The State of Delaware

Overview of health care landscape for Medicare-eligible retirees

SEBC Retiree Healthcare Benefits Advisory Subcommittee

March 27, 2023

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State Benchmarking

Medicare plan options by state

Medicare Supplement only	Choice of Medicare Supplement or Medicare Advantage	Medicare Advantage only	Individual HRA for retiree to purchase coverage (Medicare Supplement or Medicare Advantage)
Alaska	Arkansas	Alabama	Indiana (state employees)
Delaware	California	Arizona	Louisiana[6]
Idaho (closed group only)[1] (*)	Florida (*)	Colorado	Nevada
Iowa (*)	Hawaii (*)	Connecticut[2]	Ohio (state employees)
Maryland (*)	Kansas	Georgia	Rhode Island
Mississippi (*)	Louisiana[6] (*)	Illinois	
Montana (*)	Massachusetts	Indiana (public education employees)[3]	
Nebraska	Michigan (*)	Kentucky	
North Dakota	New Jersey	Maine	
South Carolina	New Mexico	Minnesota	
South Dakota	New York (*)	Missouri[4]	
Tennessee	North Carolina (*)	New Hampshire	
Utah	Ohio (public education employees)	Pennsylvania (state employees)	
Vermont (state employees) (*)	Oklahoma	Texas (public education employees)	
Virginia	Oregon	Vermont (state teachers)	
Wyoming (*)	Pennsylvania (school employees)	West Virginia[5]	
	Texas (state employees)		
	Washington		
	Wisconsin		

- 19 (38%) states offer choice between Medicare Supplement and MA plans for some or all Medicare-eligible retirees
- Some states offer different plan options to different groups of retirees
  - Examples: OH, PA, TX, VT
- 5 (10%) states provide a Health Reimbursement Account to purchase retiree medical coverage (Medicare Supplement and/or Medicare Advantage), and all except Indiana offer access to a Medicare marketplace to facilitate retirees' purchase of coverage
- Idaho is the only state that does not offer retiree medical coverage for the majority of future Medicare-eligible retirees

(*) Offers the same plan(s) as active employees. | See next slide for numbered footnotes. | Data originally collected in January 2023; verified in March 2023.

Medicare plan options by state

Notes on selected states

[1] Idaho has limited retiree medical eligibility as follows: Retirees hired after June 30, 2009 are not eligible for coverage unless they have credited state service of at least 20,800 hours before June 30, 2009 and subsequent to reemployment, election, or reappointment on or after July 1, 2009 accumulate an additional 6,240 continuous hours of credited state service and are otherwise eligible for coverage. https://ogi.idaho.gov/retiree/eligibility-enrollment/.

[2] Retired state employees that are Medicare-eligible are offered only Medicare Advantage coverage. Retirees of partnership employers (i.e., are a Participating Employer in the Connecticut Medical Partnership Plan) are not eligible for medical benefits (which match the state employee plan) once the retiree becomes eligible to participate in Medicare Parts A and B, which would be the case for Medicare retirees (https://www.osc.ct.gov/ctpartner/docs/PlanDocument-Partnership-Medical-063022.pdf).

[3] Indiana as a state entity offers retirement medical benefits accounts (i.e., a Health Reimbursement Account) to retired state employees and several group Medicare Advantage plan options to retired public education employees (https://www.in.gov/inprs/my-fund/). Retired public employees have the option of joining the Retired Indiana Public Employees Association, a not-for-profit corporation that does not receive any tax dollars and is entirely supported by member dues (https://www.ripea.org/index.php/about-us); this association sponsors several medical plan options including Medicare Supplement plans and Medicare Advantage plans for members. However, since this organization does not receive any public funding from the state of Indiana, its medical plan options were not factored into the above chart.

[4] State agency retirees are eligible for a Medicare Advantage plan (http://mchcp.org/stateMembers/benefitsAndEnrollment.asp), whereas retirees of other public entities that have joined the Missouri Consolidated Health Care Plan are eligible for the same plan as active employees, with Medicare paying primary (http://mchcp.org/publicEntity/enrollment/medicare.asp). State retirees make up the vast majority of retired plan participants covered under the Missouri Consolidated Health Care Plan, compared to retired members of participating public entities: as of 6/30/2022, state retirees numbered 21,691 participants and public entity retirees numbered 2 participants; source: http://mchcp.org/aboutUs/documents/annualReport_2022.pdf.

[5] In its Medicare Advantage plan booklet (https://peia.wv.gov/Forms-Downloads/Documents/medicare_advantage_plan_booklets/MAPD2022-2023_web.pdf), West Virginia noted that the majority of its retirees are enrolled in its group Medicare Advantage plan option; however, there are some additional retirees that have been permitted to enroll in a Medicare Supplement plan on a case-by-case basis (i.e., those who are unable to access providers in the Medicare Advantage plan and those who become eligible for Medicare benefits during a plan year).

[6] Louisiana offers retirees a choice between access to a marketplace with a Health Reimbursement Account and enrollment in employer-sponsored (group) Medicare Advantage plans or in the state's active medical plan options (but coordinated with Medicare).

