JUNE 20, 2023

State of Delaware SEBC
The Value of CCMU

HIGHMARK DELAWARE

Who We Are

EXECUTIVE LEADERSHIP

Nick Moriello
President
Highmark BCBS Delaware

CLIENT MANAGEMENT

Wendy Beck
Executive Client Manager

Lisa Mantegna
Senior Client Service Manager

CLINICAL MANAGEMENT

Dr. Ben Edelshain
Vice President, Clinical Engagement
& Digital Innovation

Dr. Mark Jacobson
Medical Director

Creating a Health Care Partnership That Goes Beyond Coverage

80+ YEAR PARTNERSHIP BETWEEN HIGHMARK DELAWARE AND THE STATE OF DELAWARE

YOUR HIGHMARK ACCOUNT MANAGEMENT TEAM AND DEDICATED MEMBER SERVICES TEAM HAVE OVER 150 YEARS OF COMBINED SERVICE WITH HIGHMARK DELAWARE

100% OF SURVEYED GHIP RESPONDENTS WERE "EXTREMELY SATISFIED" WITH HIGHMARK BCBS DELAWARE

99% NETWORK UTILIZATION
MOST COMPREHENSIVE NETWORK IN DELAWARE

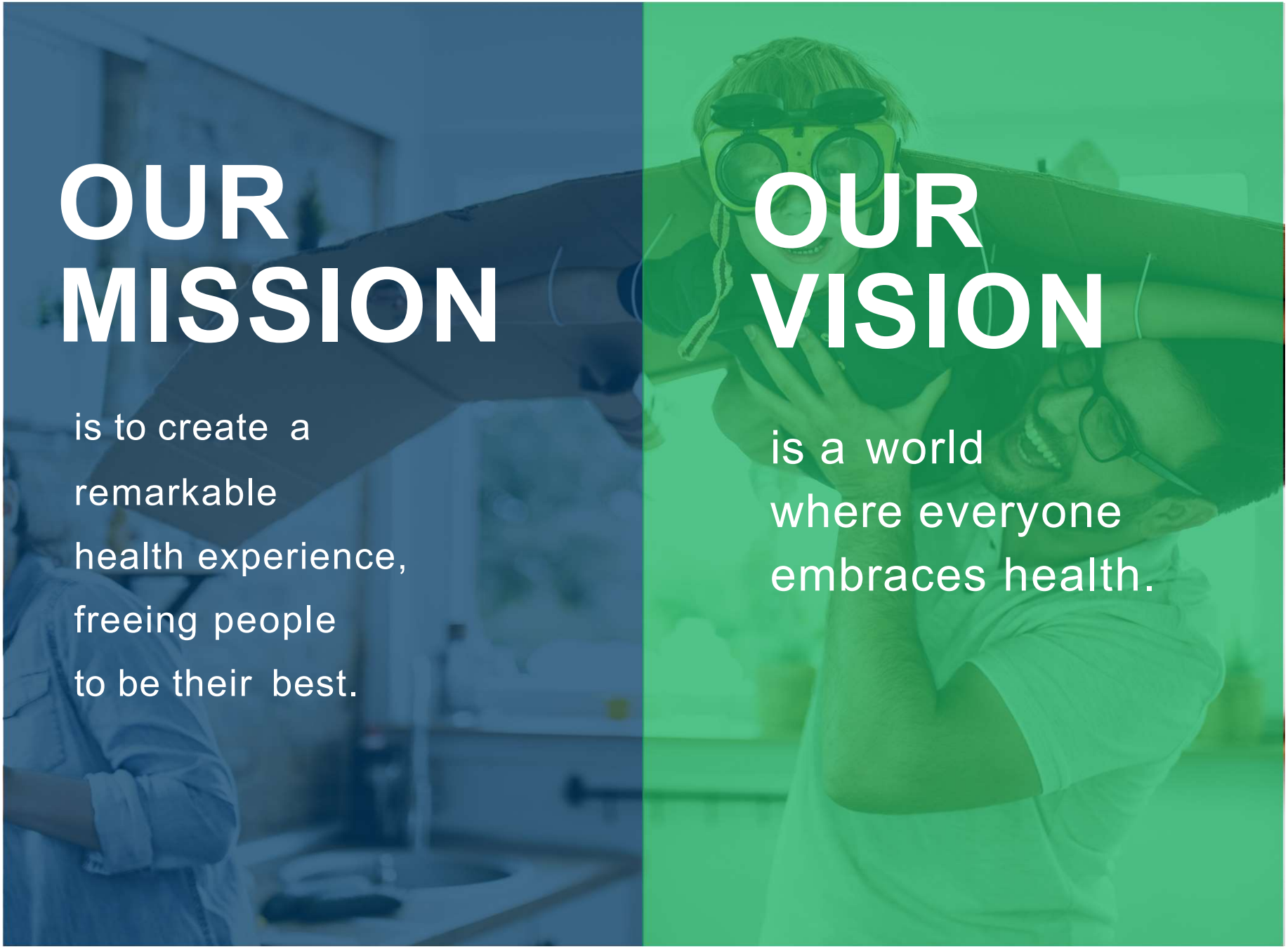
DEEPLY INVESTED IN OUR COMMUNITY:

BLUEPRINTS FOR THE COMMUNITY: $36M+ IN GRANTS TO DATE

DHIN: $12.5M+ (2016-2022)

HEALTH CARE PROVIDER LOAN REPAYMENT PROGRAM: $1M (2021)

COMMUNITY SPONSORSHIPS: $5.7M (2011 – 2022)



OUR MISSION

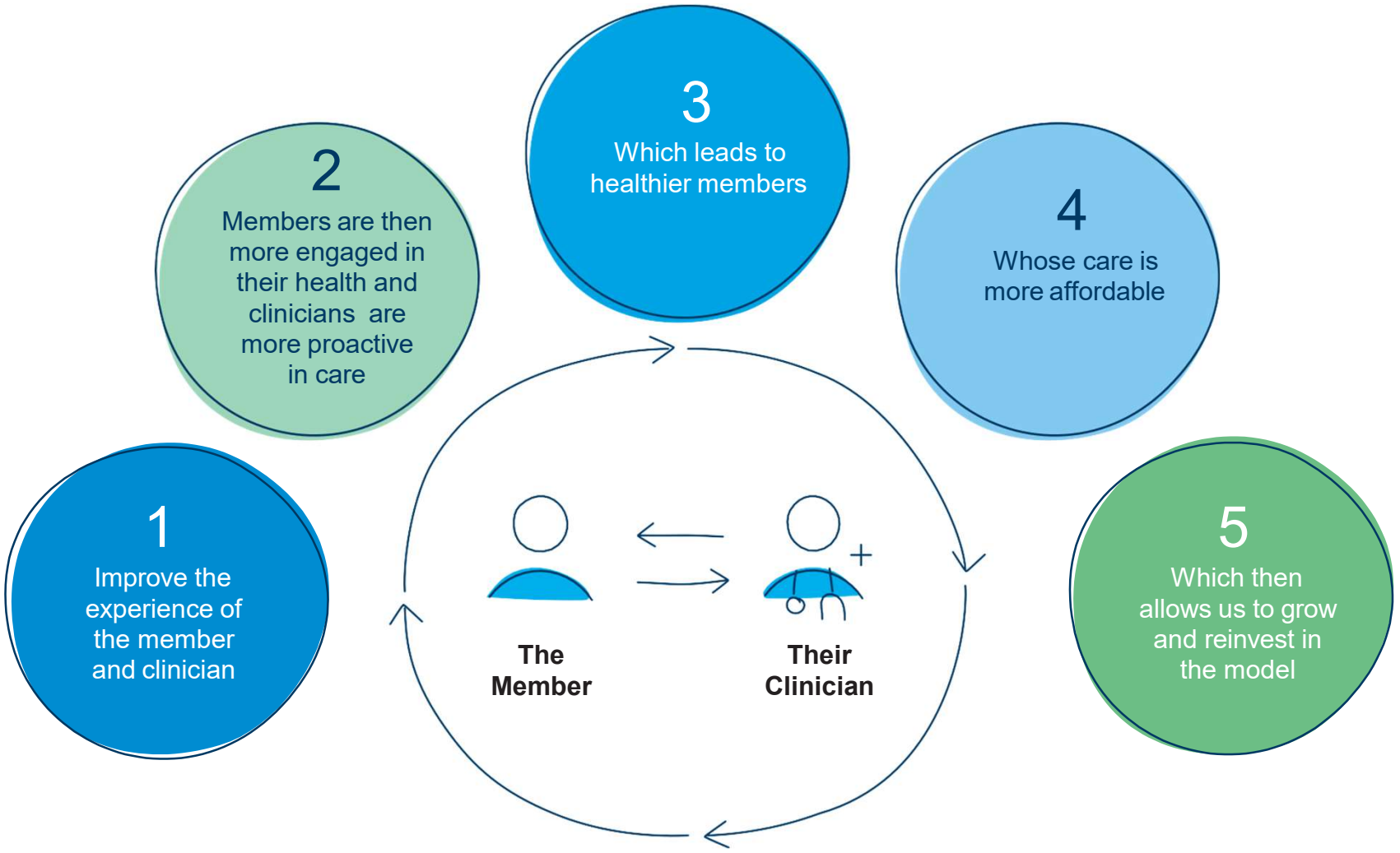
is to create a remarkable health experience, freeing people to be their best.

