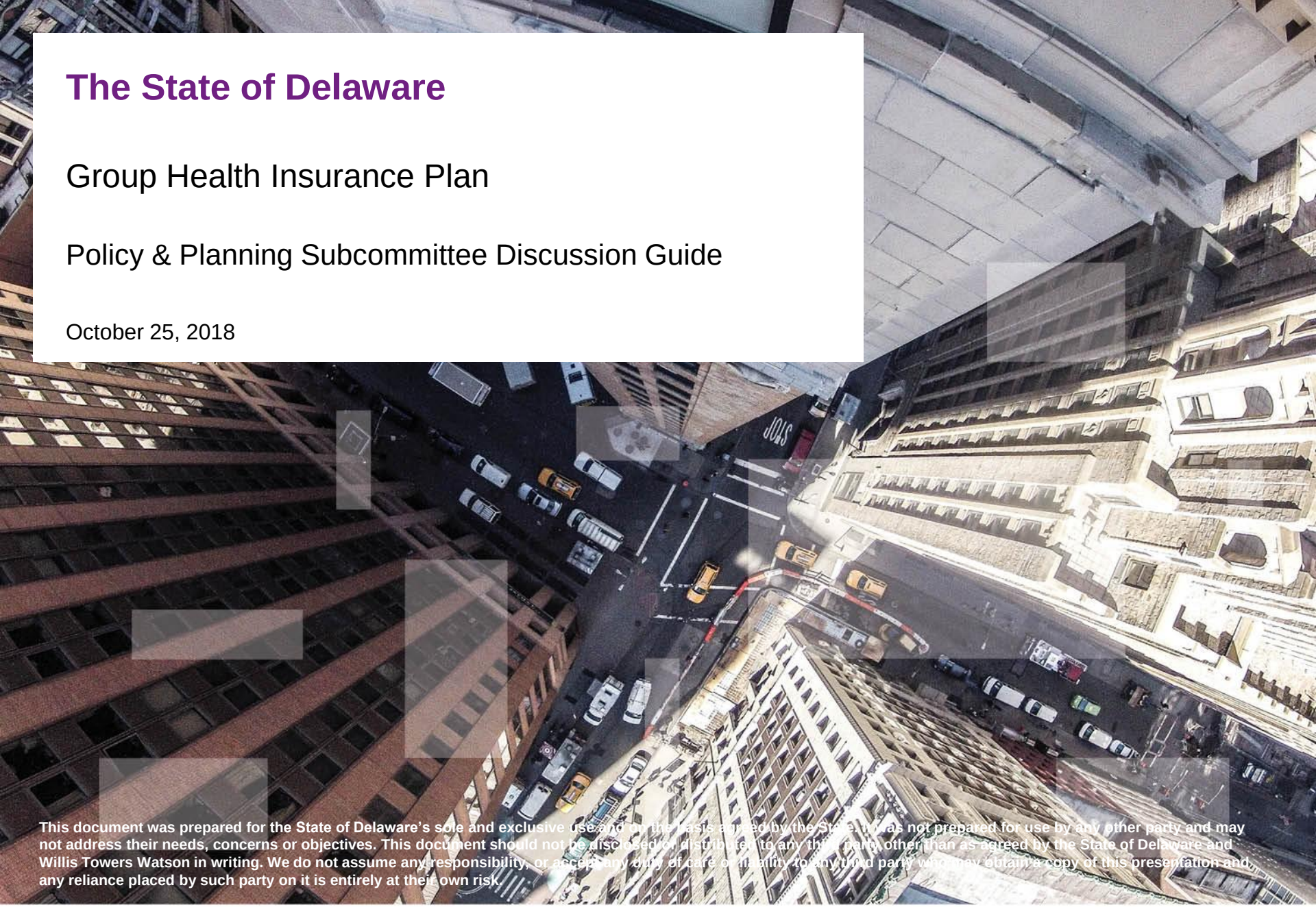
The State of Delaware

Group Health Insurance Plan

Policy & Planning Subcommittee Discussion Guide

October 25, 2018

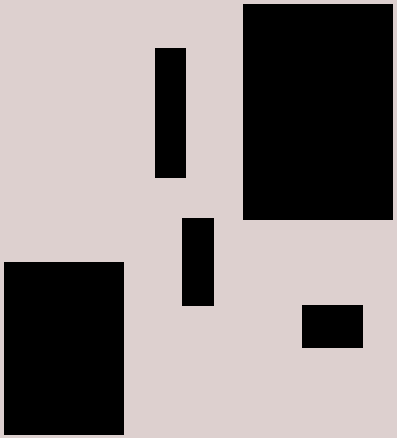


Willis Towers Watson

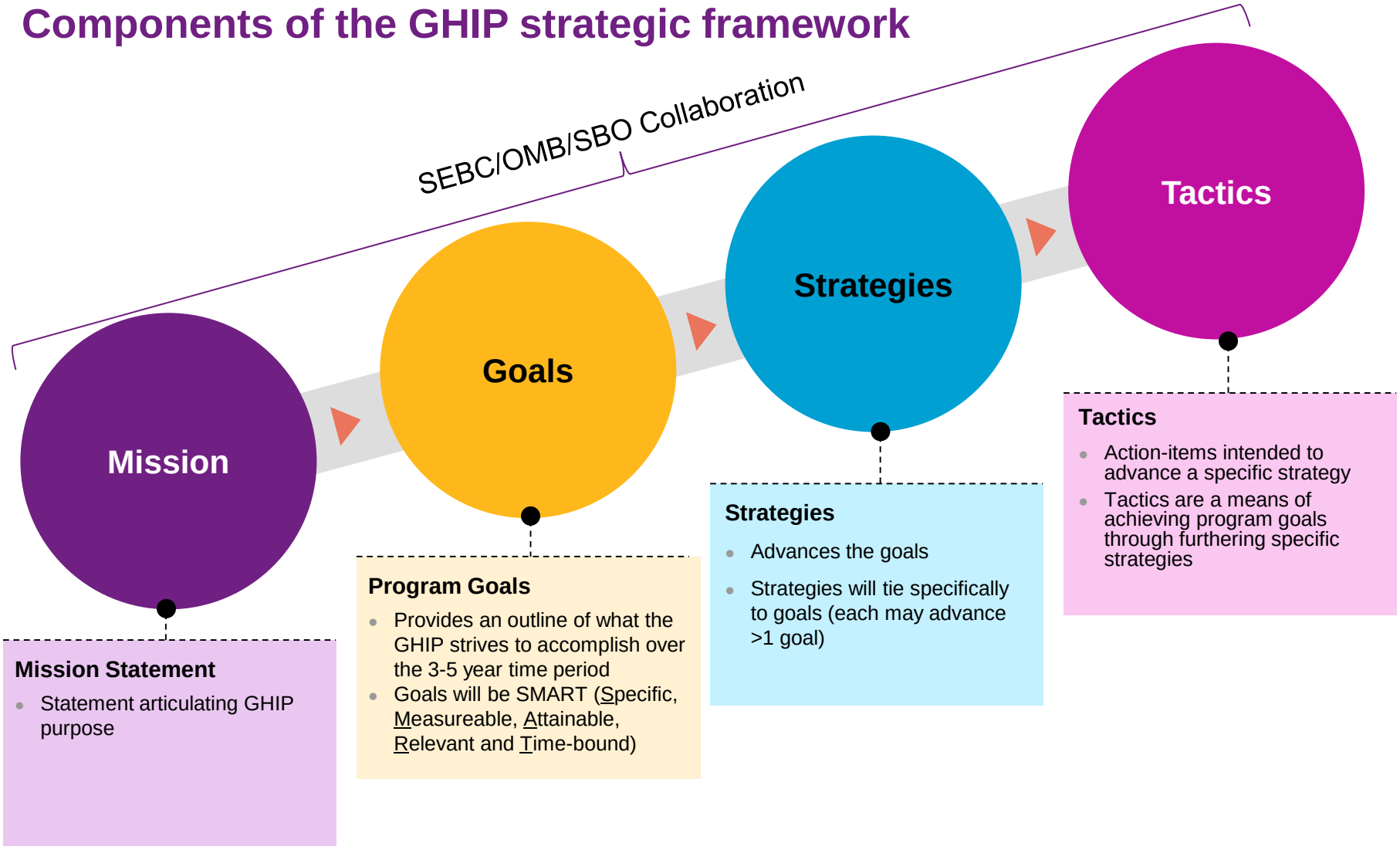
Today's discussion

- Overview of GHIP planning discussions with the SEBC
- FY20 Planning – Short term opportunities
- Next steps