Medicare plan options by state

Comparison of plan options and retiree contributions when choice of Medicare plans offered

	PLAN OPTIONS (Med+Rx Coverage)		RETIREE PREMIUM CONTRIBUTIONS (Med+Rx Coverage, rounded to nearest $1)	
STATE	**Medicare Supplement (MS)/Other**	**Medicare Advantage (MA)**	**Medicare Supplement (MS)/Other**	**Medicare Advantage (MA)**
Arkansas	One MS option	One MA option	$212	$17
California	Two MS options	Nine MA options	$111 - $138	$0 - $80
Florida	Active plan options coordinated with Medicare	Three MA options	$257 - $430	$45 - $195
Hawaii	Active plan option coordinated with Medicare	Two MA options	$0 - $237	$0 - $220
Kansas	Three MS options	Two MA options	$222 - $434	$104 - $192
Louisiana	Active plan options coordinated with Medicare	Multiple MA options	$137 - $236*	$8 - $112*
Massachusetts	Three MS options	One MA option	$43 - $87	$36 - $72
Michigan	Active plan option coordinated with Medicare	Four MA options	$0	$36 - $56
New Jersey	Five MS options	Four MA options	$487 - $660	$346 - $465
New Mexico	One MS option	Four MA options	$241 - $470	$0 - $121
New York	Active plan options coordinated with Medicare	Multiple MA options	$0 - $162	$94 - $159
North Carolina	Active plan options coordinated with Medicare	Two MA options	$0 - $472	$0 - $73
Ohio (public education employees)	PPO plan coordinated with Medicare	Multiple MA options	$128 - $288	$31 - $274
Oklahoma	Three MS options	Four MA options	$339 - $425	$186 - $238
Oregon	One MS option	Five MA options	$337	$224 - $268
Pennsylvania (school employees)	Two MS options	Multiple MA options	$127 - $335	$242 - $481
Texas (state employees)	Active plan option coordinated with Medicare	One MA option	$0 - $312	$0 - $108
Washington	One MS option	Four MA options	$99	$123 - $176
Wisconsin	One MS option	Multiple MA options	$365	$195
Delaware GHIP Medicfill			**$0 - $459 ****	

- Delaware's Group Health Insurance Plan (GHIP) Medicfill plan covers nearly 100% of all eligible, non-Medicare covered medical expenses
- Therefore, Medicare Supplement plans offered by other states can only be as rich as Medicfill if they also cover nearly 100% of all eligible, non-Medicare covered medical expenses
  - Further details on the medical benefits covered by each state's Medicare Supplement plan offerings are provided on slide 9
- The proposed Highmark MA plan design cost sharing provisions (e.g., cost for PCP office visits) are largely aligned with the Medicfill plan (further details on slide 10) though the MA plan differs in prior authorization and network requirements; MA plan has a $0 premium and $0 retiree contribution (medical only)

*Retiree premium contributions provided for partial employer subsidy (56%). Louisiana differentiates rates based on several employer subsidy levels for retired employees (19% / 38% / 56% / 75% subsidy).
**See slide 7 for additional detail on how State share varies based on years of service. 65% of retirees receive 100% State share.

Medicare Supplement – Special Medicfill Plan

Rates effective January 1, 2023 – December 31, 2023

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

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

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

Medicare Supplement – Special Medicfill Plan

Medicfill Contributions by State Share

			Per Retiree Contribution	
Health Plan	State Share %	Number of Med Retirees	Annual	Monthly
Pensioners Retired After July 1, 2012				
Special Medicfill	100	5,818	$0.00	$0.00
Special Medicfill	75	1,035	$1,584.78	$132.07
Special Medicfill	50	466	$2,894.04	$241.17
Special Medicfill	0	85	$5,512.56	$459.38
Special Medicfill	Double State Share*	325	$271.20	$22.60
Special Medicfill w/o Rx	100	98	$0.00	$0.00
Special Medicfill w/o Rx	75	40	$898.32	$74.86
Special Medicfill w/o Rx	50	33	$1,640.64	$136.72
Special Medicfill w/o Rx	0	19	$3,125.28	$260.44
Special Medicfill w/o Rx	Double State Share*	6	$156.00	$13.00
Pensioners Retired On or Prior to July 1, 2012				
Special Medicfill	100	15,581	$0.00	$0.00
Special Medicfill	75	311	$1,378.14	$114.85
Special Medicfill	50	224	$3,031.91	$252.66
Special Medicfill	0	33	$5,512.56	$459.38
Special Medicfill w/o Rx	100	440	$0.00	$0.00
Special Medicfill w/o Rx	75	3	$781.32	$65.11
Special Medicfill w/o Rx	50	21	$1,562.64	$130.22
Special Medicfill w/o Rx	0	18	$3,125.28	$260.44
Total		24,556		

Data source: February 2023 Office of Pensions reporting.

* Definition of Double State Share, from 29 Del Code 5202(d)(5):

If both spouses are Medicare eligible and 1 or both retired on or after July 1, 2017, only 1 50 percent pensioner only, or $25 per month premium, whichever is greater, shall apply when separate contracts are required for a Medicare Advantage Plan.

If both spouses are Medicare eligible and both retired after July 1, 2012, and before July 1, 2017, each Medicare eligible pensioner shall be charged $25 per month premium when separate contracts are required for a Medicare Advantage Plan.