OUR VISION

is a world where everyone embraces health.

Living Health Strategy – Member Journey

Reinventing the health experience for members and clinicians.



Custom Care Management Unit (CCMU)

A care management solution that effectively manages health care cost and trend through personalized member interventions.

Built Through a Strategic Collaboration

Highmark + wtw

Dedicated team supporting resource integration (e.g., digital health, wellness) and ongoing Willis Towers Watson oversight.

Enhanced Identification

Members with greatest care impact potential are identified and outreached to in real time.

- Expanded and focused triggers
- Earlier identification

Holistic Management

Acute, complex, and chronic conditions. Nurse-in-the-family support:

- Proactive Case Mgmt.
- White Glove Concierge
- Decision support
- Gaps in care closure
- Integrated Care Team
- Centers of Excellence education and steerage
- High-Touch Case Management

Proven Outcomes

- Engagement
- Utilization
- Clinical
- Savings/ROI

Executive Summary

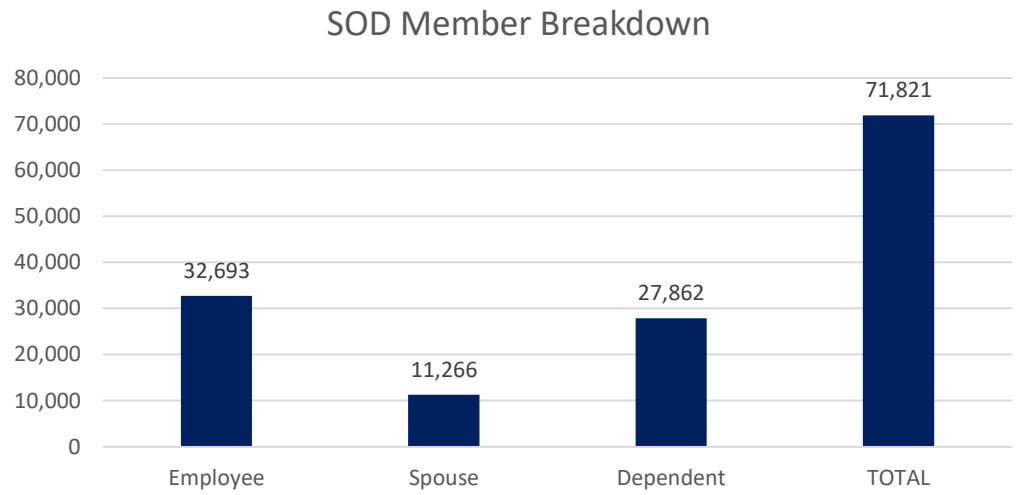
Highmark CCMU delivers outcomes and savings for the State of Delaware

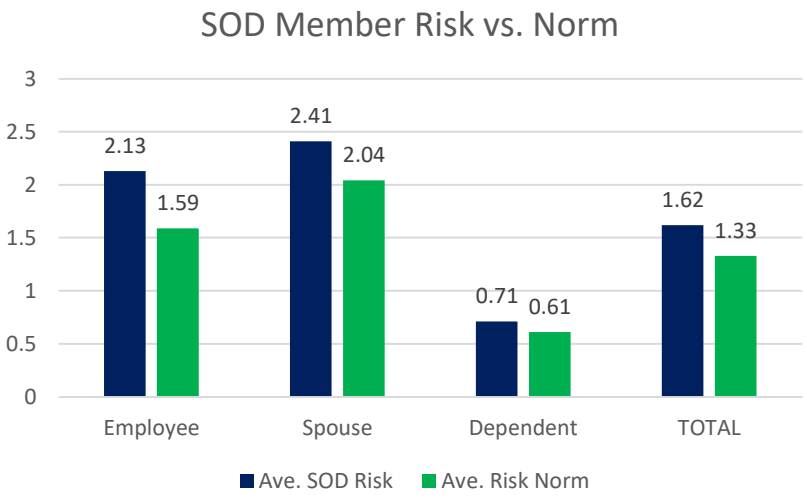
Today's discussion:

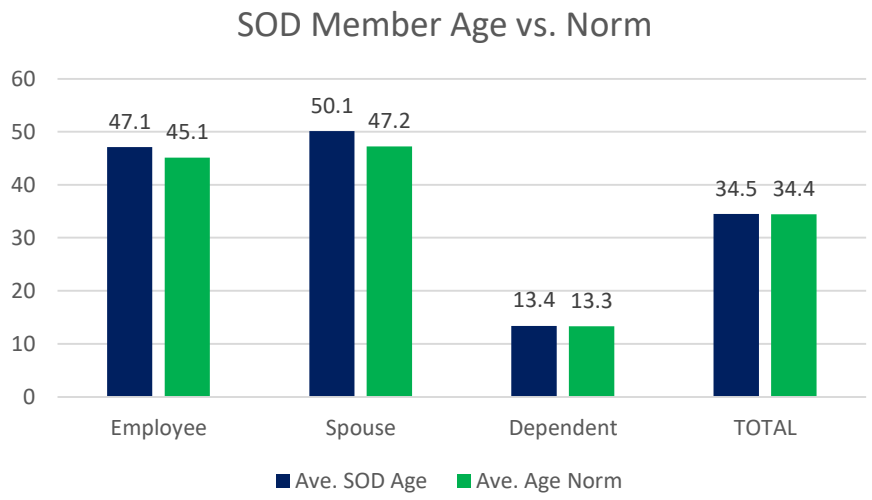
- State's active & under 65 retiree population **age** is **greater** than the norm
- State's active & under 65 retiree population **risk** is **22% greater** than the norm
- State's healthcare cost trend **1.7% below** Highmark's Book of Business trend
- Member satisfaction ratings remain very high: **99%** (2021) & **100%** (2022)

"Norm" and "Highmark Book of Business" refer to the Highmark National Book of Business

State of Delaware Active Commercial Population Demographic Overview & Prospective Risk







"Norm" refers to the Highmark National Book of Business

Population Condition Prevalence

38.6% of Members have more than one condition; norm is 29%

Top 4 Conditions

MUSCULOSKELETAL			BEHAVIORAL HEALTH			GASTROINTESTINAL			HIGH CHOLESTEROL		
28,124 Members	39.0%	29.2% Norm	16,323 Members	22.7%	17.5% Norm	14,611 Members	20.3%	15.7% Norm	13,956 Members	19.4%	12.8% Norm
48.0% Employees	47.6% Spouses	26.2% Dependents	26.7% Employees	22.5% Spouses	18.4% Dependents	24.8% Employees	24.6% Spouses	13.8% Dependents	30.4% Employees	35.1% Spouses	1.6% Dependents