Overview of GHIP planning discussions with the SEBC



Components of the GHIP strategic framework



Mission Statement

- Statement articulating GHIP purpose

Program Goals

- Provides an outline of what the GHIP strives to accomplish over the 3-5 year time period
- Goals will be SMART (Specific, Measureable, Attainable, Relevant and Time-bound)

Strategies

- Advances the goals
- Strategies will tie specifically to goals (each may advance >1 goal)

Tactics

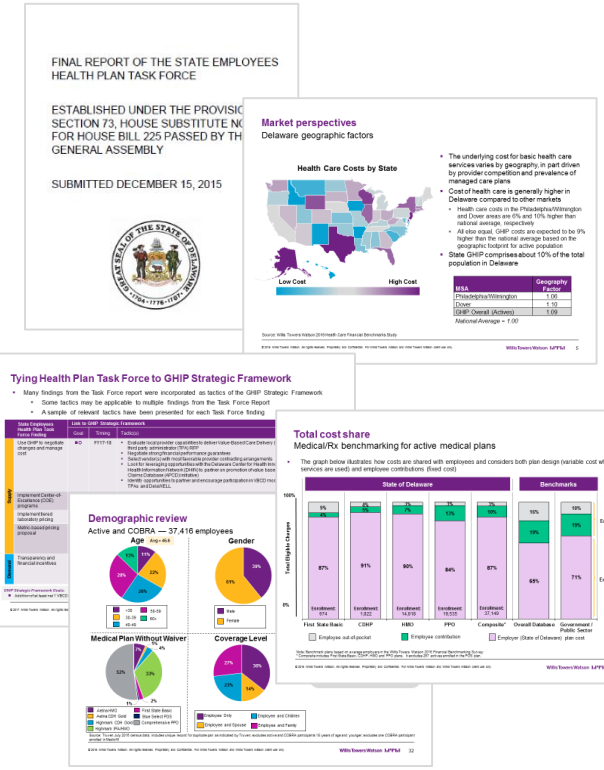
- Action-items intended to advance a specific strategy
- Tactics are a means of achieving program goals through furthering specific strategies

Final strategic framework including all four components above was approved by the SEBC in December 2016

“Primary inputs” for the GHIP strategic framework

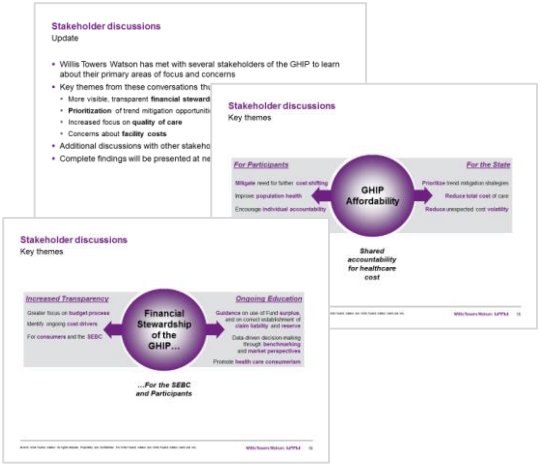
Fact-Finding

- Health Plan Task Force report
- “Current state assessment” based on recent demographics, plan experience and population health



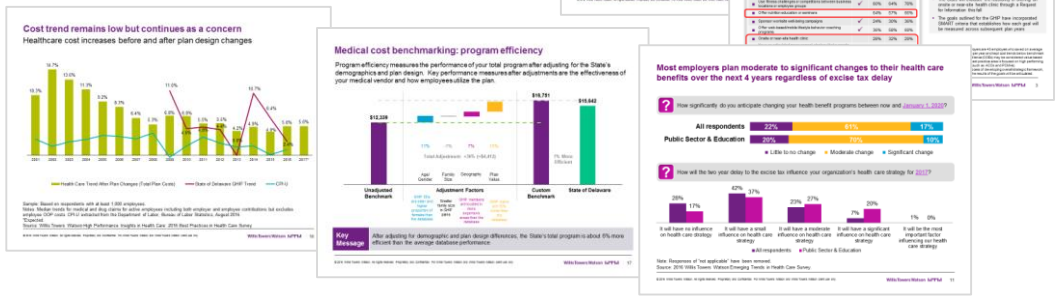
Stakeholder discussions

- Met with various stakeholders to learn primary areas of focus and concern, including:
  - Controller General / elected officials
  - Treasurer
  - Chief Justice
  - Health and Social Services



Market Perspectives

- Leverage survey data to identify employer best practices
- Utilize peer benchmarking to assess competitive position



Health Plan Task Force report

Summary and organization of findings

- Feedback from stakeholder discussions included a desire to leverage the findings from the Health Plan Task Force report along with the need to prioritize those findings
- Findings were incorporated into the GHIP strategic framework using a construct that resonated with the SEBC during the framework development process, i.e., concept of health care cost as a function of both supply and demand
- Findings were bucketed into supply-related health care and demand-related health care
  - Supply-related health care: Focus on smarter production of care (i.e., network modifications, utilization of value-based care models, on-site clinics)
  - Demand-related health care: Focus on smarter consumption of care (i.e., use of consumer-driven plans, utilization of transparency tools, plan design diversity)

Supply
Use GHIP to negotiate changes and manage cost
Implement Center-of-Excellence programs
Implement tiered laboratory pricing
Metric-based pricing proposal

Demand
Transparency and financial incentives
Pilot of high cost procedures of diagnostic tests
Benchmarking
Incentivize member cost accountability
Increase member participation and engagement and reduce cost and risk
Validate number of plan offerings
Health plan audits
Implementation of special vendor programs

Supply Demand

Summarization of findings from Section V of the Health Plan Task Force Report, dated December 15, 2015.

GHIP mission statement

Approved by the SEBC in December 2016

Offer State of Delaware employees, retirees and their dependents adequate access to high quality healthcare that produces good outcomes at an affordable cost, promotes healthy lifestyles, and helps them be engaged consumers.

GHIP goals – current and proposed

Tied to the GHIP mission statement

Mission Statement:

Offer State of Delaware employees, retirees and their dependents ***adequate access*** *to* ***high quality healthcare that produces good outcomes…***

Goals:

- ✓ Addition of at least net 1 value-based care delivery (VBCD) model by end of FY2018

New Proposed:

- Reduction of GHIP diabetic cost per-member-per-month (PMPM) by 5% by the end of FY2021

at an ***affordable cost****…*

- Reduction of gross GHIP medical and prescription drug trend by 2% by end of FY2020[1]

promotes ***healthy lifestyles,*** *and helps them be* ***engaged consumers.***

- GHIP membership enrollment in a consumer-driven or value-based plan exceeding 25% of total population by end of FY2020[2]

New Proposed:

- Incremental increase to unique users engaged in a specific consumerism tool by at least 5% annually

[1] Gross trend is inclusive of total increase to GHIP medical plan costs (both "employer" and "employee") and will be measured from a baseline average trend of 6% (based on a blend of the State's actual experience and Willis Towers Watson market data).

[2] Note: To drive enrollment at this level, the State will need to make plan design and employee contribution changes that may require changes to the Delaware Code.

GHIP strategies – linked to GHIP goals

Framework for the health care marketplace

	Health Care Services	Health Status of the Population
Providers	**Provider Care Delivery** ■ Continue to support medical TPAs' efforts to contract with providers on a "pay-for-value" basis ■ Continue to support the DHIN, including encouraging medical TPAs' participation, and other data-driven approaches to provider care delivery ○ Continue managing medical TPA(s)	**Provider-led Health and Wellness Initiatives** ■ Leverage community-based diabetes prevention programs and hospital-based health & wellness classes ○ Continue managing medical TPA(s)
Participants	**Participant Care Consumption** ○ Implement changes to GHIP medical plan options and price tags ▲ Ensure members understand benefit offerings and value provided ▲ Promote price and quality transparency tools ▲ Offer meaningfully different medical plan options to meet the diverse needs of GHIP participants, and targeted programs to support special needs ■ Ensure members are aware of how to find high quality, high value providers	**Participant Engagement in Health and Wellness** ○ Offer and promote resources that will support member efforts to improve and maintain their health ▲ Drive GHIP members' engagement in their health ■ Encourage member awareness and usage of diabetes self-care resources and lifestyle risk reduction programs

Group Health Insurance Program

Goals:

New Proposed:

■ Reduction of GHIP diabetic cost per-member-per-month (PMPM) by 5% by the end of FY2021