States' Medicare Supplement plans compared to CMS standards

Details on Medicare Supplement plan provisions for states offering choice of Medicare plan options

- Chart below compares selected medical plan provisions for each state that offers at least one Medicare Supplement plan as a choice alongside one or more Medicare Advantage plans
  - CMS requires individual Medicare Supplement (Medigap) policies to include certain standardized benefits, which CMS encourages consumers to consider when evaluating Medigap plan options; state laws may affect these standardized benefits as well
  - The list of standard benefit provisions was used as a basis for comparing states' group Medicare Supplement plans against Delaware's GHIP Medicfill plan as well as the CMS standard benefits for individual Medicare Supplement plans
  - States that offer choice of Medicare plan options that are not "true" Medicare Supplement plans (e.g., active plan option coordinated with Medicare) were omitted below (FL, HI, LA, MI, NY, NC, OH, TX)
- This is not intended to reflect an exhaustive list of coverage provisions under each plan; additionally, the CMS standard Medigap provisions for foreign travel coverage has been omitted below

Medicare Supplement medical plan provisions (% indicates plan cost share of any excess charge)	**GHIP Medicfill**	**AR**	**CA**	**KS**	**MA**	**NJ**	**NM**	**OK**	**OR**	**PA (school EEs only)**	**WA**	**WI**	**Individual Market Medigap Plan (2023)**									
													A	**B**	**C***	**D**	**F***	**G**	**K**	**L**	**M**	**N**
Part A coinsurance and hospital costs up to an additional 365 days after Medicare benefits are used up	✓	✓	✓	✓	✓	Varies based on plan option	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Part B coinsurance or copayment	✓	✓	✓	✓	✓	Varies based on plan option	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	50%	75%	✓	✓**
Blood (first 3 pints)	✓	✓	Varies based on plan option	✓	✓	Varies based on plan option	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	50%	75%	✓	✓
Part A hospice care coinsurance or copayment	✓	✓	✓	✓	✓	Varies based on plan option	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	50%	75%	✓	✓
Skilled nursing facility care coinsurance	✓	✓	Varies based on plan option	✓	Varies based on plan option	Varies based on plan option	✓	✓	✓	✓	✓	✓	X	X	✓	✓	✓	✓	50%	75%	✓	✓
Part A deductible ($1,600 for 2023)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	X	✓	✓	✓	✓	✓	50%	75%	50%	✓
Part B deductible ($226 for 2023)	✓	✓	✓	Varies based on plan option	✓	✓	X	X	X	✓	X	✓*	X	X	✓	X	✓	X	X	X	X	X
Part B excess charge	100%	80%	X	Varies based on plan option	Varies based on plan option	Varies based on plan option	80%	Varies based on plan option	100%	80%	100%	X	X	X	X	X	✓	✓	X	X	X	X
Out-of-pocket limit***	N/A	N/A	Varies	N/A	Varies	Varies	N/A	N/A	N/A	Varies	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	$6,940	$3,470	N/A	N/A

✓ Plan covers at 100%

X Plan does not share cost (fully paid by retiree)

*Not available to individuals who are new to Medicare on or after January 1, 2020. However, individuals eligible for Medicare before January 1, 2020 but not yet enrolled may be able to get this benefit.

**Plan N pays 100% of the Part B coinsurance, except for a copayment of up to $20 for some office visits and up to a $50 copayment for emergency room visits that don't result in inpatient admission.

***For Plans K and L, after annual out-of-pocket limit and annual Part B deductible are met, plan pays 100% of covered services for rest of calendar year.

Medical plan comparison

Delaware's Medicfill Medicare Supplement plan with the proposed Highmark Medicare Advantage plan

	Original Medicare	Medicfill 2023		Proposed Highmark MA Plan	
Medical Benefits	**Original Medicare Pays**	**Medicfill Pays**	**Member Pays**	**In-Network Member Pays**	**Out-of-Network Member Pays**
Deductible	Part A and Part B deductible	Not applicable	Not applicable	$0	$0
PCP/Specialist office visits	80% after deductible	Part B deductible, then 20%	$0	$0	$0
Inpatient hospital	100% after deductible	Part A deductible	$0	$0	$0
Skilled nursing facility (up to 100 days per benefit period)	Days 1–20: Medicare pays 100% Days 21–100: Medicare pays all but coinsurance per day	Days 1–20: Plan pays nothing Days 21–100: Plan pays coinsurance per day	$0	$0	$0
Emergency room and urgent care	80% after deductible	Part B deductible, then 20%	$0	$0	$0
Inpatient coverage outside the U.S.	Medicare pays nothing	Plan pays Part A deductible and remaining coinsurance	$0 for services covered by Medicare or for admission not covered by Medicare	$0 if urgent or emergency care, or if admission is coverable under Medicare policy in the U.S.	
Outpatient facility coverage outside the U.S.	Medicare pays nothing	Plan pays Part B deductible and 20%	$0 for services covered by Medicare or for services not covered by Medicare	$0 if urgent or emergency care, or if services are coverable under Medicare policy in the U.S.	
Outpatient professional services outside the U.S.	Medicare pays nothing	Plan pays Part B deductible and 20% for services covered by Medicare Plan pays 20% of the allowable amount for services not covered by Medicare	$0 for services covered by Medicare, 80% for services not covered by Medicare	$0 if urgent or emergency care, 80% if services are coverable under Medicare policy in the U.S.	
Out-of-pocket maximum	Not applicable	Not applicable	Not applicable	$1,000[1] Includes all Part A and Part B services and Outpatient Professional services outside of the U.S. Excludes Private Duty Nursing.	
Other Considerations					
Prior authorization	Required for a limited set of services[2]	Claims for benefits are submitted first through Medicare, then through the Medicfill plan For outpatient professional services outside the U.S., services not covered by Medicare require approval for payment by the plan.		Required for a larger set of non-emergency services, with expedited reviews for urgent medical service/supply requests.	
Provider network	Any provider that accepts Medicare assignment	Any provider that accepts Medicare assignment		Any provider that accepts Medicare assignment and agrees to see patients enrolled in this MA plan. Out-of-network/non-contracted providers are under no obligation to treat MA plan members, except in emergencies.	