All Other Conditions

	OVERALL			EMPLOYEES	SPOUSE	DEPENDENTS
CONDITIONS	MEMBERS		NORM	MEMBERS	MEMBERS	MEMBERS
BACK PAIN	12,875	17.9%	12.6%	25.2%	24.6%	7.5% ▲
HYPERTENSION	11,614	16.1%	13.3%	25.6% ▲	30.0% ▲	0.7%
METABOLIC SYNDROME	10,185	14.1%	10.2%	22.5%	26.4%	0.5%
OBESITY	7,563	10.5%	8.2%	16.6%	15.1%	2.2%
ASTHMA	5,061	7.0%	4.0%	7.5%	5.9%	7.0%
DIABETES	4,416	6.1%	5.2%	9.4%	11.7%	0.5%
MATERNITY	1,877	2.6%	1.7%	3.4%	3.3%	1.4%
CORONARY ARTERY DISEASE	1,703	2.4%	2.0%	3.2%	5.7%	0.2%
TOBACCO USE	1,495	2.1%	3.0%	3.0%	3.3%	0.6%
CONGESTIVE HEART FAILURE	615	0.9%	0.7%	1.2%	2.0%	0.1%
CHRONIC OBSTRUCTIVE PULMONARY DISEASE	598	0.8%	0.8%	1.2%	2.0%	0.0%

"Norm" refers to the Highmark National Book of Business
All Percentages Based on Specifc Population Category Breakdown
▲ *Indicates the highest prevalence for the categories in the All Other Conditions section.*

Data: FY 2022

CCMU Engagement

Overall CCMU Engagement	Advocate Engagement
Q4 FY22	28.9%
Q4 FY21	29.5%

Case Management	% Members Identified	Identified/ Reached	Engagement Rate	% Engaged	UTR
Q4 FY22	11.0%	70.8%	88.6%	6.9%	29.3%
Q4 FY21	9.9%	65.1%	83.9%	5.4%	35.1%

UTR Demographics Q4 FY22	Employees	Spouses	Dependents
Total = 2,321	1,351 (58.2%)	510 (22%)	460 (19.8%)

Definitions:

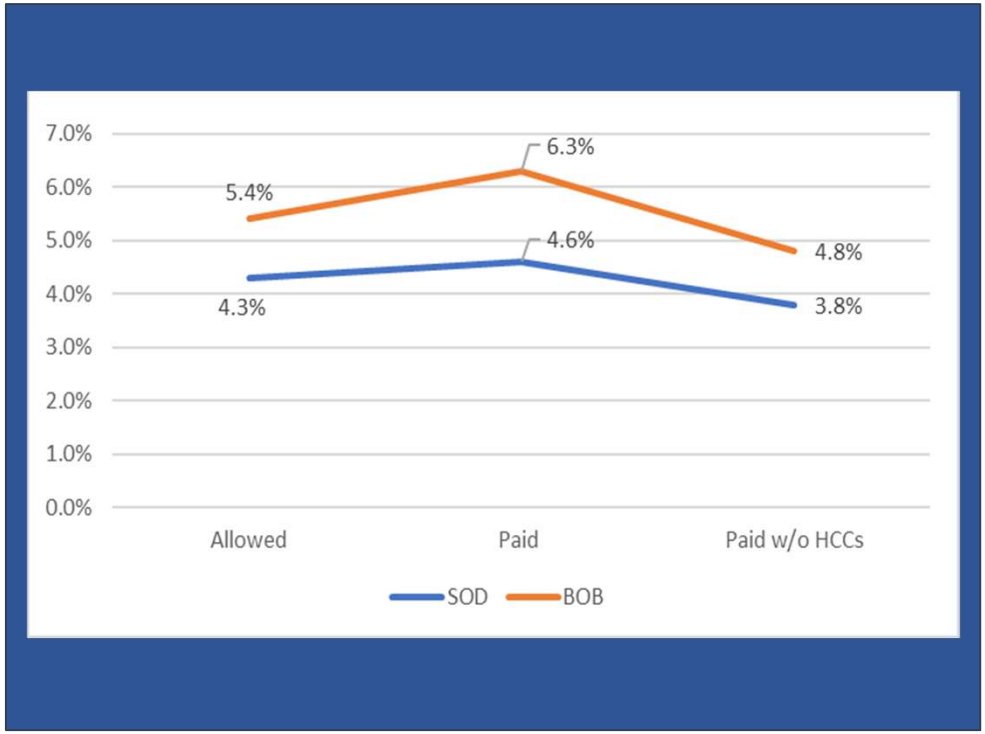
- **Engagement Rate** - Percentage is equal to the number of members engaged divided by number of members reached.
- **% Engaged -** Percentage is equal to the number of engaged members divided by total number of eligible members.
- Total UTR (Unable to Reach) members in this document refers to any member that was UTR at any time within Q1 FY 2021 and members can be counted more than once in subsequent quarters.

Trend Analysis

3-Year and 5-Year Trend for State of Delaware GHIP Compared to Norm

5-Year Trend

3-Year Trend

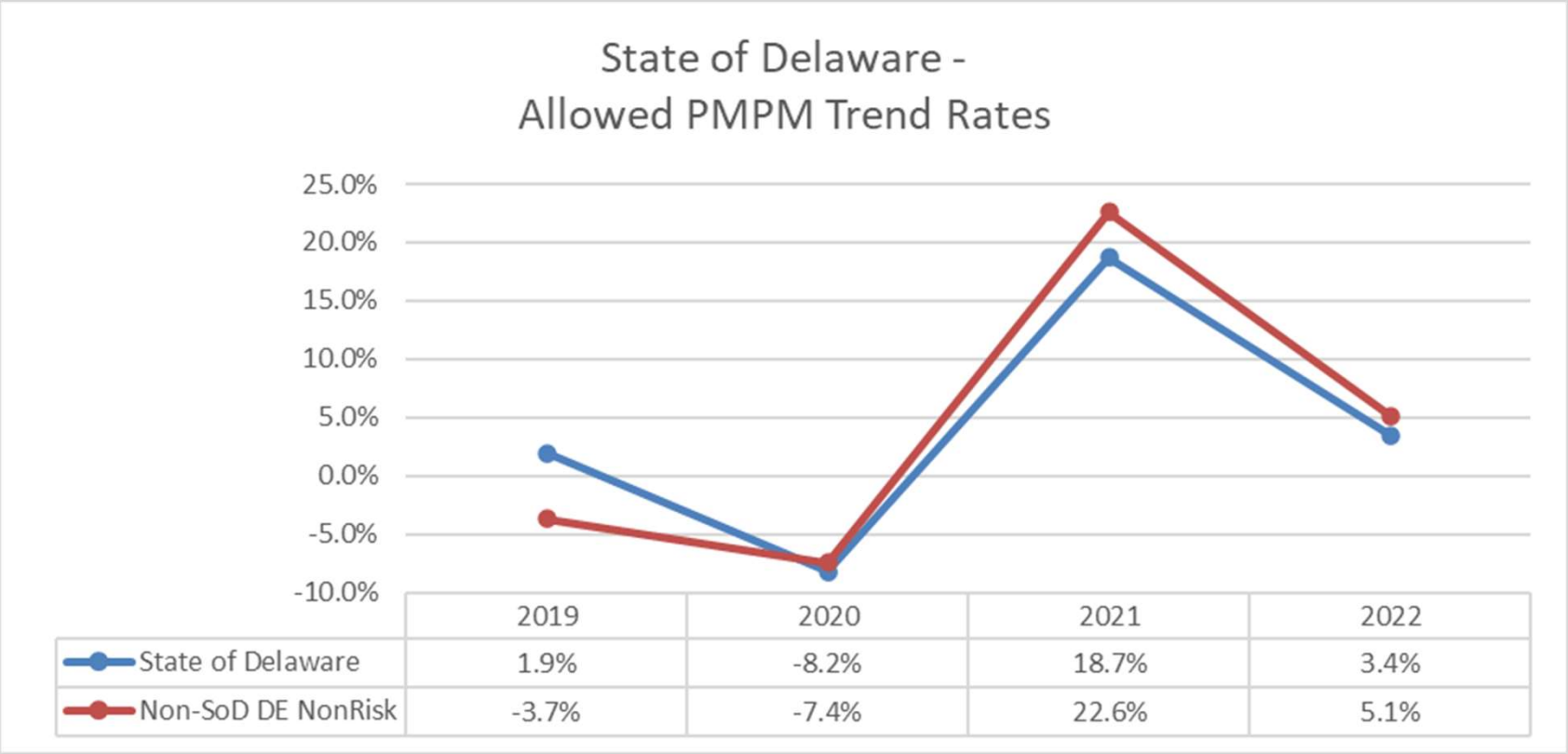


SOD refers to the State of Delaware GHIP population
BOB refers to the Highmark National Book of Business
HCC refers to High-Cost Claims

Trend Analysis

The exhibit compares the year-over-year total allowed trend for State of Delaware active employees against a benchmark of non-State of Delaware non-risk clients with more than 1,000 contracts, applying a $250K annual HCC threshold.