○ Reduction of gross GHIP medical and prescription drug trend by 2% by end of FY2020[1]

▲ GHIP membership enrollment in a consumer-driven or value-based plan exceeding 25% of total population by end of FY2020[2]

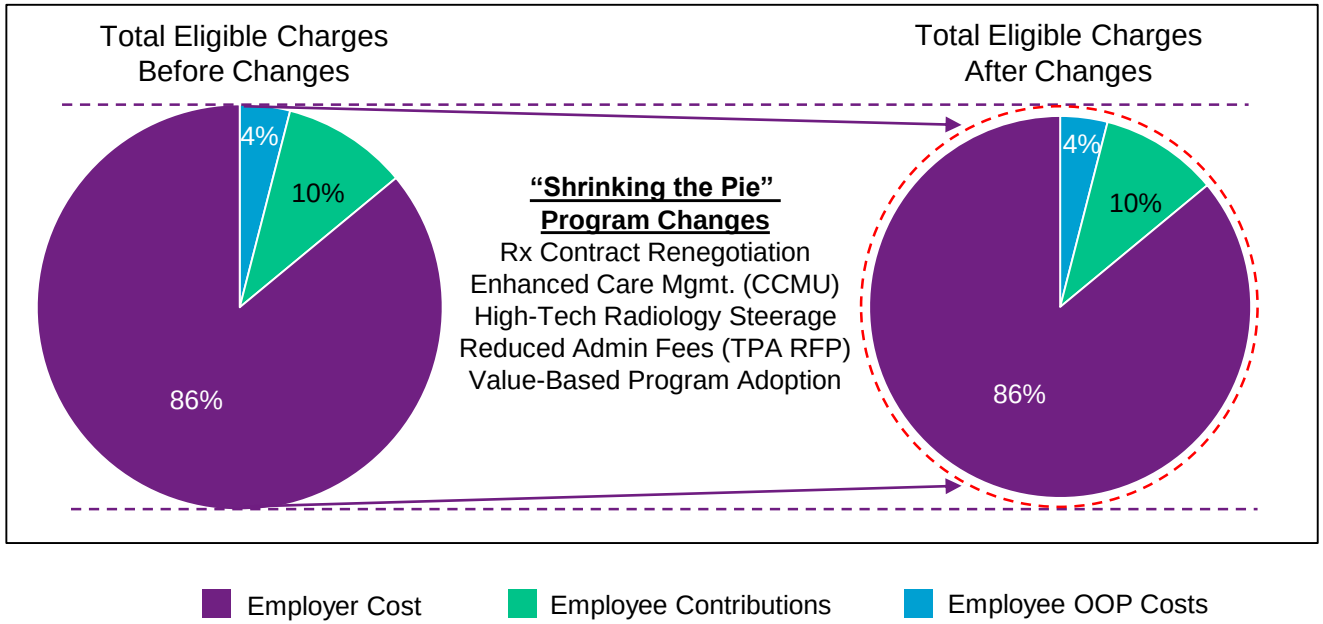
New Proposed:

▲ Incremental increase to unique users engaged in a specific consumerism tool by at least 5% annually

Supply Demand

“Shrinking the pie”

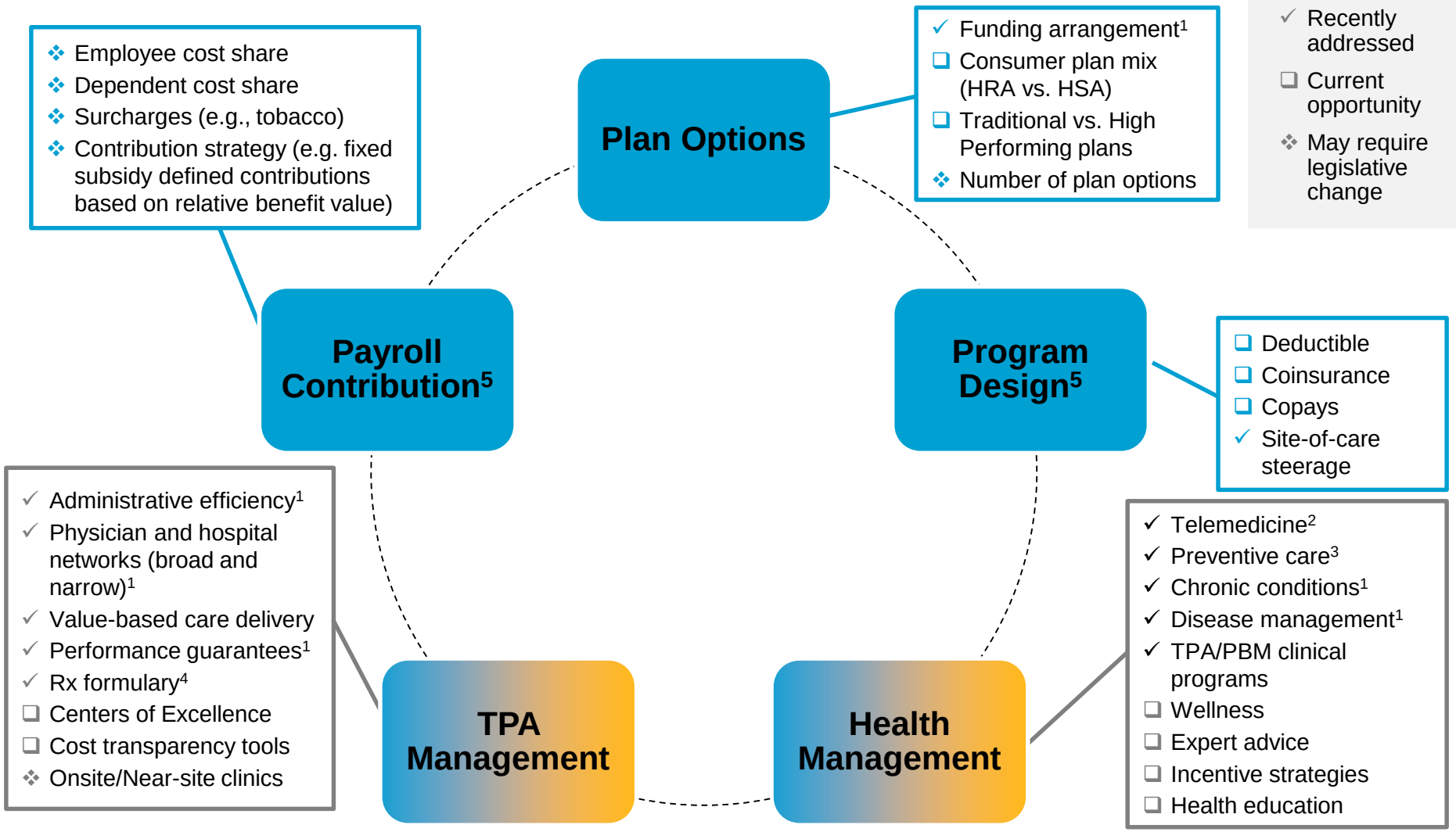
- Linked to mission statement’s emphasis on providing adequate access to high quality healthcare at an **affordable cost**
- Tactics implemented by the SEBC to-date have been largely focused on improving the efficiency of the GHIP program – to “shrink the pie” or take money out of the system
  - Efficiency can be achieved by shifting how and where members utilize services, changing how providers and payers are reimbursed, and/or improving the overall health of the GHIP population
  - Reduces the overall cost for the GHIP (both State and members covered under the plan) without necessarily reducing the value of the benefits provided to members



Size of above cost charts shown as illustrative. Impact of general health care inflation not shown.