Adapted from proposed Highmark MA plan highlights sheet, available at https://dhr.delaware.gov/benefits/medicare/documents/ma-plan-highlights.pdf.
1 Applicable to any medical costs incurred by members during travel outside of the U.S., but which would otherwise be defined by Medicare as covered services.
2 Source: https://www.cms.gov/research-statistics-data-systems/medicare-fee-service-compliance-programs/prior-authorization-and-pre-claim-review-initiatives

Group Medicare Advantage – prior authorization requirements

- Purpose of a prior authorization
  - Mitigates the plan's utilization of expensive treatments and prescriptions by first requiring the plan participant to try a lower-cost alternative
  - Avoid potentially dangerous medication combinations
  - Avoid prescribed treatments and medications that a plan participant may not need or those that could be addictive
- Prior Authorization requirements are unique to the carrier, not the state or plan
  - e.g., a Medicare Advantage plan with Aetna in Colorado has the same prior authorization requirements as a different Medicare Advantage plan with Aetna in New York
- Medical Prior Authorization
  - Prior authorization ensures that services provided are reasonable relative to medically necessary standards
  - Plan participants have ability to appeal decisions
  - CMS sets standards for prior authorization and approvals of the prior authorization list submitted by the health plan to ensure there are minimal adverse effects to plan participants in order to receive a 4-star rating
    - Highmark has a 4-star rating – Aetna 3.5, Humana 4 and UHC 4
- Prescription Drug Prior Authorization
  - Since Medicare Part B covers a limited set of outpatient prescription drugs under certain conditions, the Medicare Advantage medical carrier may require re-certification or a prior authorization on some Part B drugs, however most carriers' transition of care processes include expedited review for Part B drugs (e.g., 24 hours or less) to allow for no gaps in care while certification is occurring
  - All other prescription drugs would be covered under the Medicare Part D Prescription Plan

Note: The major national carriers in the Group Medicare Advantage space are UnitedHealthcare, Humana, BCBS plans, and Aetna/CVS

Group Medicare Advantage – network access

- All major national carriers offer robust national networks for their group Medicare Advantage plans
- Under Medicfill, members have access to all providers who accept Medicare
- Under the Highmark MA plan (“Delaware Freedom Blue PPO plan”), members have access to all of those same providers, as indicated below:
  - If in the Highmark BCBS Medicare Advantage network, provider has agreed to Highmark’s reimbursement rate whether higher or lower than Medicare
  - If not in the Highmark BCBS Medicare Advantage network, provider can refuse care; however, the provider would be reimbursed at exactly the same rate as the Medicare approved amount (up to the Medicare limiting amount for providers that do not accept Medicare assignment)
- Highmark could provide a disruption analysis that would illustrate network provider access against the providers currently used by Medicfill plan participants

Group Health Insurance Plan (GHIP) Budget Setting Overview and FY24 Projections

Overview of GHIP projection data sources and methodology

Underlying Data

- Groups: Active employees and pre-65 retirees (Aetna/Highmark/CVS) and post-65 Medicare retirees (Highmark/CVS); includes State and non-Payroll groups including University of Delaware
- Headcount: Employees and dependents enrolled during experience period
- Utilizing data from vendor experience reports (claims, enrollment, rebates, Employer Group Waiver Plan (EGWP) payments) and DHR's monthly health fund report (expenses)
- 24 months of historical claims and enrollment reviewed for experience period (weighted 65% most recent 12-months)

Assumptions & Methodology

- Claims experience is combined for all groups (active, pre-65 retiree, Medicare retiree)
- Claims experience is adjusted to reflect:
  - Plan design, vendor, program, and/or network changes
  - Legislative changes
- Incurred but not reported (IBNR; also referred to as claim liability) factors adjust to an incurred basis, estimating the value of claims *incurred but not reported*
- Health care inflation factors, determined annually from marketplace and WTW survey data, and with approval from SEBC, project past claims into the future
- Offsets for prescription drug rebates and Medicare EGWP income reduce claims cost
- Health care administrative and legislative fees, including applicable ACA fees, are added to projected claims experience
- **Uniform rate action applied to all plans, including Medicfill – individual plan rates may not align with the underlying *actuarial value* of plan options**

Recommended best practice: rate active and retiree plans separately and set plan rates based on actuarial value of benefits

GHIP long term health care cost projections

March 2023 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	$1,236.2
9.4% rate increase FY24-FY26			*$78.8*	*$174.5*	*$281.0*	
Other Revenues[3]	$194.7	$183.3	$215.6	$221.1	$237.8	$257.5
Total Operating Revenues	**$1,034.4**	**$1,089.5**	**$1,209.7**	**$1,320.0**	**$1,452.4**	**$1,493.7**
GHIP Expenses						
Operating Expenses[4]	$1,029.6	$1,177.4	$1,238.1	$1,304.9	$1,392.9	$1,487.4
% Change Per Member	*2.1%*	*13.2%*	*4.1%*	*4.4%*	*5.7%*	*5.7%*
Adjusted Net Income	**$4.8**	**($87.9)**	**($28.4)**	**$15.1**	**$59.5**	**$6.3**
Balance Forward	$152.3	$157.2	$69.3	$40.9	$56.0	$115.5
Ending Balance	$157.2	$69.3	$40.9	$56.0	$115.5	$121.8
- Less Claims Liability[5]	$61.0	*$69.8*	*$73.4*	*$77.4*	*$82.6*	*$88.2*
- Less Minimum Reserve[5]	*$24.3*	*$27.8*	*$29.2*	*$30.8*	*$32.9*	*$35.1*
GHIP Surplus (After Reserves/Deposits)	**$71.9**	**($28.3)**	**($61.7)**	**($52.2)**	**$0.0**	**($1.5)**