For 2022, State of Delaware's total trend of 3.4% is running under this benchmark's trend of 5.1%.



	2019	2020	2021	2022
State of Delaware	1.9%	-8.2%	18.7%	3.4%
Non-SoD DE NonRisk	-3.7%	-7.4%	22.6%	5.1%

3-Year and 5-Year Trend Comparison from Underwriting

HCC refers to High-Cost Claims

PMPM refers to Per Member Per Month

State of Delaware - Member Testimonials

"[My Highmark Case Manager] was wonderful. Her phone call came at a time early in my health crisis when I needed as much support as possible. She helped me navigate through some important issues I was faced with. She was always professional and showed the utmost courtesy and respect. There was never a time where I didn't feel like she genuinely cared about my well-being. I am truly grateful. Thank you!"

"I did not even know this service was part of my benefits. What a very welcomed surprise. [The Highmark nurse] was very attentive to my needs, answered questions, and even had answers to questions I didn't think to ask. When you are not well, it feels good to have someone to explain things more thoroughly and put you at ease about what's going on in your body. A+++"

"[Our Highmark Case Manager] was extremely wonderful to talk to. She was very caring and attentive. Our communications were very personable, and I always felt comfortable talking to her. She is not someone that just follows her script and goes through the motions. I feel she got to know our family and truly cared about my son's well being."

"[The Highmark nurse] was WONDERFUL, even gave more insight for the care of my daughter and how to offset some side effects of medications! She was VERY detailed and compassionate."

"Speaking to [my Highmark Coach] was like speaking to a friend. It was always a time I looked forward to and I felt great afterwards. She was an awesome accountability partner!"

CCMU Shared Goals & Results

FY2022 Financial Trend - **GOAL EXCEEDED**

Operational Measures – Actively Engage

High-Cost Claimant Engagement

Attempt to Reach Frequent ER Utilizers

OTHER NOTEABLE KEY CLINICAL OUTCOMES:

- Reduction in hospital admissions per 1,000 members: **Goal ✓; achieved ✓+**
- Reduction in outpatient emergency room (ER) visits per 1,000 members: **Goal ✓; achieved ✓+**
- Hospital readmission percentage reduction: **Goal ✓; achieved ✓+**

* OVERALL MEMBER SATISFACTION RESULTS:

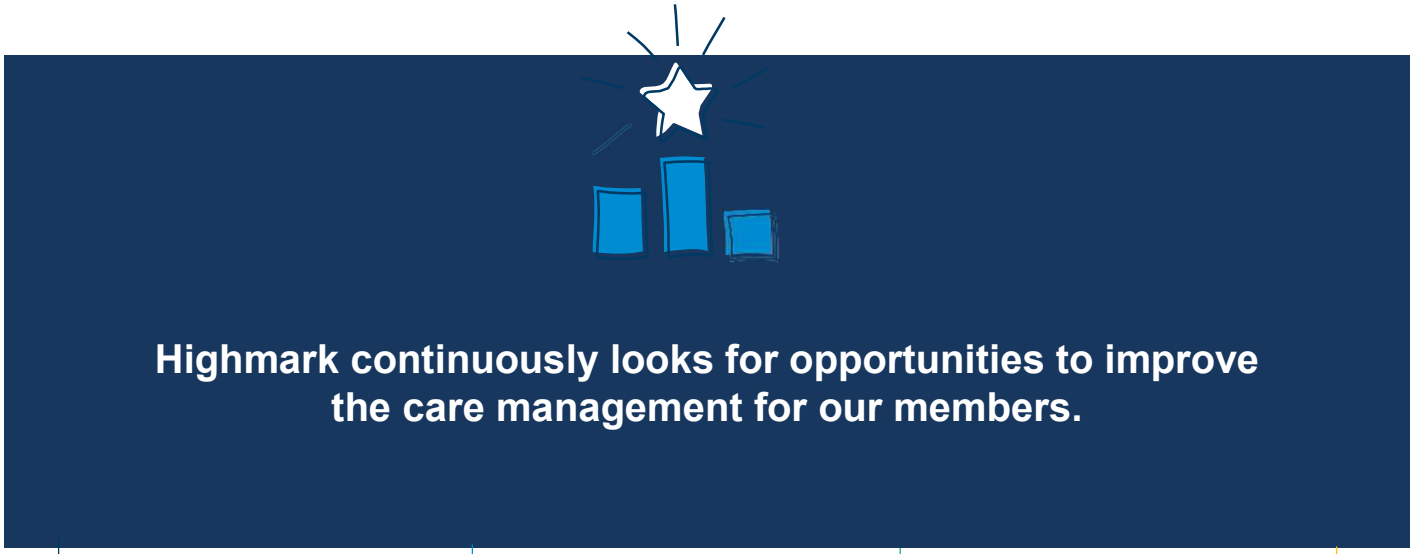
- FY 2021: 99%
- **FY 2022: 100%**

*Member satisfaction refers to their overall experience with Highmark Delaware.

Data: FY 2022

A single check mark indicates that the goal was met, and a check mark paired with a plus sign indicates that the goal was exceeded.

Current & Future Highmark Clinical Innovation Solutions



Highmark continuously looks for opportunities to improve the care management for our members.

- **Well360 Clarity** Right Provider Navigation
- **Digital Behavioral Health Enhancements**
- **Utilization Management Expansion**
- **Virtual Disease Management**

Questions, comments or suggestions

Appendix

OVERVIEW

This presentation includes the two-year analysis of utilization and cost for State Of Delaware with the metrics shown for the total client and for Active and Under 65 Employee Segment Groups (ESGs). The analysis is based on claims incurred from July 2020 through June 2021 and paid through August 2021 compared to claims incurred from July 2021 through June 2022 and paid through August 2022. The years are referenced as prior and current.

The data is presented by Inpatient and Outpatient settings. Professional Claims are included with the applicable facility cost to show a comprehensive cost per diagnosis and procedure. Most metrics are compared to Highmark's National Book of Business Norms.

Major Diagnostic Categories (MDCs) are based on ICD-10 codes. The Health Status MDC has been modified to move certain diagnosis codes that are usually grouped into the Health Status into the applicable MDC.

High Cost Members are defined as members who incur $100,000 or more in claims. The data in the presentation is for medical claims only. No drug claims are included.

Google Collaboration

Highmark Health will lead the collaboration to build its Living Health Dynamic Platform on Google Cloud, which will be designed to help overcome the complexities and fragmentation within the health care industry.

HIGHMARK HEALTH

Google

A collaboration built to reengineer the health care delivery model.

- The construction of a highly secure and scalable platform built on Google Cloud.
- The application of Google Cloud's advanced analytic and artificial intelligence capabilities to supercharge Highmark Health's existing clinical and technology capabilities.
- The engagement of a highly skilled professional services team that will collaborate to drive rapid innovation.
- The use of Google Cloud's health care-specific solutions, including the Google Cloud Healthcare API, to enable rapid innovation, interoperability, and a seamless *Living Health* experience.

Living Health — Solving the Health Care Equation

The Living Health model helps solve the issues that can make health care challenging. Living Health delivers a seamless experience — enabling the best outcomes for members and providers.