GHIP influencing levers

Tactics for affecting change and "shrinking the pie"



[1] Medical TPA RFP conducted in FY17.
[2] Implemented effective 7/1/16.
[3] Covered at 100% plan paid in network.
[4] Updated quarterly by Express Scripts.
[5] Tactics for affecting change in these categories may increase employee/pensioner share, with the goal of shrinking the pie overall

Multi-year framework – *initial set of tactics*

Goal	To prepare for 2018 and beyond (7/1/16 – 6/30/2017)	To prepare for 2019 and beyond (7/1/17 – 6/30/2018)	To prepare for 2020 and beyond (7/1/18 – 6/30/2019)
Addition of at least 1 value-based care delivery (VBCD) model by end of FY2018	• *Evaluate local provider capabilities to deliver VBCD models via medical third party administrator (TPA) RFP* • *State-sponsored Health Clinic Request for Information (RFI)* • *Implementation of VBCD models from RFP (including COEs)* • *Evaluation of clinical data to implement more value-based chronic disease programs* • *Promote medical plan TPAs' provider cost/quality transparency tools*	• *Implementation of VBCD models from RFP (including COEs)* • *Look for leveraging opportunities with the DCHI and DHIN to partner on promotion of value based networks (including APCD initiative)* • *Identify opportunities to partner and encourage participation in VBCD models using outside vendors, TPAs and DelaWELL* • *Educate GHIP population on other provider quality tools from CMS, Health Grades, Leapfrog, etc.*	• *Continue to monitor and evaluate VBCD opportunities*
Reduction of gross GHIP medical and prescription drug trend by 2% by end of FY2020	• Negotiate strong financial performance guarantees • *Select vendor(s) with most favorable provider contracting arrangements* • *Select vendor(s) that can best manage utilization and population health* • *Evaluate bidder capabilities surrounding Centers of Excellence via medical TPA RFP* • *Educate GHIP members on the importance of preventive care and the State's preventive care benefits (covered at 100% in-network)* • *Evaluate vendor capabilities surrounding UM/DM/CM* via medical TPA RFP* • Evaluate feasibility of reducing plan options and/or replacing copays with coinsurance* • *Educate GHIP members on lower cost alternatives to seek care outside of the emergency room (i.e., telemedicine, urgent care centers, retail clinics)* • *Evaluate incentive opportunities through incentive-based activities and/or challenges* • Change certain plan inequities, e.g., double state share and Medicfill subsidy*	• *Explore and implement medical TPA programs, such as tiered pricing for lab services, high cost radiology UM* and other medical and Rx UM programs, where necessary* • *Explore avenues for building "culture of health" statewide* • *Continuation of education of GHIP members on the importance of preventive care and the State's preventive care benefits (covered at 100% in-network)* • *Continuation of education of GHIP members on lower cost alternatives to seek care outside of the emergency room (i.e., telemedicine, urgent care centers, retail clinics)* • Continuation of the evaluation of feasibility of reducing plan options and/or replacing copays with coinsurance—based on emerging market and value-based design*	• *Explore and implement medical TPA programs, such as tiered pricing for lab services, high cost radiology UM* and other medical and Rx UM programs, where necessary* • *Continuation of education of GHIP members on the importance of preventive care and the State's preventive care benefits (covered at 100% in-network)* • *Continuation of education of GHIP members on lower cost alternatives to seek care outside of the emergency room (i.e., telemedicine, urgent care centers, retail clinics)* • Continuation of the evaluation of feasibility of reducing plan options and/or replacing copays with coinsurance—based on emerging market and value-based design*
GHIP membership enrollment in a consumer-driven or value-based plan exceeding 25% of total population by end of FY2020	• *Launch healthcare consumerism website* • *Roll out and promote SBO consumerism class to GHIP participants* • Evaluate recommendations for creative ways to drive engagement and participation in consumer driven health plans via medical TPA RFP through leveraging vendor tools and technologies	• *Offer a medical plan selection decision support tool (e.g., Truven's "My Benefits Mentor" tool)* • *Promote cost transparency tools available through medical TPA(s)* • *Evaluate feasibility of offering incentives for engaging in wellness activities*	• Change medical plan designs and employee/retiree contributions to further differentiate plan options* • Change the number of medical plans offered*

*May require changes to the Delaware Code.

Blue italicized text denotes tactic for "shrinking the pie".

GHIP tactics – *proposed*

To prepare for 2020 and beyond (7/1/2018 – 6/30/2019)

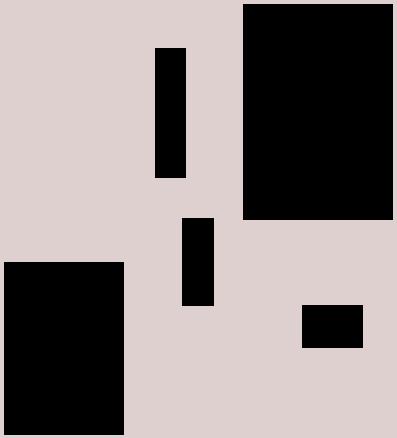
	New Proposed:			*New Proposed:*
Addition of at least net 1 VBCD model by end of FY2018	**Reduction of GHIP diabetic cost per-member-per-month (PMPM) by 5% by the end of FY2021**	**Reduction of gross GHIP trend by 2% by end of FY2020**	**Enrollment in a CDHP or value-based plan >25% by end of FY2020**	**Incremental increase in users engaged in consumerism tool by ≥ 5% annually**
▪ *Continue to monitor and evaluate VBCD opportunities*	▪ Measure baseline diabetes prevalence and cost ▪ *Explore and implement ways to further promote cost transparency tools to support member decisions about the providers they choose* ▪ *Continue to promote health care consumerism and member education* ▪ *Explore opportunities to expand access to primary care for GHIP participants (e.g., employer-sponsored health care, more intensive telehealth care)* ▪ *Continue to hold medical TPAs accountable for expanding their pay-for-value contracts with providers* ▪ Continue to require medical TPAs to submit GHIP claim data to the DHIN and other value-based contracts (e.g., ACOs) where applicable	▪ *Explore and implement medical TPA programs, such as tiered pricing for lab services, high cost radiology utilization management (UM) and other medical and Rx UM programs, where necessary* ▪ *Continuation of education of GHIP members on the importance of preventive care and the State's preventive care benefits (covered at 100% in-network)* ▪ *Continuation of education of GHIP members on lower cost alternatives to seek care outside of the emergency room (i.e., telemedicine, urgent care centers, retail clinics)* ▪ Continuation of the evaluation of feasibility of reducing plan options and/or replacing copays with coinsurance—based on emerging market and value-based design*	▪ Change medical plan designs and employee/retiree contributions to further differentiate plan options* ▪ Change the number of medical plans offered*	▪ *Continue promoting cost and quality transparency tools* ▪ *Consider incentives to drive additional utilization of cost and quality transparency tools* ▪ Strongly encourage active participation in the FY20 open enrollment period for active employees and non-Medicare eligible retirees

*May require changes to the Delaware Code.

Blue italicized text denotes tactic for "shrinking the pie".

FY20 Planning

Opportunities for Discussion



GHIP influencing levers

Confirming priorities & evaluating trade-offs

Influencer Lever	Range of Focus		
Plan Options	**Limited choice, traditional designs**	**Areas of consideration:** Funding arrangement, consumer plan mix (HRA vs. HSA), traditional vs. high performing plans, number of options	**Significant choice, curation of designs**
Program Design	**Limited member out-of-pocket exposure**	**Areas of consideration:** modifications for deductibles, coinsurance, copays, changes to steerage in site-of-care	**Highly encourages consumerism**
Health Management	**"Carrot" or incentive approach**	**Areas of consideration:** Sites-of-care (PCP, telemedicine), focus on chronic conditions, disease management, clinical conditions, wellness, incentive strategies	**"Stick" or penalty approach**
TPA Management	**At the market/ "Tried and true"**	**Areas of consideration:** Administration of program, physician and hospital networks, value-based care delivery, Rx formulary, COEs, transparency tools	**Lead the market/ Disruptive or untested**
Payroll Contribution	**Status quo**	**Areas of consideration:** Employee cost share, dependent cost share, surcharges, contribution strategy (i.e., pricing equity or defined contribution)	**Alignment with actuarial value and desired behavior**

Supply

Demand

GHIP long term health care cost projections

Illustrative: Increase premium rates by 2% annually starting in FY20

GHIP Costs ($ millions)	FY17 Actual	FY18 Actual	FY19 Projected[1]	FY20 Projected[6]	FY21 Projected[6]	FY22 Projected[6]	FY23 Projected[6]
Average Enrolled Members	123,132	125,488	127,350	129,897	132,495	135,145	137,848
GHIP Revenue							
Premium Contributions (Increasing with Enrollment)[2]	$799.0	$810.9	$817.1	$833.4	$850.1	$867.1	$884.4
2.0% Annual Premium Increase Starting FY20	-	-	-	*$16.7*	$34.1	$52.9	$72.8
Other Revenues[3]	$81.6	$92.1	$91.7	$98.0	$105.0	$112.5	$120.5
Total Operating Revenues	**$880.6**	**$903.0**	**$908.8**	**$948.1**	**$989.2**	**$1,032.5**	**$1,077.7**
GHIP Expenses (Claims/Fees)							
Operating Expenses (No Change)	$816.8	$853.9	$932.1	$999.7	$1,070.7	$1,146.7	$1,228.1
% Change Per Member		*2.6%*	*7.6%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*
Excise Tax Liability[4]						$9.1	$16.3
Adjusted Net Income (Revenue less Expense)	**$63.8**	**$49.1**	**($23.3)**	**($51.6)**	**($81.5)**	**($123.3)**	**($166.7)**
Balance Forward	$38.9	$102.7	$151.8	$128.5	$76.9	($4.6)	($127.9)
Ending Balance	$102.7	$151.8	$128.5	$76.9	($4.6)	($127.9)	($294.6)
- Less Claims Liability[5]	*$54.0*	*$58.9*	*$61.3*	*$65.7*	*$70.4*	*$75.4*	*$80.8*
- Less Minimum Reserve[5]	*$24.0*	*$24.0*	*$24.3*	*$26.1*	*$28.0*	*$30.0*	*$32.1*
GHIP Surplus (After Reserves/Deposits)	**$24.7**	**$68.9**	**$42.9**	**($14.9)**	**($103.0)**	**($233.3)**	**($407.5)**

