90.4)
- Less Claims Liability[5]	$61.0	*$69.8*	*$73.3*	*$77.2*	*$82.4*	*$88.0*
- Less Minimum Reserve[5]	*$24.3*	*$27.8*	*$29.2*	*$30.7*	*$32.8*	*$35.0*
GHIP Surplus (After Reserves/Deposits)	**$71.9**	**($29.0)**	**($0.3)**	**($8.3)**	**($78.8)**	**($213.4)**

- Projections reflect claims through February 2023 and all items voted on by SEBC as of February 20th, 2023 SEBC meeting and assume no additional program or legislative changes impacting GHIP spend
- Excludes potential impact of Primary Care Law (Senate Bill 120), unknown if bill will impact GHIP
- Every 1% increase in healthcare trend (medical + Rx) will increase FY24 claims by $11.3M

GHIP long term health care cost projections

FY23 Q2 update – 9.4% rate increase FY24-FY26 (3-year smoothing method)

GHIP Costs ($ millions)[1]	FY22 Actual	FY23 Projected	FY24 Projected	FY25 Projected	FY26 Projected	FY27 Projected
Average Enrolled Members	130,141	131,442	132,756	134,084	135,425	136,779
GHIP Revenues						
Premium Contributions[2]	$839.7	$906.2	$915.3	$924.4	$933.6	$1,234.6
9.4% rate increase FY24-FY26			*$78.4*	*$173.6*	*$279.5*	
Other Revenues[3]	$194.7	$182.6	$215.2	$220.2	$236.7	$256.3
Total Operating Revenues	**$1,034.4**	**$1,088.8**	**$1,208.9**	**$1,318.2**	**$1,449.8**	**$1,490.9**
GHIP Expenses						
Operating Expenses[4]	$1,029.6	$1,177.4	$1,237.1	$1,302.5	$1,390.3	$1,484.5
% Change Per Member	*2.1%*	*13.2%*	*4.0%*	*4.2%*	*5.7%*	*5.7%*
Adjusted Net Income	**$4.8**	**($88.6)**	**($28.2)**	**$15.7**	**$59.5**	**$6.4**
Balance Forward	$152.3	$157.2	$68.6	$40.4	$56.1	$115.6
Ending Balance	$157.2	$68.6	$40.4	$56.1	$115.6	$122.0
- Less Claims Liability[5]	$61.0	*$69.8*	*$73.3*	*$77.2*	*$82.4*	*$88.0*
- Less Minimum Reserve[5]	*$24.3*	*$27.8*	*$29.2*	*$30.7*	*$32.8*	*$35.0*
GHIP Surplus (After Reserves/Deposits)	**$71.9**	**($29.0)**	**($62.1)**	**($51.8)**	**$0.4**	**($1.0)**

- Projections reflect claims through February 2023 and all items voted on by SEBC as of February 20th, 2023 SEBC meeting and assume no additional program or legislative changes impacting GHIP spend
- Excludes potential impact of Primary Care Law (Senate Bill 120), unknown if bill will impact GHIP
- Every 1% increase in healthcare trend (medical + Rx) will increase FY24 claims by $11.3M

FY24 monthly rates and employee/retiree contributions

Illustrative: 16.8% increase effective 7/1/2023

- FY24 reflects employee contribution increases of $5.09 - $49.82 per employee per month ($61.08 - $597.84 per year) and State subsidy increases of $121.87 - $328.79 per employee per month ($1,462.44 - $3,945.48 per year) effective 7/1/2023