DATA AND ANALYTICS + PERSONALIZED CARE SOLUTIONS − COMPLEXITY = OPTIMIZED MEMBER OUTCOMES

Advanced technology platforms and collaborations empower us to identify member needs and deliver the best solutions.

Working together with providers, we deliver personalized, holistic care solutions. These solutions include virtual condition management, specialized utilization management, and improved advocacy and care programs.

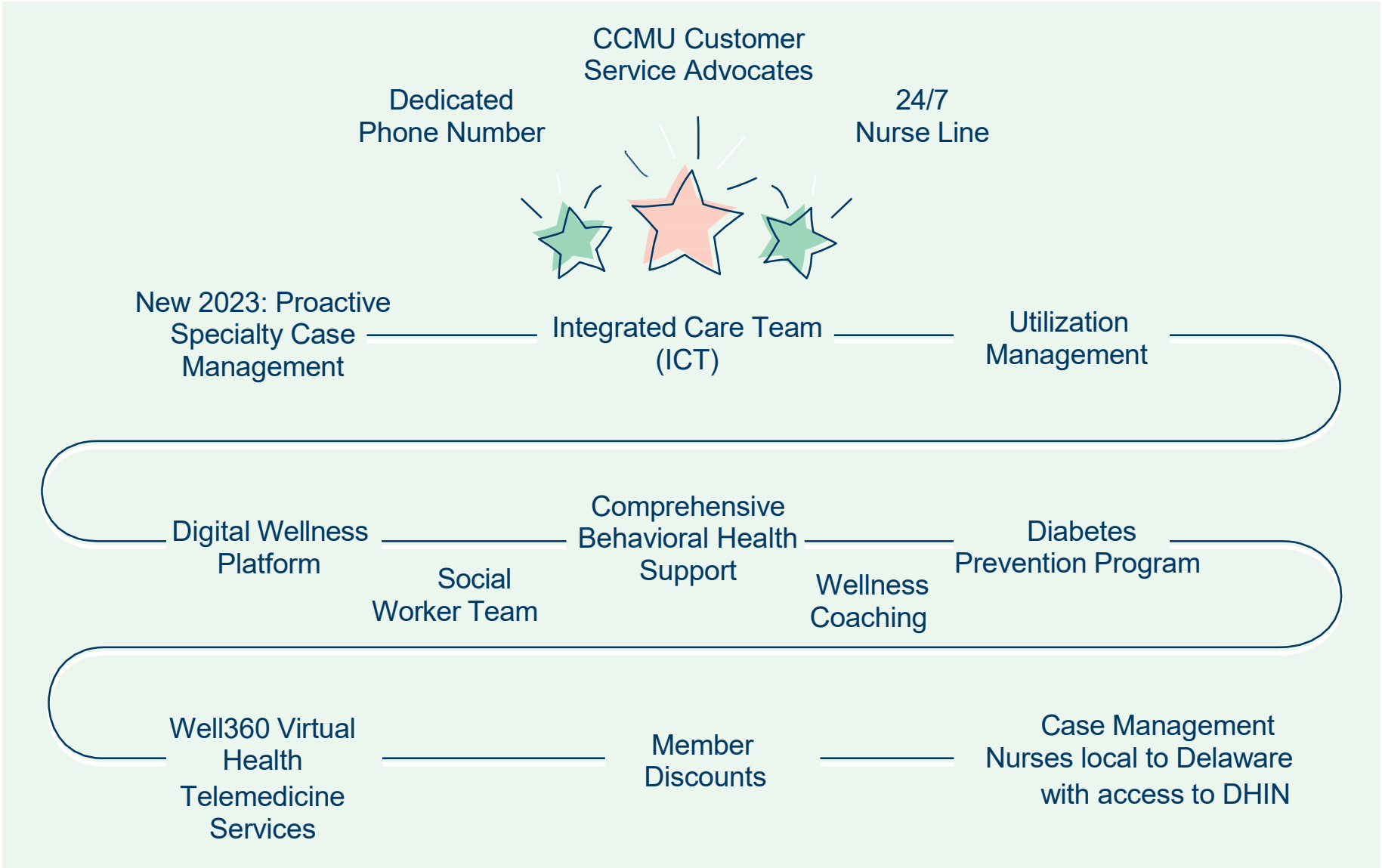
Living Health mitigates complexity by leveraging easy-to-use digital platforms, integrated care teams, and adaptable health solutions. By eliminating barriers to access, we deliver a seamless experience for members and their providers.

Living Health has proven to enhance health outcomes, increase engagement, and lower the total cost of care.*

**Onduo Depression & Anxiety Discovery, Internal Study Well360 Connect: An Integrated Clinical Care Management Model, Whitepaper Well360 Focus: A Multi-Channel Clinical Care Management Model, Whitepaper*

CCMU: Dedicated Clinical Team & Member Resources

Helps members navigate care, make healthy lifestyle changes, and manage chronic conditions.



Proactive Specialty Case Management

New for 2023

Proactive outreach occurs before unwanted utilization or high cost.

Expected ROI
3.4 to 1

NEW SPECIALTY COHORT	VALUE PROPOSITION
High Risk Pregnancy with Social Determinants of Health (SDOH)	Complex case managers and social workers provide focused support with SDOH interventions for this high-risk population.
Inflammatory Bowel Disease (IBD)	New specialized team will focus on earlier, proactive engagement to help reduce annual spend for this population.
Proactive Oncology	New team will drive interventions for patients/members identified at or near diagnosis for C1, C2, and C3 cancer groups.
Hemophilia	New specialized team will focus on earlier, proactive engagement to help reduce inpatient admissions and annual spend for this population.

The Next-Gen Identification and Stratification (ID & Strat)

Highmark information system integration and member-first interventions with proven clinical value.

Health Events	Interventions	Outcomes

Examples:

- Gap in care plan
- New diagnosis
- First sign of recurrence of cancer
- Post-surgery care coordination
- At-risk for chronic disease progression
- Post-acute care transitions
- Emergency room visit follow-up

Health Plan:

- Clinical Services
- Customer Service
- Vendors

Telephonic

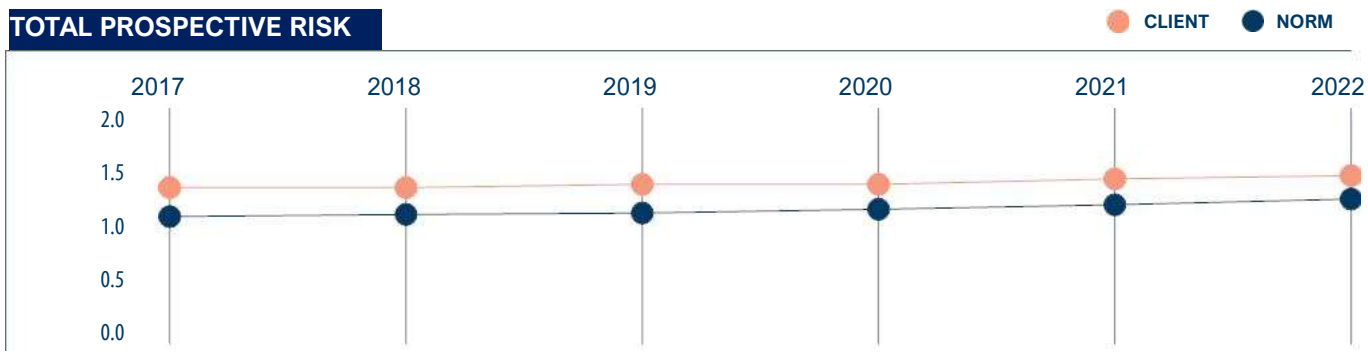
Digital

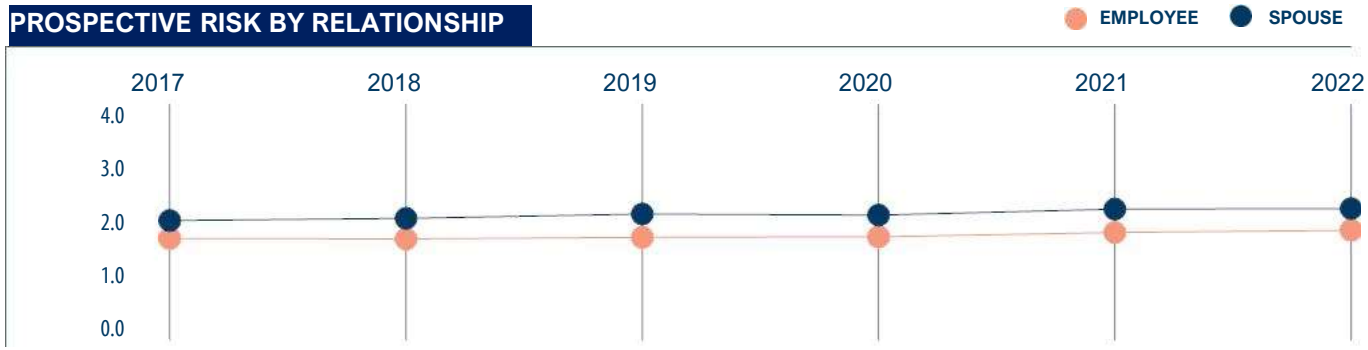
Provider

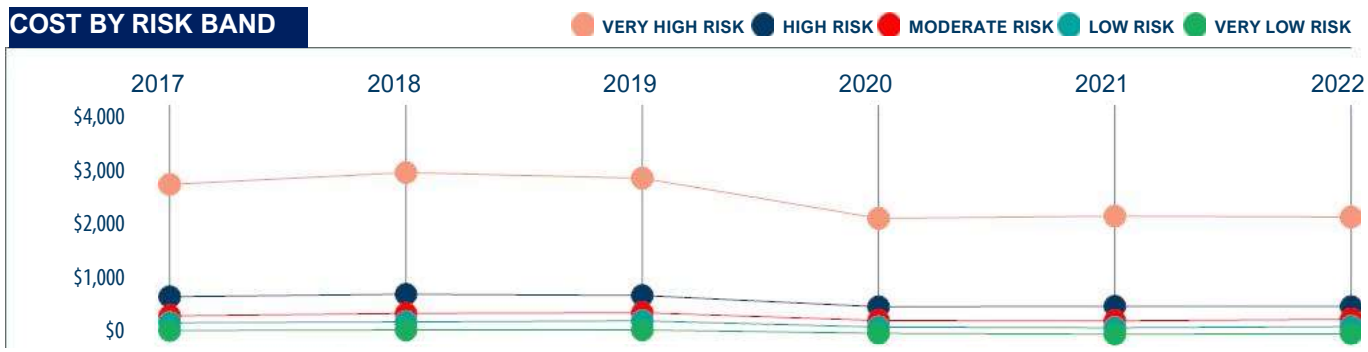
Examples:

- Enhanced continuity of care
- Timely intervention
- Appropriate triage of care
- Integrated care coordination
- Improved tracking and reporting

Risk Analysis – Historical Trend







Prospective Risk Score Range:

VERY HIGH RISK: >=3

HIGH RISK: 1.5-2.90

MODERATE RISK: 1.0-1.49

LOW RISK: 0.5-0.99

VERY LOW RISK: <0.49

Data: FY 2017 – FY 2022

Top 5 Major Diagnostic Category (MDC) Cost Drivers

OVERALL CLIENT - PERCENT OF TOTAL

	1	2	3	4	5
	NEOPLASMS	MUSCULOSKELETAL	PREGNANCY/CHILDBIRTH	SYMPTOMS/ILL-DEFINED	CIRCULATORY SYSTEM
% PMPM	12.5%	11.5%	7.7%	7.3%	7.1%

HIGH COST CLAIMANT - PERCENT OF TOTAL

	1	2	3	4	5
	NEOPLASMS	CIRCULATORY SYSTEM	INFECTIOUS / PARASITI	INJURY / POISONING	ENDOCRINE / METABOLIC
% PMPM	25.1%	12.6%	8.1%	8.1%	6.1%

KEY FINDINGS

The top five overall MDCs account for 46.1% of the total PMPM in FY 2022.

The top five HCC MDCs account for 59.9% of the total PMPM in FY 2022.

Data: FY 2022

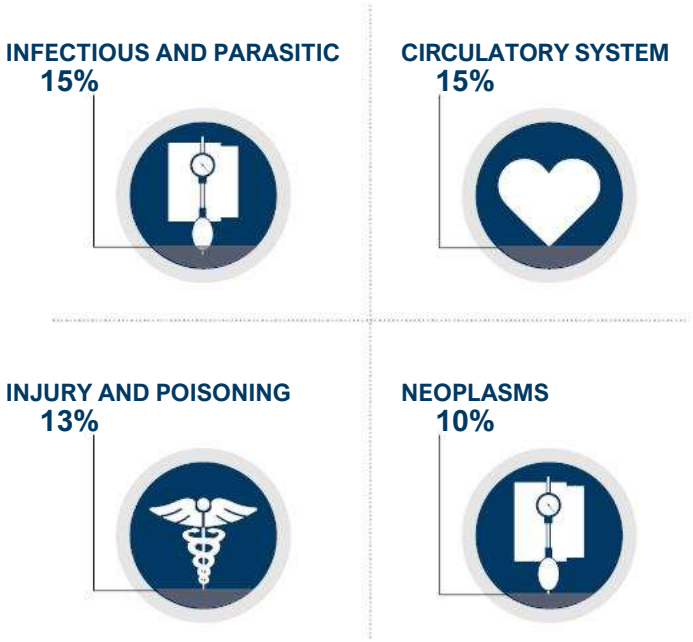
Integrated Care Team (ICT) Outcomes

BSBCA Blues Innovation Award winning solution – clinical innovation & value

ICT OUTCOMES

(580) ICT CASES

TOP DIAGNOSIS



KEY FACTS

METRIC	CURRENT
AVE.LENGTH OF STAY	8.6
AUTHORIZATIONS PER CASE	2.0
AVE. CLAIMS PER ENGAGED MEMBER	$94,670
AVE. SAVINGS PER CASE	$2,464

KEY FINDINGS

- The average risk score of the members in the ICT program is 9.6 (high risk).
- ICT targeted 68.0% of the members with an admission that triggered for the program and 1.1% of total members.
- There were 580 cases triggered for the ICT program and of those, 508 were engaged in case management.
- The ICT identifies members that are high cost or have the potential to become high cost that are high risk with inpatient admissions for more immediate intervention from Highmark's case management and utilization management teams.

PROGRAM VALUE

PROJECTED IMPACTABLE SPEND
$16,612,620

PROGRAM INVESTMENT*
$0

*ICT is included in the CCMU clinical model.

Data: FY 2022

Specialty Drug Management - Medical Specialty Site of Care

Program Overview

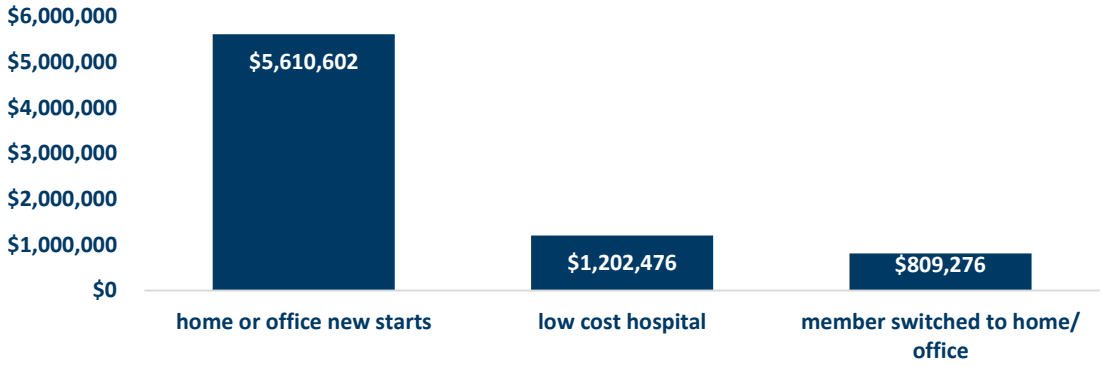
Provides members with safe, cost-effective site of administration alternatives for select medical infusion drugs which historically have been administered in a hospital outpatient setting

Expanded alternate locations include **Member Home**, **Infusion Centers**, and **the Physician's Office***.