Note: FY17 Actual based on final June 2017 Fund Equity report; FY18 Actual based on final June 2018 Fund Equity report; FY19 enrollment as of July 2018; reflects ESI FY17 Q4 restated claims; numbers in table may not add up due to rounding

[1] Includes approved design changes for site-of-care steerage for imaging/outpatient lab and COE services and proposed design changes for $0 statin coverage and preventive 3D mammography effective 7/1/2018; includes financial impact of legislative bills impacting GHIP ($1.2m increase to FY19 budget and $2.4m increase to FY20 projection); assumes no additional program changes in FY20 and beyond.

[2] Includes State and employee/pensioner premium contributions; assumes 2% annual enrollment growth for FY20-FY23; FY17 and FY18 actual premiums include 5% risk fee surcharge for participating non-State groups but not reflected in FY19 through FY23 premium totals

[3] Includes Rx rebates, EGWP payments, other revenues; FY17/FY18 Actuals and FY19 Projected include participating group fees; assumed to increase proportionally with membership growth and health care trend

[4] 40% excise tax on the value of employer sponsored health care coverage over specified thresholds starting CY 2022. Threshold assumed to increase at 2% annually

[5] FY19 Claims Liability and FY19 Minimum Reserve levels updated with data through June 2018; future years assumed to increase with overall GHIP expense growth

[6] FY20-FY23 projections based on 5% composite trend (assumes 6% underlying trend less 1% for future GHIP cost reduction initiatives); assumes no additional program changes in FY20; assumes 2% annual growth in GHIP membership.

Short-term focus: eliminating the projected deficit for FY20

GHIP Costs ($ millions)	FY20 Projected[6]
Average Enrolled Members	129,897
GHIP Revenue	
Premium Contributions (Increasing with Enrollment)[2]	$833.4
2.0% Annual Premium Increase Starting FY20	*$16.7*
Other Revenues[3]	$98.0
Total Operating Revenues	**$948.1**
GHIP Expenses (Claims/Fees)	
Operating Expenses (No Change)	$999.7
% Change Per Member	*5.0%*
Excise Tax Liability[4]	n/a
Adjusted Net Income (Revenue less Expense)	**($51.6)**
Balance Forward	$128.5
Ending Balance	$76.9
- Less Claims Liability[5]	*$65.7*
- Less Minimum Reserve[5]	*$26.1*
GHIP Surplus (After Reserves/Deposits)	**($14.9)**

Two key decision points for SEBC and subcommittee:

- Should GHIP surplus be used to offset the FY20 deficit?
- Which opportunities for offsetting the projected deficit for FY20 should be considered?

Initial opportunities presented to the SEBC:

- *Health management point solutions*
- *Centers of Excellence*
- *Site-of-care steerage*
- *Plan design changes*
- *Premium rate increases*

Deadline for SEBC approval to ensure readiness by 7/1/19: February 11, 2019

Note: Presented to the SEBC on 9/24/18. FY20 enrollment as of July 2018 plus 2% increase in headcount; reflects ESI FY17 Q4 restated claims; numbers in table may not add up due to rounding

[1] Reflects 2% annual increase in premiums and 2% annual membership growth assumption effective 7/1/2019

[2] Includes State and employee/pensioner premium contributions; assumes no increase to premium rates 7/1/2018 and beyond; 2% annual enrollment growth for FY20;

[3] Includes Rx rebates, EGWP payments, other revenues; assumed to increase proportionally with membership growth and health care trend

[4] 40% excise tax on the value of employer sponsored health care coverage over specified thresholds starting CY 2022

[5] FY20 Claims Liability and FY20 Minimum Reserve levels assumed to increase with overall GHIP expense growth

[6] FY20 projection based on 5% composite trend (assumes 6% underlying trend less 1% for future GHIP cost reduction initiatives); assumes no additional program changes in FY20

Health management point solutions

Targeted solutions that address specific health needs

- Point solutions include a number of newer vendors that are focused on management of a specific chronic condition (e.g., diabetes)
- For many employers, metabolic syndrome and diabetes is the top clinical area of focus as a means of improving member health and reducing costs over the next three years[1]
  - GHIP Active prevalence of diabetes in FY18 was 76 patients per 1,000 (Truven benchmark is 49 patients per 1,000)
- Metabolic syndrome and diabetes vendor offerings currently in the marketplace:
  - Span from digital coaching to condition management to remote patient monitoring
  - Target different segments of the workforce population
- Three types of solutions available and leading vendors are:

Diabetes Management (DM)	Diabetes Prevention Program (DPP)	Weight Management
Targets individuals who already have diabetes envolve PeopleCare glooko Livongo	Targets individuals at high risk for diabetes or have metabolic syndrome and/or pre-diabetes newtopia omada #RETROFIT	Targets individuals at risk for diabetes or other weight-related conditions Real Appeal weightwatchers
Experience in the GHIP		
Highmark analysis suggests the State could save about $1.0m in FY20 by implementing Livongo	Retrofit and YMCA DPP has been in place since FY18 with both Highmark and Aetna.	Weight Watchers was previously offered through Highmark and Aetna and paid as a claim but was discontinued due to cost.

Note: Willis Towers Watson has a partnership with Livongo and is working on developing one with Omada.
1 Source: 2017 Willis Towers Watson Best Practices in Health Care Employer Survey.

Illustrative options for reducing FY20 budget deficit

- Estimated range of potential FY20 savings through implementing Livongo for Highmark plan participants and Centers of Excellence through a carve-out COE vendor is $1.5m - $2.0m
- Additional cost avoidance for targeted changes related to site-of-care steerage can be achieved by increasing the copay differential for existing site-of-care steerage options such as telemedicine, basic imaging, high-tech imaging and outpatient lab

Service	FY19 Design	Illustrative Changes
Telemedicine	$15/$20 copay (HMO/PPO)	$5/$10 copay (HMO/PPO)
Basic Imaging ▪ Freestanding Facility (preferred) ▪ Hospital-based Facility	▪ $0 copay ▪ $35 copay	▪ $0 copay ▪ $50 copay
High Tech Imaging ▪ Freestanding Facility (preferred) ▪ Hospital-based Facility	▪ $0 copay ▪ $50 copay	▪ $0 copay ▪ $75 copay
Outpatient Lab ▪ Preferred Lab ▪ Other Lab	▪ $10 copay ▪ $20 copay	▪ $0 copay ▪ $50 copay

Additional annual cost avoidance of ~$1.0M[1] could be achieved by increasing copay differential to further incentivize care at appropriate, cost effective settings

- Estimated range of potential FY20 cost avoided through implementing deductibles for the HMO and PPO plan options

FY20 Deductible	$50 / $100	$100 / $200	$150 / $300	$200 / $400	$250 / $500
HMO	$1.0 M	$2.0 M	$3.0 M	$4.0 M	$5.0 M
PPO	$2.0 M	$3.0 M	$4.0 M	$6.0 M	$7.0 M
Total	**$3.0 M**	**$5.0 M**	**$7.0 M**	**$10.0 M**	**$12.0 M**

