The State of Delaware

Group Health Insurance Plan

Financial Subcommittee Discussion Guide

November 7, 2018

This document was prepared for the State of Delaware's sole and exclusive use and on the basis agreed by the State. It was not prepared for use by any other party and may not address their needs, concerns or objectives. This document should not be disclosed or distributed to any third party other than as agreed by the State of Delaware and Willis Towers Watson in writing. We do not assume any responsibility, or accept any duty of care or liability to any third party who may obtain a copy of this presentation and any reliance placed by such party on it is entirely at their own risk.

willistowerswatson.com
© 2018 Willis Towers Watson. All rights reserved. Proprietary and Confidential. For Willis Towers Watson and Willis Towers Watson client use only.

Willis Towers Watson

Today's discussion

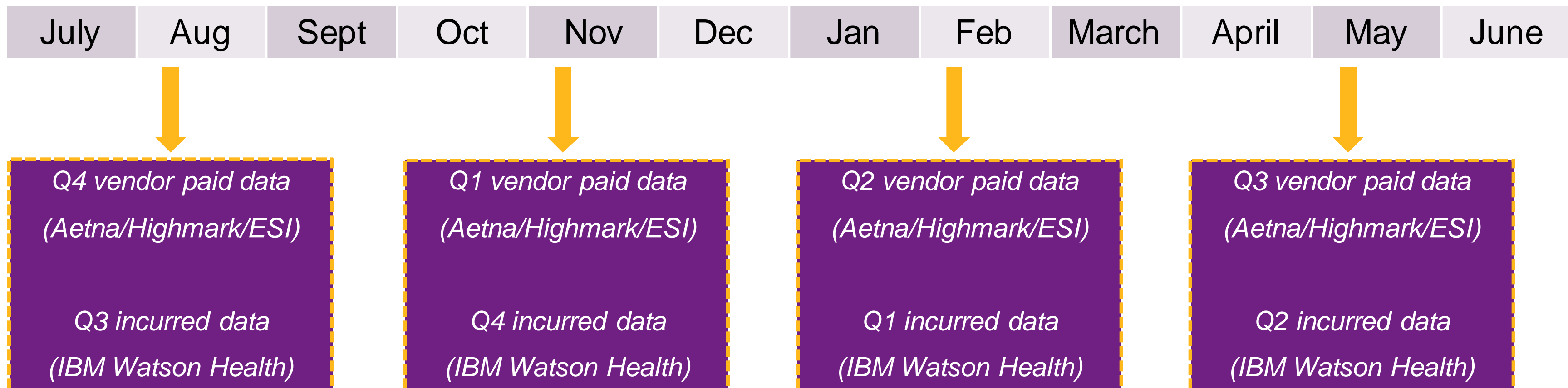
- Reporting review
  - FY18 Q4 IBM Watson Health Executive Dashboard
  - FY18 Q4 IBM Watson Health Incurred Report
- Reserve, Claim Liability & Surplus Methodology
- Next steps

© 2018 Willis Towers Watson. All rights reserved. Proprietary and Confidential. For Willis Towers Watson and Willis Towers Watson client use only.

Financial reporting

Current financial reporting and timing

- Current reporting:
  - Monthly Fund Equity report (cash basis)
  - WTW Quarterly Financial Report – budget vs. actual, year-over-year trend (paid basis)
  - IBM Watson Executive Dashboard – key utilization metrics (paid basis) ★
  - IBM Watson Quarterly Modeling Report – key utilization metrics (incurred basis) ★
  - Quarterly financial and utilization reports from Aetna, Highmark, and ESI (paid basis)



★ Deep dive review in today's meeting

© 2018 Willis Towers Watson. All rights reserved. Proprietary and Confidential. For Willis Towers Watson and Willis Towers Watson client use only.

Financial reporting

Key metrics

Metrics for regular review by Financial Subcommittee	Metrics to bring to Policy & Planning Subcommittee	Metrics to bring to SEBC

© 2018 Willis Towers Watson. All rights reserved. Proprietary and Confidential. For Willis Towers Watson and Willis Towers Watson client use only.