See Appendix page 27 for footnotes

- Projections reflect all items voted on by SEBC as of March 6th, 2023 SEBC meeting and assume no additional program or legislative changes impacting GHIP spend
- Excludes potential impact of the Primary Care law (unknown if it will impact GHIP)
- Every 1% increase in healthcare trend (medical + Rx) will increase FY24 claims by $11.4M

See Appendix for detailed footnotes

GHIP long term health care cost projections

FY24 Projections by Actives, Pre-65, and Medicare

GHIP Costs ($ millions)[1]	FY24 Projection			
	Actives	Pre-65	Medicare	Total
Average Enrolled Members	92,543	10,922	29,290	**132,756**
GHIP Revenues				
Premium Contributions *(including 9.4% FY24 increase)*[2]	$720.8	$104.4	$168.8	**$994.1**
Other Revenues[3]	$71.1	$15.1	$129.4	**$215.6**
Total Operating Revenues	**$791.9**	**$119.5**	**$298.2**	**$1,209.7**
GHIP Expenses				
Operating Expenses[4]	$815.9	$149.0	$273.1	**$1,238.1**
Adjusted Net Income	**($24.0)**	**($29.5)**	**$25.1**	**($28.4)**

- Because the GHIP is a self-funded healthcare program, premium equivalent rates are established to generate the necessary revenues to fund the State's benefit obligations
- Premium revenues are determined and funded in aggregate to offset total projected expenses for the GHIP
- Premium equivalents for the GHIP apply uniform rate action to all plans and populations, including Medicfill
- Individual plan rates do not align with the underlying actuarial value of plan options
- **Premium equivalents/revenues therefore should only be used to measure underlying GHIP performance in aggregate, not by population**

See Appendix for detailed footnotes

GHIP long term health care cost projections

FY24 Projections by Actives, Pre-65, and Medicare

GHIP FY24 Costs ($ millions)	Net Operating Expenses[1]	Employee/Pensioner Contributions	Percentage Covered by Contributions
GHIP Total	$1,022.5	$96.0	9%
Pre-Medicare Retirees	$133.9	$11.1	8%
Medicare Retirees/Pensioners	$143.7	$6.7[2]	5%
Active Employees	$744.8	$78.2	10%

1 Net operating expense = claims and fees less offsetting revenues (e.g., rebates and EGWP subsidies)
2 Medicare contributions based on February 2023 actuals, annualized, as provided by DHR; amounts shown adjusted to FY24

- Plan participants fund healthcare expenses in two ways: premium contributions and out-of-pocket expenses
- Premium contributions are calculated as fixed percentages of the premium equivalent rates, varying based on plan election, coverage tier, and years of service/date of retirement for Medicare pensioners
- Actives (10%) and pre-65 retirees (8%) contribute a greater share of their expenses via premium contributions than Medicfill retirees (5%), with approx. 65% of Medicfill retirees paying $0 in premium contributions for their supplemental coverage as of Feb. 2023
  - However, Medicare retirees pay Part B premium ($164.90 per month for 2023)
- Medicfill also covers nearly 100% of expenses not covered by traditional Medicare, while active and pre-65 retirees are responsible for higher cost sharing at the point of care via deductibles, copays and coinsurance for their state-sponsored coverage
  - Annual medical out-of-pocket expense: $26.3M active employees, $3.1M pre-65 retirees, $5K Medicfill
  - Based on Merative reporting, incurred claims December 2021 – November 2022

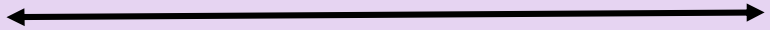
Individual Marketplace Overview and Plan Comparison

Individual Medicare marketplace overview

Medigap (Medicare Supplement) plans

Sample of Medicap plans offered:

Lower Premium,
Higher Cost at Point of Care



Higher Premium,
Lower Cost at Point of Care

Plan K

Benefits include 50% of Part A deductible and 50% coinsurance for most services after Part B deductible ($226 in 2023)

Plan N

Benefits include office visit copay of $20, ER copay of $50 and Part B deductible ($226 in 2023). All other Medicare covered services covered at 100%

Plan G

Benefits offer 100% coverage for all Medicare covered services after Part B deductible ($226 in 2023)

\+ **Stand alone Medicare Part D prescription drug plan (PDP)**

Medicare Advantage + Prescription Drug Plans (MAPD)

HMO

Must use network providers and may require a referral. Costs and plan designs vary.

PPO

Can use network or non-network providers and no referrals. Costs and plan designs vary.