	FY 2023			FY 2024 with Increase			$ 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	$755.64	$30.22	$725.42	$882.60	$35.31	$847.29	$5.09	$61.08	$121.87	$1,462.44
Employee + Spouse	$1,563.42	$62.54	$1,500.88	$1,826.08	$73.06	$1,753.02	$10.52	$126.24	$252.14	$3,025.68
Employee + Child	$1,148.66	$45.94	$1,102.72	$1,341.64	$53.66	$1,287.98	$7.72	$92.64	$185.26	$2,223.12
Family	$1,954.34	$78.18	$1,876.16	$2,282.68	$91.32	$2,191.36	$13.14	$157.68	$315.20	$3,782.40
CDH Gold										
Employee	$782.08	$39.10	$742.98	$913.48	$45.68	$867.80	$6.58	$78.96	$124.82	$1,497.84
Employee + Spouse	$1,621.60	$81.08	$1,540.52	$1,894.04	$94.71	$1,799.33	$13.63	$163.56	$258.81	$3,105.72
Employee + Child	$1,194.90	$59.74	$1,135.16	$1,395.64	$69.78	$1,325.86	$10.04	$120.48	$190.70	$2,288.40
Family	$2,060.10	$103.00	$1,957.10	$2,406.20	$120.31	$2,285.89	$17.31	$207.72	$328.79	$3,945.48
Aetna HMO										
Employee	$788.88	$51.28	$737.60	$921.42	$59.91	$861.51	$8.63	$103.56	$123.91	$1,486.92
Employee + Spouse	$1,663.28	$108.12	$1,555.16	$1,942.72	$126.28	$1,816.44	$18.16	$217.92	$261.28	$3,135.36
Employee + Child	$1,206.80	$78.44	$1,128.36	$1,409.54	$91.62	$1,317.92	$13.18	$158.16	$189.56	$2,274.72
Family	$2,075.40	$134.90	$1,940.50	$2,424.08	$157.56	$2,266.52	$22.66	$271.92	$326.02	$3,912.24
Comprehensive PPO										
Employee	$862.68	$114.30	$748.38	$1,007.62	$133.51	$874.11	$19.21	$230.52	$125.73	$1,508.76
Employee + Spouse	$1,790.16	$237.20	$1,552.96	$2,090.92	$277.06	$1,813.86	$39.86	$478.32	$260.90	$3,130.80
Employee + Child	$1,329.54	$176.16	$1,153.38	$1,552.91	$205.76	$1,347.15	$29.60	$355.20	$193.77	$2,325.24
Family	$2,237.94	$296.52	$1,941.42	$2,613.92	$346.34	$2,267.58	$49.82	$597.84	$326.16	$3,913.92

FY24 monthly rates and employee/retiree contributions

Illustrative: 9.4% increase effective 7/1/2023

- FY24 reflects employee contribution increases of $2.84 - $27.88 per employee per month ($34.08 - $334.56 per year) and State subsidy increases of $68.20 - $183.98 per employee per month ($818.40 - $2,207.76 per year) effective 7/1/2023

	FY 2023			FY 2024 with Increase			$ 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	$755.64	$30.22	$725.42	$826.68	$33.06	$793.62	$2.84	$34.08	$68.20	$818.40
Employee + Spouse	$1,563.42	$62.54	$1,500.88	$1,710.38	$68.42	$1,641.96	$5.88	$70.56	$141.08	$1,692.96
Employee + Child	$1,148.66	$45.94	$1,102.72	$1,256.64	$50.26	$1,206.38	$4.32	$51.84	$103.66	$1,243.92
Family	$1,954.34	$78.18	$1,876.16	$2,138.06	$85.54	$2,052.52	$7.36	$88.32	$176.36	$2,116.32
CDH Gold										
Employee	$782.08	$39.10	$742.98	$855.60	$42.78	$812.82	$3.68	$44.16	$69.84	$838.08
Employee + Spouse	$1,621.60	$81.08	$1,540.52	$1,774.04	$88.71	$1,685.33	$7.63	$91.56	$144.81	$1,737.72
Employee + Child	$1,194.90	$59.74	$1,135.16	$1,307.22	$65.36	$1,241.86	$5.62	$67.44	$106.70	$1,280.40
Family	$2,060.10	$103.00	$1,957.10	$2,253.76	$112.68	$2,141.08	$9.68	$116.16	$183.98	$2,207.76
Aetna HMO										
Employee	$788.88	$51.28	$737.60	$863.04	$56.11	$806.93	$4.83	$57.96	$69.33	$831.96
Employee + Spouse	$1,663.28	$108.12	$1,555.16	$1,819.64	$118.28	$1,701.36	$10.16	$121.92	$146.20	$1,754.40
Employee + Child	$1,206.80	$78.44	$1,128.36	$1,320.24	$85.82	$1,234.42	$7.38	$88.56	$106.06	$1,272.72
Family	$2,075.40	$134.90	$1,940.50	$2,270.50	$147.58	$2,122.92	$12.68	$152.16	$182.42	$2,189.04
Comprehensive PPO										
Employee	$862.68	$114.30	$748.38	$943.78	$125.04	$818.74	$10.74	$128.88	$70.36	$844.32
Employee + Spouse	$1,790.16	$237.20	$1,552.96	$1,958.44	$259.51	$1,698.93	$22.31	$267.72	$145.97	$1,751.64
Employee + Child	$1,329.54	$176.16	$1,153.38	$1,454.52	$192.72	$1,261.80	$16.56	$198.72	$108.42	$1,301.04
Family	$2,237.94	$296.52	$1,941.42	$2,448.32	$324.40	$2,123.92	$27.88	$334.56	$182.50	$2,190.00

Appendix

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.