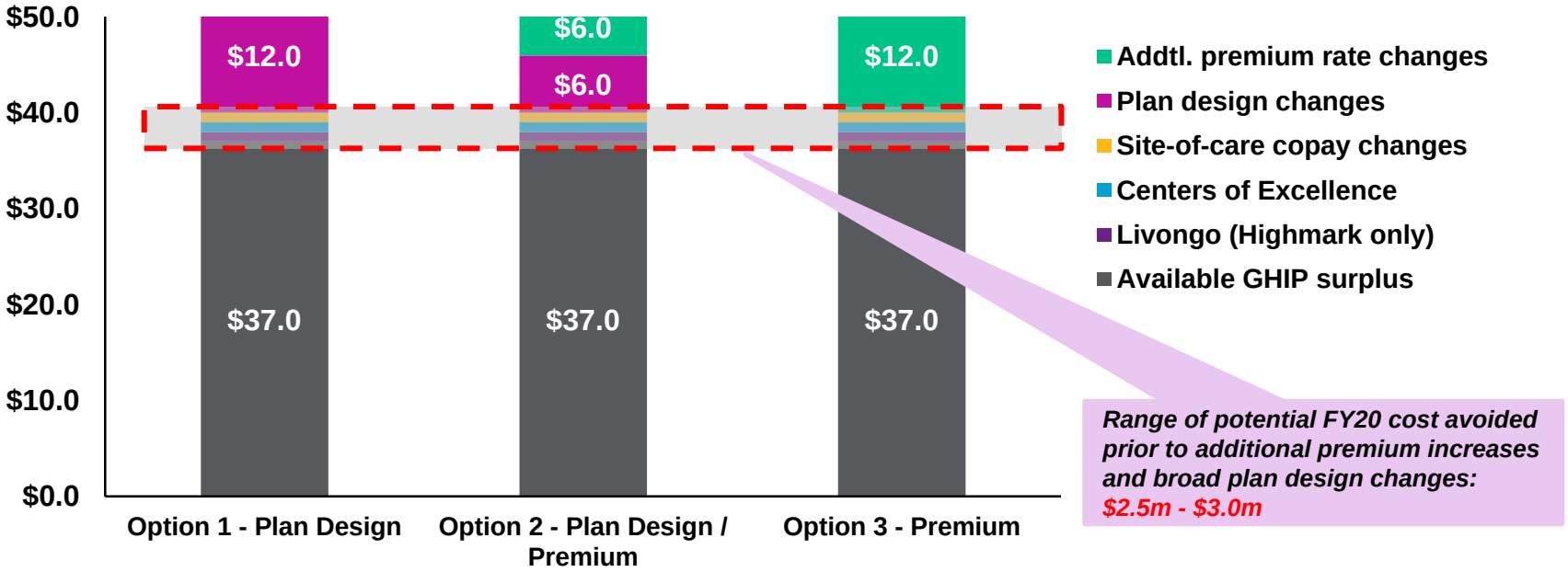
[1]Further analysis with Aetna/Highmark needed to finalize savings estimates

Illustrative options for reducing FY20 budget deficit

- Remaining budget deficit would need to be addressed through broader plan design changes and/or additional **premium rate increases**

Every 1% increase in FY20 premiums reduces the FY20 budget deficit by approximately $8M

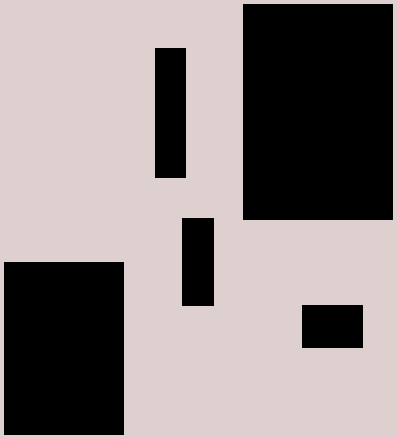
$ in millions



Range of potential FY20 cost avoided prior to additional premium increases and broad plan design changes: $2.5m - $3.0m

- Option 1 – Plan Design: Eliminate FY20 budget deficit through broad plan design changes
- Option 2 – Plan Design / Premium: Eliminate FY20 budget deficit through broad plan design changes and additional premium rate increases ($6.0M in premium revenue requires **additional 0.7%** premium rate increase)
- Option 3 – Premium : Eliminate FY20 budget deficit through additional premium rate increases ($12.0M in premium revenue requires **additional 1.4%** premium rate increase)

Next Steps



Next steps

Planning & Policy Subcommittee topics through December 2018

October 25th

Discussion Topics:

1. Committee business rules
2. Overview of GHIP planning discussions with the SEBC
3. FY20 Planning – Short term opportunities

November 7th

Discussion Topics:

1. FY20 Planning – Short term opportunities
2. Centers of Excellence plan design

December 4th

Discussion Topics:

1. FY20 Planning – Short term opportunities
2. Centers of Excellence plan design

December 18th

Discussion Topics:

1. FY20 Planning – Short term opportunities*
2. Centers of Excellence plan design*

November 13th SEBC Meeting

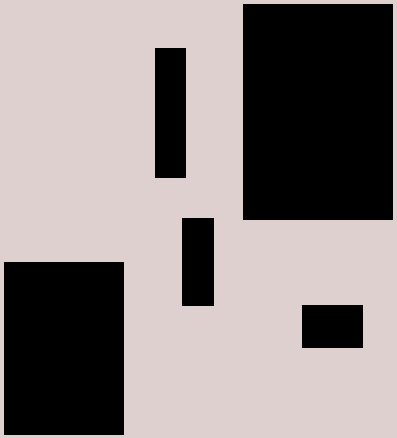
1. DHSS update on Healthcare Benchmark
2. Clinical management programs – FY18 results
3. Policy & Planning Subcommittee update

December 10th SEBC Meeting

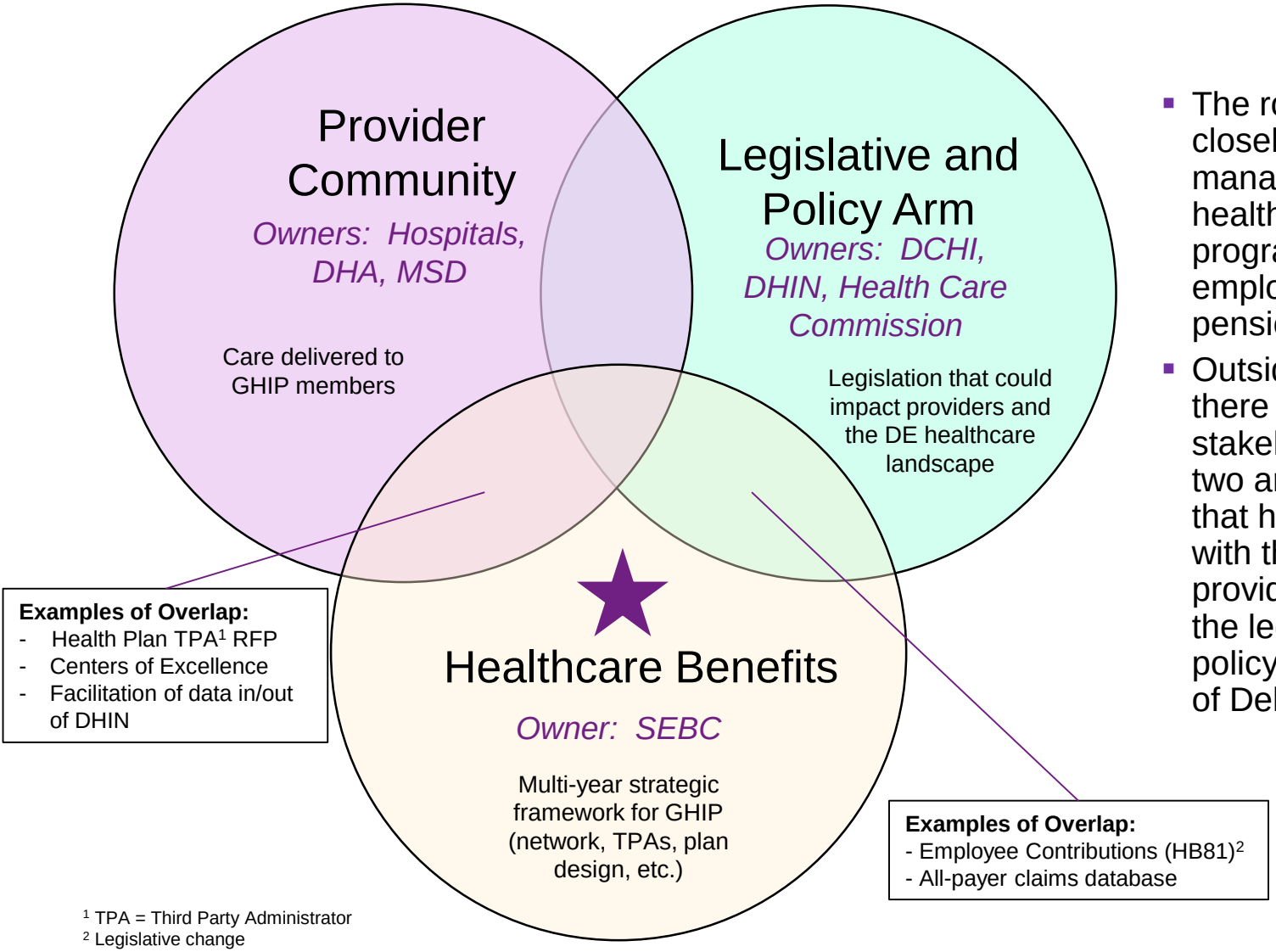
1. Policy & Planning subcommittee update