Availability of plans/carriers in Delaware:

- 8 Medigap plans (2 carriers)
- 18 Part D PDPs (6 carriers)
- 20 Medicare Advantage plans (7 carriers)

Availability of plans/carriers for all State Medicare retirees:

- 23 Medigap plans (3 carriers)
- 20 Part D PDPs (7 carriers)
- 35 Medicare Advantage plans (8 carriers)
- 98% have access to Medigap plans, 96% have access to a $0 Medicare Advantage plan

Comparison of Plan Designs (Medical, member cost-share)
Medicfill, Proposed Highmark MA, and Individual Medicare Supplement Plans (2023)

		GHIP Medicfill	Proposed Highmark MA	Medigap K	Medigap N	Medigap G
Medicare Part A Services	Deductible	$0	$0	$800	$0	$0
	Inpatient hospital copays	$0	$0	$0	$0	$0
	Skilled nursing facility copays	$0	$0	50%	$0	$0
Medicare Part B Services	Deductible	$0	$0	$226	$226	$226
	Plan coinsurance	$0	$0	50%	Copays	$0
	Physician office visit copays	$0	$0	50%	$20	$0
	Emergency room copays	$0	$0	50%	$50	$0
Out of pocket maximum		N/A	$1,000[1]	$6,940	N/A	N/A

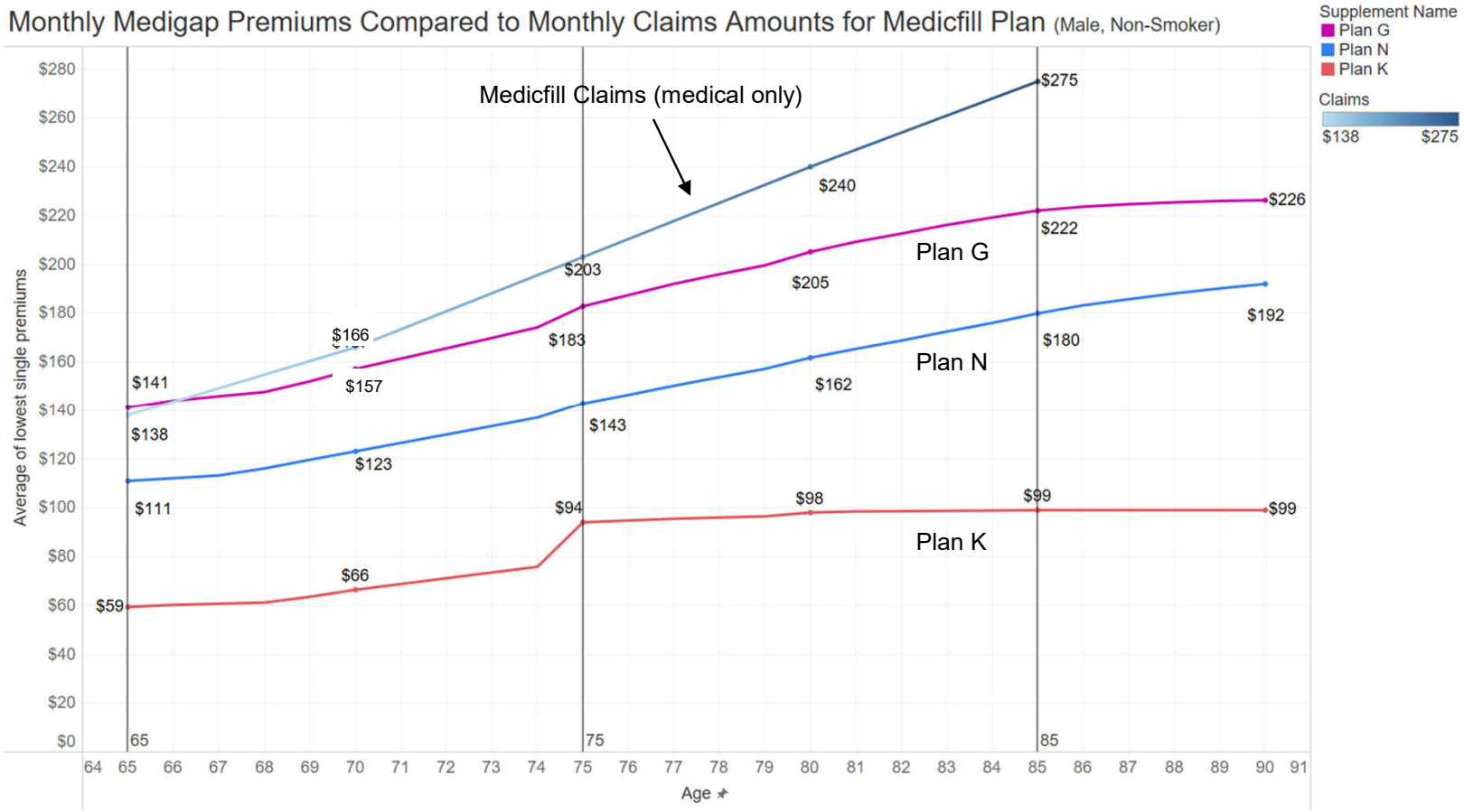
- Individual Medicare Supplement plan designs are standardized across carriers/geographies
- Employer-sponsored group plans like Medicfill and Highmark MA have more flexibility in plan design provisions

1 Applicable to any medical costs incurred by members during travel outside of the U.S., but which would otherwise be defined by Medicare as covered services.