The Results

Our program has provided you with total care and cost management. We have effectively identified members that were able to worry less about their treatments all while providing savings.

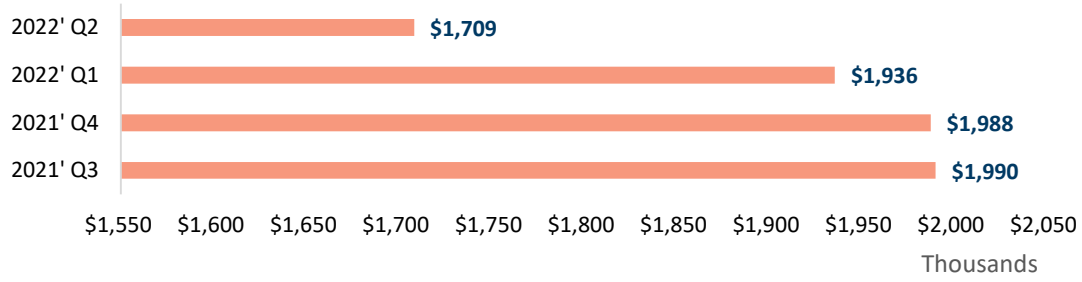
Savings by Setting**



Gross Savings**

$7,622,349 from 274 members

Savings by Quarter**



Data: FY 2022

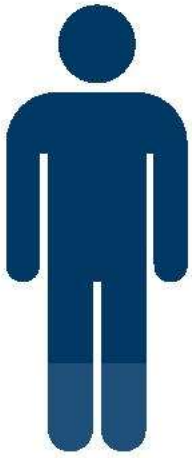
*Physician Office and Infusion centers not affiliated with a hospital

**Savings includes plan cost and member cost share

Diabetes Management Program Engagement

OVERVIEW

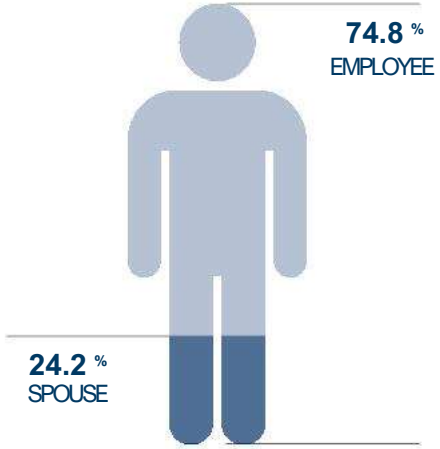
ENGAGEMENT



100%
(4,501)
TRIGGERED

20%
(896) ENGAGED

RELATIONSHIP



Data: FY 2022

KEY FINDINGS

- Participating members have access to Certified Diabetes Educators (CDEs), expert coaching, and digital tools to help them manage their diabetes.
- Eligible members also have access to free, unlimited test strips, a free blood glucose meter that connects with the app., and the capability to send blood sugar trend results to their provider via email from the app.
- 20% of the eligible members were participating in FY2022 (896 members).
- Over 90% of participants have activated their free blood glucose meter and connected it to the digital app.
- For members with a baseline A1C of >7.0, there was an average reduction of -1.4 points. An A1C lower than 7.0 indicates better controlled diabetes.
- This solution also encourages participants to adopt and maintain health lifestyle habits and behavior change with self-guided activities.

Diabetes Management Outcomes

OUTCOMES ● CURRENT ● PRIOR

Member Utilization

	PRIOR		CURRENT	
	ENGAGED	NOT ENGAGED	ENGAGED	NOT ENGAGED
PCP OFFICE VISITS	2,606	2,430	2,721	2,699
SPECIALIST OFFICE VISITS	3,691	3,361	3,867	3,596
EMERGENCY ROOM VISITS (ALL)	365	415	345	411
ADMISSIONS	136	174	108	142
RE-ADMISSIONS	7	14	6	13

*AVERAGE VISITS PER 1,000

Chronic Condition Care - Diabetes

	PRIOR		CURRENT	
	ENGAGED	NOT ENGAGED	ENGAGED	NOT ENGAGED
EYE EXAM	31.6%	29.1%	31.8%	30.3%
HBA1C	86.6%	79.7%	84.4%	81.6%
LIPID PANEL	79.7%	72.0%	76.9%	72.7%
MICROALBUMIN	69.6%	60.8%	67.6%	61.5%
OFFICE VISIT	97.8%	97.5%	97.1%	97.9%

*DISEASE MANAGEMENT COMPLIANCE

KEY FACTS

Participating members have greater compliance with diabetes management metrics such as:

- ✓ A1C testing
- ✓ Eye exams to identify potential complications
- ✓ Lipid panel (cholesterol test)
- ✓ Microalbumin testing (urine analysis for potential kidney complications)
- ✓ Primary Care Physician (PCP) office visits
- ✓ Specialist office visits (i.e., Endocrinologist)

Participating members had less:

- ✓ ER visits
- ✓ Hospital admissions
- ✓ Hospital re-admissions

Data: FY 2022 compared to FY 2021

Diabetes Management Program SOD Member Testimonials

"This meter system SAVED MY LIFE. I can now identify and monitor the foods that change my levels and work to correct the situation before it becomes a problem.

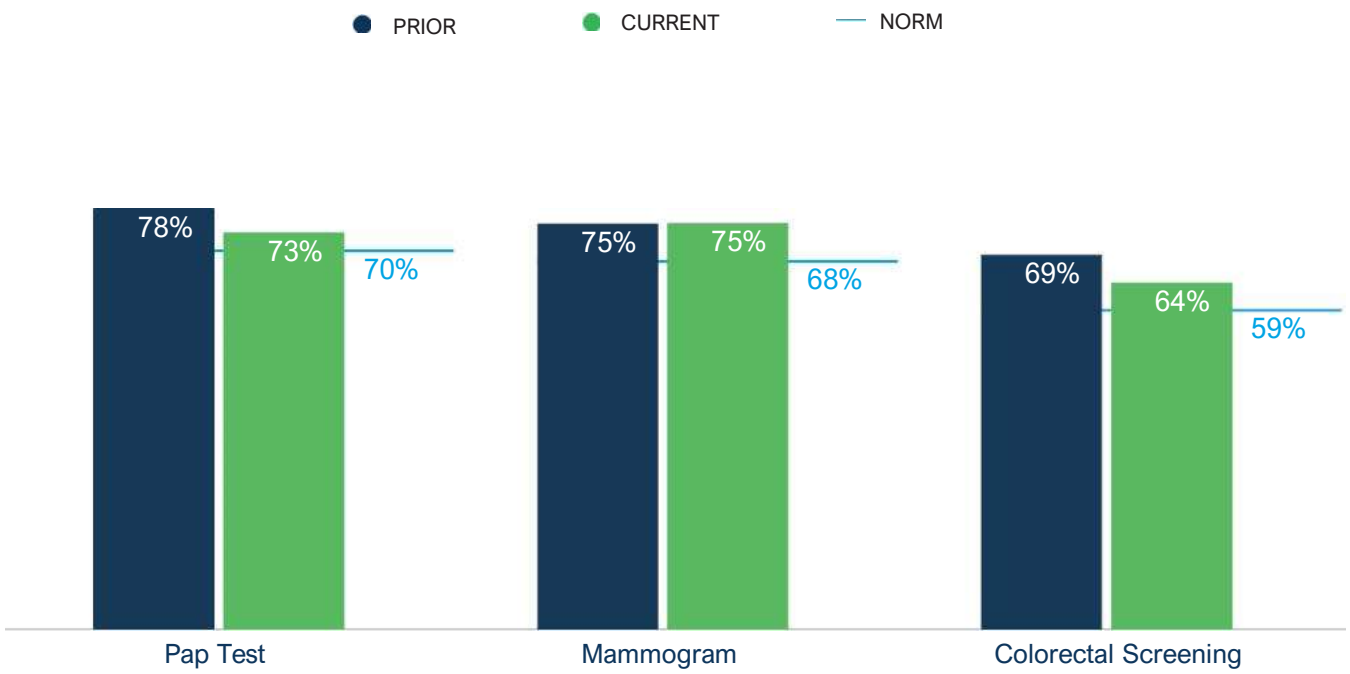
"The ability to track the readings was a major contributor to my management of diabetes.