* Denotes subcommittee vote on recommendations for further consideration by the SEBC

Appendix



Key influencers on GHIP



- The role of the SEBC is closely aligned with managing the healthcare benefits programs offered to employees and pensioners
- Outside of the SEBC, there are many stakeholders, of which, two are identified here, that have partial overlap with the committee: the provider community and the legislative and policy arm of the State of Delaware

[1] TPA = Third Party Administrator
[2] Legislative change

Confines of the GHIP strategic development process

Potential tactic to address strategy	Illustrative example(s)	Requires legislative change?
Traditional plan design changes	Increase deductible by $100	No
Non-traditional plan design changes	Implement reference-based pricing 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 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 an COE	Possibly
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.

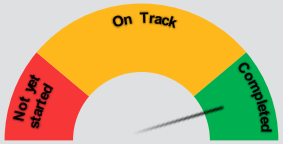
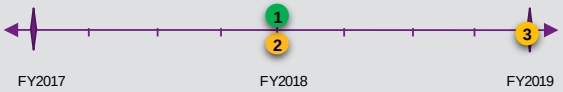
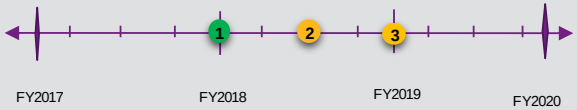
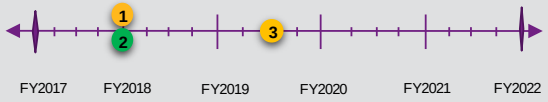
GHIP goals

Tracking the progress

Strategic Framework Scorecard

Progress review date: August 20, 2018

Progress Evaluation - Tracking Against Goals

Goals	Progress	Timing	Steps Taken / Actions Planned
Goal 1: Addition of at least net 1 value-based care delivery (VBCD) model by end of **FY2018**			1 Introduction of AIM HMO model via Aetna/CareLink partnership, effective 7/1/2017 2 Continue to work with Highmark and the State's other carriers to identify opportunities to implement other VBCD models 3 COE steerage design, effective 7/1/2018
Goal 2: Reduction of gross GHIP medical and prescription drug trend by 2% by end of **FY2020**			1 Adoption of cost reduction programs, i.e., CCMU, Diabetes Prevention Program, AIM HMO 2 Additional changes to promote use of high quality/efficient providers are under consideration 3 Site of care steerage design differentials, effective 7/1/2018
Goal 3: GHIP membership enrollment in a consumer-driven or value-based plan exceeding 25% of total population by end of **FY2020**			1 6% of employees enrolled in the CDH Gold plan[1] 2 25% of employees enrolled in the Aetna HMO AIM Model[1] 3 Introduction of Health Savings Account plan, under consideration for 7/1/20

Not yet started On track Completed

1. Based on enrollment reported by Aetna as of July 2018.

GHIP tactics

To prepare for 2020 and beyond (7/1/2018 – 6/30/2019)

Addition of at least net 1 VBCD model by end of FY2018	***New Proposed:*** Reduction of GHIP diabetic cost per-member-per-month (PMPM) by 5% by the end of FY2021	Reduction of gross GHIP trend by 2% by end of FY2020	Enrollment in a CDHP or value-based plan >25% by end of FY2020	***New Proposed:*** Incremental increase in users engaged in consumerism tool by ≥ 5% annually
▪ Continue to monitor and evaluate VBCD opportunities	▪ Measure baseline diabetes prevalence and cost ▪ Explore and implement ways to further promote cost transparency tools to support member decisions about the providers they choose ▪ Continue to promote health care consumerism and member education ▪ Explore opportunities to expand access to primary care for GHIP participants (e.g., employer-sponsored health care, more intensive telehealth care) ▪ Continue to hold medical TPAs accountable for expanding their pay-for-value contracts with providers ▪ Continue to require medical TPAs to submit GHIP claim data to the DHIN and other value-based contracts (e.g., ACOs) where applicable	▪ Explore and implement medical TPA programs, such as tiered pricing for lab services, high cost radiology utilization management (UM) and other medical and Rx UM programs, where necessary ▪ Continuation of education of GHIP members on the importance of preventive care and the State's preventive care benefits (covered at 100% in-network) ▪ Continuation of education of GHIP members on lower cost alternatives to seek care outside of the emergency room (i.e., telemedicine, urgent care centers, retail clinics) ▪ Continuation of the evaluation of feasibility of reducing plan options and/or replacing copays with coinsurance—based on emerging market and value-based design*	▪ Change medical plan designs and employee/retiree contributions to further differentiate plan options* ▪ Change the number of medical plans offered*	▪ Continue promoting cost and quality transparency tools ▪ Consider incentives to drive additional utilization of cost and quality transparency tools ▪ Consider requiring an active enrollment for the FY20 open enrollment period for active employees and non-Medicare eligible retirees

*May require changes to the Delaware Code

GHIP tactics

To prepare for 2021 and beyond (7/1/2019 – 6/30/2020)

	New Proposed:			*New Proposed:*
Addition of at least net 1 VBCD model by end of FY2018	**Reduction of GHIP diabetic cost per-member-per-month (PMPM) by 5% by the end of FY2021**	**Reduction of gross GHIP trend by 2% by end of FY2020**	**Enrollment in a CDHP or value-based plan >25% by end of FY2020**	**Incremental increase in users engaged in consumerism tool by ≥ 5% annually**

▪ Continue to monitor and evaluate VBCD opportunities	▪ Explore opportunities to further reduce barriers to accessing care for diabetes (e.g., additional reduction in diabetes medication copays; waived copays for high quality, high value PCPs and/or select specialist physicians)
	▪ Further leverage and promote use of centers of excellence for treatment of comorbid conditions prevalent among diabetics (e.g., bariatric, orthopedic, spine, cardiac COEs)
		▪ Continue to educate GHIP members on:
		  ▪ Importance of preventive care and the State's preventive care benefits (covered at 100% in-network)
		  ▪ Lower cost alternatives to seek care outside of the emergency room (i.e., telemedicine, urgent care centers, retail clinics)
		▪ Continue to evaluate feasibility of reducing plan options and/or replacing copays with coinsurance—based on emerging market and value-based design*
			▪ Continue to evaluate medical plan designs and employee/retiree contributions to maintain meaningful differences between medical plan options*	▪ Continue promoting cost and quality transparency tools
				▪ Consider reviewing plan design provisions that could promote additional utilization of cost and quality transparency tools

*May require changes to the Delaware Code

Recap of Medical TPA RFP

Introduction

- A Request for Proposal (RFP) for medical third party administrators (TPAs) to serve the State's Group Health Insurance Program (GHIP), effective July 1, 2017, was released on August 15, 2016
- The following vendors submitted responses to the RFP:
  - Aetna, Cigna, Highmark of Delaware (Highmark) and UnitedHealthcare (UHC)
- Vendor responses were reviewed from both a qualitative and quantitative perspective, with a focus on the following objectives:
  - *Financial:* Reduce total cost of care for GHIP participants and the State; reduce program expenses through improved contractual and financial terms; support financial rewards for providers that meet certain cost and quality standards
  - *Access to high quality providers and to information on provider cost/quality:* Facilitate consumer choice of providers who deliver higher quality care at a lower total cost; provide GHIP participants with the tools and resources that will promote transparency in provider cost and quality and encourage participants to make informed decisions about their health
  - *Care and disease management:* Promote consumerism and health management through member tools and resources; provide care management programs that are effective at engaging members and steering them to the most effective care at the right time with the right providers
  - *Improved operational efficiency:* Streamline the number of vendors administering each medical plan offering, administer core account management functions with an eye toward administrative ease and simplicity
- The RFP was utilized as a tactic to address the State's broader strategic framework