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,

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,

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/

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.

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

Weight loss medication coverage

East Coast states and other public employee health plans that offer coverage

Public Entity	Source: Weight loss drug coverage
New York	(1) https://www.cs.ny.gov/employee-benefits/nyship/shared/drug-lists/2023/empire-plan-advanced-flexible-formulary-preferred-jan-2023.pdf (2) https://www.cs.ny.gov/employee-benefits/nyship/shared/drug-lists/2023/empire-plan-advanced-flexible-formulary-comprehensive-jan-2023.pdf
New Jersey	https://www.optumrx.com/oe_sonjactiveleee/prescription-drug-list
Massachusetts	https://www.express-scripts.com/art/open_enrollment/GICRXPLN18615_NPFList.pdf
Rhode Island	https://employeebenefits.ri.gov/sites/g/files/xkgbur816/files/2022-10/01-2023%20PDL%20SC%20ACSF.pdf
Virginia	https://www.anthem.com/cova/
North Carolina	(1) https://www.shpnc.org/media/2668/open (2) https://www.shpnc.org/media/2669/open
Georgia	https://www.caremark.com/portal/asset/SHBP_PDL.pdf
Florida	https://www.mybenefits.myflorida.com/health/weight_management_pilot_program
Federal Government	(1) https://www.caremark.com/portal/asset/FEP_Blue_Focus_Formulary.pdf (2) https://www.caremark.com/portal/asset/z6500_drug_list807.pdf (3) https://www.caremark.com/portal/asset/z6500_drug_list.pdf

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)	▪ $0 copay
▪ Hospital-based facility	▪ $50 copay *(+$15 from FY19)*
High Tech Imaging (MRI, CT, PET scan)	
▪ In-network non-hospital affiliated freestanding facility (preferred)	▪ $0 copay
▪ Hospital-based facility	▪ $75 copay *(+$25 from FY19)*
Outpatient Lab	
▪ In-network non-hospital affiliated preferred lab	▪ $10 copay
▪ Other lab	▪ $50 copay *(+$30 from FY19)*
Emergency / Urgent Care	
▪ Urgent Care	▪ $15 HMO / $20 PPO
▪ Emergency Room	▪ $200 copay *(+$50 from FY19)*
Outpatient Surgeries (through medical carrier network provider)	
▪ Ambulatory Surgery Center	▪ $50 copay
▪ Hospital	▪ $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.

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.

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.

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.

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**

COVID-19 benefit enhancements under the GHIP

Incremental cost of COVID-19 vaccines and oral antivirals once PHE ends

- At the end of the PHE (May 11, 2023), federal government funding for the ingredient cost of COVID-19 vaccines and COVID-19 oral antivirals will end
  - Will result in increased cost to the GHIP to maintain current coverage of these products
  - Additionally, the end of the PHE marks the end of the requirement for group health plans to cover over-the-counter (OTC) COVID-19 test kits that can be self-administered and self-read without the involvement of a health care provider

- Initial estimated range of annual incremental cost to the GHIP: $2.4 million - $8.3 million
  - Ingredient cost of COVID-19 vaccine estimated at $110-130/shot (Pfizer's estimated[1] range of commercial cost per dose)
  - Ingredient cost of COVID-19 oral antivirals estimated at $530/course of treatment (federal government's negotiated rate[2] for Paxlovid; future cost under commercial insurance is expected to be higher)
  - Future GHIP utilization estimated based on national average bivalent booster rates reported by the CDC[3] and annualized GHIP utilization rate of oral antivirals during CY2022
  - Assumes GHIP coverage of OTC test kits will cease when PHE ends (estimated annual spend for CY2022: $800,000, factored into the above range as an offset to the increased cost of COVID-19 vaccines and oral antivirals)

1 https://www.reuters.com/business/healthcare-pharmaceuticals/pfizer-expects-price-covid-vaccine-110-130-per-dose-2022-10-20/
2 https://www.npr.org/sections/health-shots/2022/02/01/1075876794/feds-contract-with-pfizer-for-paxlovid-has-some-surprises
3 https://covid.cdc.gov/covid-data-tracker/#vaccinations_vacc-total-admin-rate-total. Low end of range based on CDC booster rates for the following age ranges: 5-17 years old, 18-64 years old, 65+ years old and assumes 1 booster per person per year. High end of range doubles the CDC booster rates for the same age groups and assumes 2 boosters per person per year.