Comparison of Plan Costs (Medical)

Medicfill cost by age relative to individual Medicare Supplement premiums

- Medicfill is a self-funded plan; the cost to the state is the claims and administrative fees
- Marketplace plans are insured; the cost to the state (or participants) is the insured premium rate, inclusive of taxes, risk margin, and profit loads not applicable to self-funded plans
- This graph compares the age-adjusted medical claims cost of Medicfill (males only) by age[1] for FY23 to average premiums for individual market[2] Medicare Supplement Plans G, N and K based on where DE retirees reside
- Individual market Medicare Supplement plan premiums vary by plan selected, zip code, and age



1 Source of Medicfill cost by age: State of Delaware Postretirement Health Plan Actuarial Valuation Report as of July 1, 2022 (Produced by Cheiron, November 2022)
2 Marketplace premiums based on average of Lowest Monthly Medigap Premiums by Age for 2023 across DE footprint; DE footprint reflects Medicfill enrollment by zip code from January 2023 census provided by Merative

Comparison of Plan Designs and Premiums

Individual Medicare Advantage (MA) plans in Delaware

Medicare Advantage Plan Name	Monthly Premium	Deductible	PCP Office Visit Copay	Specialist Office Visit Copay	ER Copay	Out of Pocket Maximum	Includes Rx Coverage?
State of Delaware Highmark MA Plan (Medical only)	$0	$0	$0	$0	$0	$1,000[1]	No – separate EGWP
Humana Choice H5216-312 (PPO)	$0	$750	$0	$20	$125	$3,650	Yes
Freedom Blue PPO Distinct (PPO)	$33	$0	$0	$0	$95	$5,500	Yes
Aetna Medicare Value (PPO)	$0	$1,000	$10	$50	$95	$7,550	Yes
Aetna Medicare Advantra Value (HMO-POS)	$0	$0	$10	$40	$95	$6,700	Yes
AARP Medicare Advantage (HMO-POS)	$0	$0	$0	$25	$90	$4,500	Yes
AARP Medicare Advantage Choice Plan 1 (PPO)	$0	$0	$0	$35	$90	$5,900	Yes
Freedom Blue PPO Signature (PPO)	$0	$0	$0	$30	$95	$6,700	Yes
Aetna Medicare Premier Plus (HMO)	$65	$0	$0	$40	$95	$7,550	Yes
HumanaChoice H5216-308 (PPO)	$0	$885	$0	$45	$95	$8,300	Yes
Cigna True Choice Medicare (PPO)	$0	$0	$0	$35	$95	$7,000	Yes
AARP Medicare Advantage Choice Plan 2 (PPO)	$29	$0	$0	$20	$90	$5,700	Yes
Humana Gold Plus H6622-010 (HMO-POS)	$0	$0	$0	$25	$125	$3,650	Yes
Aetna Medicare Premier Plus (PPO)	$67	$50	$10	$40	$95	$7,550	Yes
HumanaChoice H5216-029 (PPO)	$69	$265	$15	$45	$95	$7,550	Yes
Cigna Preferred Medicare (HMO)	$0	$0	$0	$30	$110	$4,200	Yes
Aetna Medicare Elite (HMO-POS)	$0	$1,600	$30	$50	$95	$7,550	Yes

- MAPD PPO and HMO plans vary in premium cost and plan design; no age rating – carriers are not permitted to vary premiums by age
- Several $0 premium individual MAPD plans available in Delaware
- The State of Delaware Highmark MA plan is more generous than the medical portion of MAPD plans available in marketplace

1 Applicable to any medical costs incurred by members during travel outside of the U.S., but which would otherwise be defined by Medicare as covered services.

Illustrative comparison of retiree costs (annual)

Sample enrollee – Medicfill compared to individual marketplace

50th Percentile

50% of individuals will have lower claims/premiums/ contributions than the illustration shown here

		Select Individual Market Options				
	GHIP Medicfill	**Medigap K**	**Medigap G**	**Medigap N**	**MAPD 1**	**MAPD 6**
Sample Retiree Financials						
Retiree Premium Contribution* at 50th percentile	$0-$276	$1,074	$2,378	$2,043	$0	$0
Out-of-pocket costs						
Medical at 50th percentile	$0	$540	$226	$277	$687	$493
Rx at 50th percentile	$393	$604	$604	$604	$604	$604
Total out-of-pocket cost	$393	$1,145	$830	$881	$1,291	$1,097
Total Retiree Cost	**$393 - $669**	**$2,219**	**$3,208**	**$2,924**	**$1,291**	**$1,097**
State Contribution**	**$4,900**	**-**	**-**	**-**	**-**	**-**

Note: comparison excludes Part B premium (would be paid by retiree under all plans shown)

* Medicfill contribution assumes 100% state share. 65% of Medicfill retirees receive 100% state share and pay $0 contribution (as of Feb. 2023)

**State contribution based on projected FY24 net operating expenses for Medicfill (claims and fees less rebates and EGWP subsidies); assumes 100% state share

Sample Illustration Statistics: 50th percentile claims, 50th percentile geography, 50th percentile premium. Does not reflect future changes to Part D cost sharing under Inflation Reduction Act (e.g., $2,000 cap on participant prescription drug out-of-pocket expenses)

Appendix

GHIP long term health care cost projection footnotes

Note: FY17-FY22 actuals based on final June Fund Equity reports for respective fiscal year; FY23+ projected operating expenses and enrollment based on experience through December 2022 (claims experience updated based on OMB weekly claims analysis through February 2023); assumed 1% annual enrollment growth; numbers in table may not add up due to rounding