"I now track my levels regularly.

"My coach helped me understand my readings and encouraged me to talk to my doctor . I did and that resulted in positive changes that have improved my glucose average.

Adherence to Preventive Care

Preventive Screening Measures



ANNUAL OFFICE VISIT ADHERENCE

Client
42.0%
Visits 24,733
Norm 37.5%

Employee
46.4%
Visits 16,760
Norm 37.1%

Spouse
33.6%
Visits 4,068
Norm 43.3%

KEY FINDINGS

• By promoting the wellness programming available through CCMU and Highmark, the population's overall adherence to preventive office visits is above the norm. Employee's adherence is above the National norm while spouse's adherence is below the norm.

• Preventive cancer screening rates have fluctuated year over year and continue to be above the National norm.

Members must have 24 months of continuous enrollment to be eligible for inclusion in the compliance rates for Mammogram and Colorectal Screening.

Members must have 36 months of continuous enrollment to be eligible for inclusion in the compliance rates for Pap Test.

Data: FY 2022

CCMU Team Referrals: External Vendors & Internal Resources

REFERRALS TO VENDOR PARTNERS	CURRENT	PREVIOUS
Pharmacy	941	877
Employee Benefit Center	6	19
Wellness	301	349
Livongo	29	37
Telemedicine	964	1,154

REFERRALS TO INTERNAL RESOURCES	CURRENT	PREVIOUS
Medical Director	459	1,193
Pharmacist	21	51
Behavioral Health	134	113
Social Worker	242	158
Specialty Clinician	1,773	1,346
Online Resources	6,676	8,303

Data: FY 2022

CCMU Remarkable Moment: Behavioral Health

Purpose

Dependent member with a diagnosis of autism spectrum disorder. Received inpatient behavioral health services in the past with inpatient stay due to behavior changes. The member's parent called in to the Highmark CCMU team behavioral health (BH) specialists for assistance.

Process

The behavioral health specialist assessed the member's current status and completed the initial assessment.

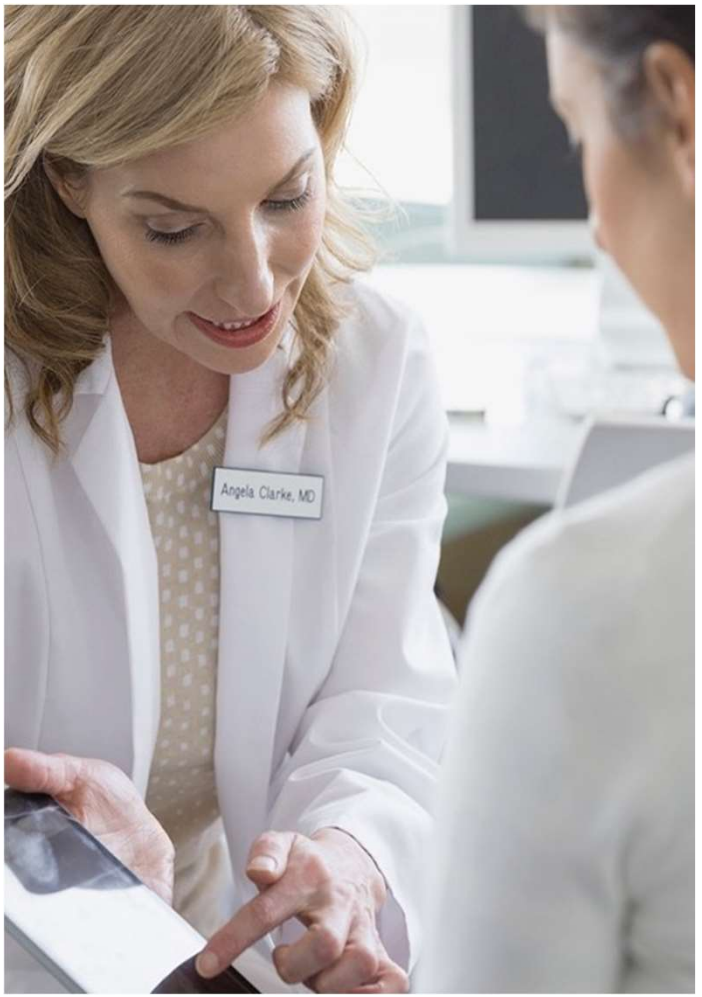
They also collaborated with local facilities, the UM team, the member's parent and BH providers in order to better understand the member's treatment plan and current BH needs.

Together, they were able to connect with the current treatment team and discuss treatment options and timeline for transitioning the member back to their home.

Proof

Member satisfaction – the BH case manager collaborated with the member, the treatment team, UM team, Social Worker, as well as providers and facilities to ensure the member had a safe discharge plan and the parent's concerns were addressed.

Avoided ER visit – the member was able to potentially avoid a costly ER visit.



CCMU Remarkable Moment: Complex Comorbidities

Purpose

Member went to the ER with shortness of breath after falling in the home. The member had very complex past medical history that included wounds that were slow to heal, cardiovascular disease, kidney disease, type II diabetes, etc. The member was an amputation candidate.

When the member was inpatient in the hospital, it was noted that they were fearful of amputation and were offered a behavioral health consultation. The member moved forward with the surgery and was discharged to inpatient rehabilitation.

Process

This was an Integrated Care Team case. The CCMU nurse case manager worked collaboratively with the member, providers, facilities, and member's spouse in order to fully support this member's recovery.

The spouse was provided on home safety measures. The member trusted the nurse case manager and would frequently call back for further support and guidance.

The nurse worked closely with the CCMU clinical team, the medical director, UM staff, and the member's family to ensure that this member received the most appropriate care at the right time and the right location, and their immediate needs were addressed holistically.

Proof

Avoided ER visits– related to wound healing challenges.

Member satisfaction –The member and spouse now have a trusted CCMU Nurse in the family at Highmark and a resource they can rely on in their time of need.

Engagement Summary Definitions

Overall Paid PMPM

This section provides the Per Member Per Month paid amount for Engaged, Non-Engaged, and Summary (combined) for each quarter.

Call and Engagement Activity

Total number of attempts and engagement statistics

TOTAL MEMBERSHIP
total members (employees, spouses and dependents) enrolled in CCMU eligible medical plans.

MEMBERS IDENTIFIED
total members who have been identified for outreach.

MEMBERS ENGAGED
total members who are actively participating in a program.

MEMBERS REACHED
total members who have been reached/answered a call.

NUMBER OF ENGAGEMENTS
total number of eligible programs or activities for engaged members.

MEMBERS DECLINED
total members who have declined to participate in a coaching program.

UNABLE TO REACH
number of members identified who were not able to be reached.

INVALID PHONE NUMBER
number of members who were UTR due to invalid phone number.

NO RETURN CALL
Number of members who were reached by voicemail or letter that did not return the call.

Digital Wellness Platform Engagement

Average Real Age is 2.0 Years Younger than participating members' biological age.

PARTICIPATION SUMMARY	
1,129	Total
48.7	Average Age
17.9%	Male
82.1%	Female

PERCENT MEMBERS SELF-REPORTED

Obesity	Depression	Asthma
0.3%	0.2%	0.1%

	CURRENT	PREVIOUS
Total Members Registered	1.6%	1.4%
RealAge Taken this Period	0.6%	1.0%
RealAge Taken (Overall)	1.5%	1.4%

Data: FY 2022

Examples of CCMU Member Monthly Wellness Challenges