Recap of Medical TPA RFP

Final decision

- The SEBC awarded sole administration of the GHIP active/retiree plan offerings as follows:
  - Aetna: CDH Gold and HMO (with AIM)
  - Highmark: Comprehensive PPO, First State Basic, Medicfill
- SEBC decisions based on RFP responses outlined below, made to support the goals and mission within the State's broader strategic framework

Objective	RFP results
Financial	Aetna and Highmark provided the strongest financial proposals with the least disruption to GHIP members
Access to high quality providers and to information on provider cost/quality	Aetna PCMH recognition model and Highmark True Performance were most robust quality provider network solutions available in Delaware; limited differentiation in carrier availability of provider pricing and quality tools
Care and disease management	Aetna AIM model selected to promote care management and primary care coordination, combined with upside/downside risk sharing arrangement
Improved operation efficiency	Sole administration for each plan to Aetna/Highmark creates administrative ease and efficiency

Onsite / Near-site health centers – considerations

- A Request for Information (RFI) was conducted in the spring of 2017 to evaluate the feasibility of state-wide, employer-sponsored (onsite or near-site) clinics
- Results of the RFI were presented to the SEBC on June 26, 2017; further discussion of employer-sponsored clinics with the SEBC did not take place until the December 11, 2017, at which the exhibit below was presented

Areas to address

Goals and operating parameters

Determine the following:

- Health center goals, and how success will be measured
- Eligible population
- Scope of services
- Staffing preferences
- Location(s) and hours of operation
- Member cost sharing

Initial draft goals and success measurements were presented at 1/22/18 SEBC meeting

Source of funding

One of the following must happen:

- State Legislature appropriates funding for a clinic
- State Legislature grants SEBC the authority to use GHIP funds to finance health center start-up and operations

Oversight

Determine ownership of health center vendor oversight:

- SEBC?
- Department of Human Resources?
- OMB – Division of Facilities Management?
- Another agency within the Executive Branch?

Proposed employer-sponsored health care goals and success measures

Based on SEBC feedback and consistent with GHIP strategic framework

Proposed goals

Expand Access to Care

With focus on primary care, prevention and wellness, with selected specialty care as needed

Improve Quality of Care

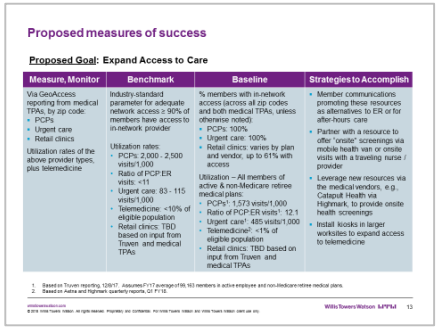
Directly through the health center and indirectly via referrals to high performing providers

Reduce Total Cost of Care

Through improved health of the covered population, and through redirection of care from expensive, suboptimal and inappropriate settings, when clinically appropriate

Success measures

For each goal, highlights key metrics to monitor, suggested benchmarks, baseline measures based on actual GHIP data, and additional strategies to accomplish the same goal

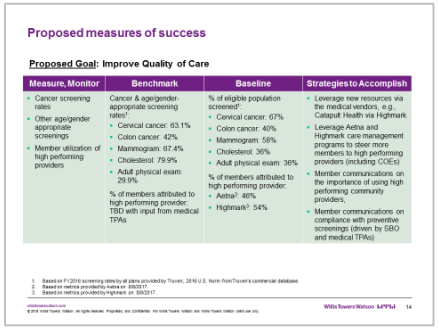


Proposed measures of success

Proposed Goal: Expand Access to Care

Measure, Monitor	Benchmark	Baseline	Strategies to Accomplish
Via GeoAccess reporting from medical TPAs, by zip code: • PCPs • Urgent care • Retail clinics Utilization rates of the above provider types, plus telemedicine	Industry-standard parameter for adequate network access ≥ 90% of members have access to in-network provider Utilization rates: • PCPs: 2,000 - 2,500 visits/1,000 • Ratio of PCP:ER visits: <11 • Urgent care: 83 - 115 visits/1,000 • Telemedicine: <10% of eligible population • Retail clinics: TBD based on input from Truven and medical TPAs	% members with in-network access (across all zip codes and both medical TPAs, unless otherwise noted): • PCPs: 100% • Urgent care: 100% • Retail clinics: varies by plan and vendor, up to 61% with access Utilization – All members of active & non-Medicare retiree medical plans: • PCPs[1]: 1,573 visits/1,000 • Ratio of PCP:ER visits[1]: 12.1 • Urgent care[1]: 485 visits/1,000 • Telemedicine[2]: <1% of eligible population • Retail clinics: TBD based on input from Truven and medical TPAs	• Member communications promoting these resources as alternatives to ER or for after-hours care • Partner with a resource to offer "onsite" screenings via mobile health van or onsite visits with a traveling nurse / provider • Leverage new resources via the medical vendors, e.g., Catapult Health via Highmark, to provide onsite health screenings • Install kiosks in larger worksites to expand access to telemedicine

1. Based on Truven reporting, 12/6/17. Assumes FY17 average of 99,163 members in active-employee and non-Medicare-retiree medical plans.
2. Based on Aetna and Highmark quarterly reports, Q1 FY16.

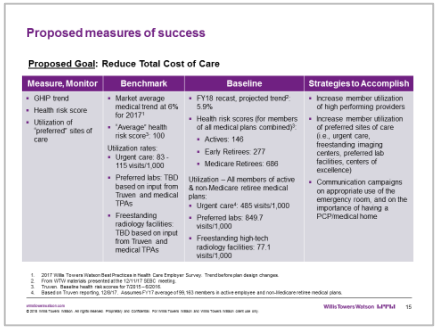


Proposed measures of success

Proposed Goal: Improve Quality of Care

Measure, Monitor	Benchmark	Baseline	Strategies to Accomplish
• Cancer screening rates • Other age/gender appropriate screenings • Member utilization of high performing providers	Cancer & age/gender-appropriate screening rates[1]: • Cervical cancer: 63.1% • Colon cancer: 42% • Mammogram: 67.4% • Cholesterol: 79.9% • Adult physical exam: 29.9% % of members attributed to high performing provider: TBD with input from medical TPAs	% of eligible population screened[2]: • Cervical cancer: 67% • Colon cancer: 40% • Mammogram: 58% • Cholesterol: 36% • Adult physical exam: 36% % of members attributed to high performing provider: • Aetna[3]: 46% • Highmark[3]: 54%	• Leverage new resources via the medical vendors, e.g., Catapult Health via Highmark • Leverage Aetna and Highmark care management programs to steer more members to high performing providers (including COEs) • Member communications on the importance of using high performing community providers, • Member communications on compliance with preventive screenings (driven by SBO and medical TPAs)

1. Based on FY2016 screening rates by all plans provided by Truven; 2016 U.S. Norm from Truven's commercial database.
2. Based on metrics provided by Aetna in 9/8/2017.
3. Based on metrics provided by Highmark on 9/8/2017.



Proposed measures of success

Proposed Goal: Reduce Total Cost of Care

Measure, Monitor	Benchmark	Baseline	Strategies to Accomplish
• GHIP trend • Health risk score • Utilization of "preferred" sites of care	• Market average medical trend at 6% for 2017[1] • "Average" health risk score[2]: 100 Utilization rates: • Urgent care: 83 - 115 visits/1,000 • Preferred labs: TBD based on input from Truven and medical TPAs • Freestanding radiology facilities: TBD based on input from Truven and medical TPAs	• FY18 recast, projected trend[3] 5.9% • Health risk scores (for members of all medical plans combined)[2]: • Actives: 1.46 • Early Retirees: 277 • Medicare Retirees: 686 Utilization – All members of active & non-Medicare retiree medical plans: • Urgent care[4]: 485 visits/1,000 • Preferred labs: 849.7 visits/1,000 • Freestanding high-tech radiology facilities: 77.1 visits/1,000	• Increase member utilization of high performing providers • Increase member utilization of preferred sites of care (i.e., urgent care, freestanding imaging centers, preferred lab facilities, centers of excellence) • Communication campaigns on appropriate use of the emergency room, and on the importance of having a PCP/medical home

1. 2017 Willis Towers Watson Best Practices in Health Care Employer Survey. Trend before plan design changes.
2. From HRA materials presented at the 12/11/17 SEBC meeting.
3. Truven. Baseline health risk scores for 7/2015 – 6/2016.
4. Based on Truven reporting, 12/6/17. Assumes FY17 average of 99,163 members in active-employee and non-Medicare-retiree medical plans.