1. FY23-FY27 projections based on 5% medical, 8% pharmacy baseline trend (Medicfill trend 3% medical/8% Rx); assumes 1% annual growth in GHIP membership; assumes Medicfill plan remains in place FY23-FY27 at CY22 premium rates
2. Includes State and employee/pensioner premium contributions; assumes 1% annual enrollment growth for FY23-FY27
3. Includes Rx rebates, EGWP payments, other revenues based on when revenues will be received; FY23 and beyond includes estimated improvements in Rx rebates based on result of PBM award to CVS Health; rebates assumed to be paid 60 days after the quarter adjudicated; includes fees for participating non-State groups (assumed to increase proportionally with membership and premium growth)
4. FY23 and beyond includes estimated reduction in pharmacy claims as a result of PBM award to CVS Health; reflects FY24 savings initiatives voted on by SEBC as of most recent SEBC meeting, including Hinge Health ($4M savings), bariatric surgery carve-out to SurgeryPlus ($1M savings), CVS Transform Diabetes Care and Drug Savings Review ($1.5M savings), Prudent Rx ($6.6M savings), increases in hospital outpatient surgery, hospital based high-tech imaging and Rx copays ($0.8M cumulative savings); reflects cost increases associated with House Bill 303 ($2.4M annual cost effective 1/1/24) and weight loss medication coverage with utilization management ($1.8M annual cost effective FY24); excludes impact of the Primary Care law (unknown if it will impact GHIP)
5. Minimum Reserve and Claim Liability updated for FY23; reserves in future years assumed to increase with overall GHIP claims growth

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

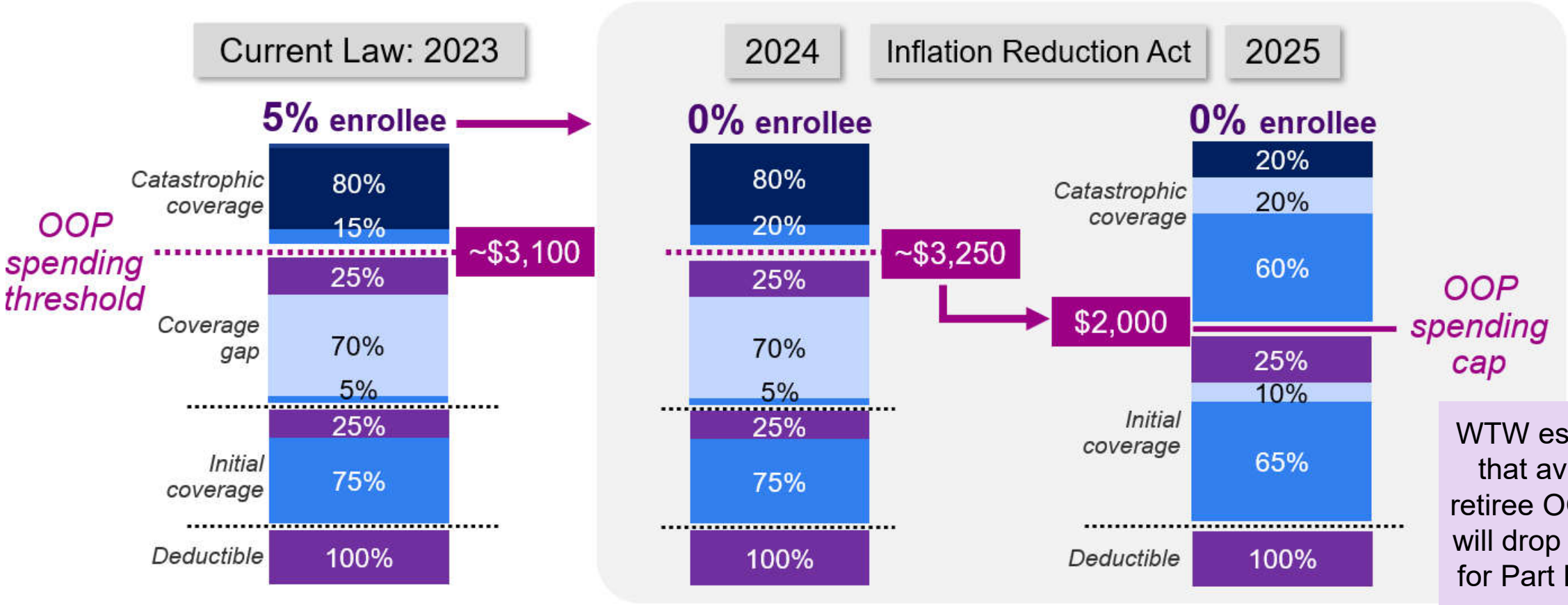
Individual Medicare marketplace overview

Impact of Inflation Reduction Act

2023-2025	2024	2025	Later
Extends the ARPA-enhanced ACA marketplace subsidies for eligible individuals (does not directly impact Medicare retirees)	Eliminate 5% catastrophic coinsurance for Part D	Caps retiree prescription drug out-of-pocket expenses under Part D at $2,000	Allows Medicare to negotiate prices for a limited number of drugs and caps insulin copays and implements manufacturer rebates when price increases exceed a threshold and reduces cost of insulin and adult vaccines

Individual Medicare marketplace overview – Part D Plan impact

Share of **brand-name drug costs** paid by: Enrollees Part D Plans Drug Manufacturers Medicare



WTW estimates that average retiree OOP cost will drop by 25% for Part D plans

NOTE: Slide from KFF. OOP is out-of-pocket. The out-of-pocket spending threshold will be $7,400 in 2023 and is projected to be $7,750 in 2024 and $8,100 in 2025, including what beneficiaries pay directly out-of-pocket and the value of the manufacturer discount on brand-name drugs in the coverage gap phase. These amounts translate to out-of-pocket spending of approximately $3,100, $3,250, and $3,400 (based on brand-name drug use only).