Financial reporting

Fund Equity

- Move forward with below recommended changes to the Fund Equity monthly summary?

	Target	YTD		EOY	
		Budget	*Actual*	*Budget*	*Forecast**
Fund Equity	85.6	146.7	156.9	128.4	138.6
Claim Liability	61.3	61.3	61.3	61.3	61.3
Reserve	24.3	24.3	24.3	24.3	24.3
Surplus/Deficit	0.0	61.1	71.3	42.8	53.0

* Forecast = Actual + Remaining Budget

© 2018 Willis Towers Watson. All rights reserved. Proprietary and Confidential. For Willis Towers Watson and Willis Towers Watson client use only.

Reserve and claim liability discussion

Overview and terminology

- To maintain the stability and financial health of the GHIP, a minimum level of funding is recommended to be held at any point in time to protect against potential future exposure, including:
  - Claim liability: estimated amount needed to pay outstanding claims if the plan was to be terminated; reflects incurred but not paid ("IBNP") claim liability
  - Fund reserve: amount needed to protect against adverse claims experience, including any "shock" claims and fluctuations in claim levels for the current population
- The Fund Equity Balance refers to the cumulative funds available to pay claims in the health fund, and varies each month depending on actual revenue (premiums, rebates, etc.) less actual expenditures (claims, fees, etc.)
- Reserve Surplus (or Deficit) refers to the amount that the claim liability and fund reserve are over (or under) funded based on fund equity balance and target reserve levels

© 2018 Willis Towers Watson. All rights reserved. Proprietary and Confidential. For Willis Towers Watson and Willis Towers Watson client use only.

Presented at 9/24 SEBC meeting

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.

© 2018 Willis Towers Watson. All rights reserved. Proprietary and Confidential. For Willis Towers Watson and Willis Towers Watson client use only.

Reserve, claim liability, and surplus discussion

Current state

GHIP Costs ($ millions)	FY19 Projected	FY20 Projected
Total Operating Revenues[1]	$908.8	$948.1
Operating Expenses (No Change)[2]	$932.1	$999.7
Adjusted Net Income (Revenue less Expense)	**($23.3)**	**($51.6)**
Balance Forward	$151.8	$128.5
Ending Balance	$128.5	$76.9
- Less Claims Liability[3]	*$61.3*	*$65.7*
- Less Minimum Reserve[3]	*$24.3*	*$26.1*
GHIP Surplus (After Reserves/Deposits)	**$42.9**	**($14.9)**

FY18 Fund Equity surplus available to cover projected $23.3m net income shortfall

Use all available surplus for FY20?

$51.6m gap in projected operating revenues vs. expenses – assumes **5%** health care cost trend and **2%** premium increase

How much reserve is needed to protect the GHIP from poor claims experience?

Financial Subcommittee to recommend FY20 savings target for SEBC (whether plan design, premium increases, or other initiatives) based on reserve target and surplus methodology

Note: Assumes enrollment as of July 2018 plus 2% assumed enrollment growth starting FY20

[1] Includes State and employee/pensioner premium contributions, Rx rebates, EGWP payments, and other revenues; excludes 5% risk fee surcharge for participating non-State groups; assumes 2% increase in premiums effective 7/1/2019

[2] FY19 projected expenses reflects 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); FY20 projections based on 5% composite trend (assumes 6% underlying trend less 1% for future GHIP cost reduction initiatives) over FY19; assumes no additional program changes in FY20

[3] FY20 Claims Liability and FY19 Minimum Reserve levels based on FY19 levels increased by overall GHIP expense growth

© 2018 Willis Towers Watson. All rights reserved. Proprietary and Confidential. For Willis Towers Watson and Willis Towers Watson client use only.

Reserve and claim liability discussion

Current claim liability methodology

Claims Liability Targets by Quarter

12/31/16	3/31/17	6/30/17	9/30/17	12/31/17	3/31/18	6/30/18
$54.3m	$54.3m	$56.5m	$59.5m	$58.9m	$58.9m	$61.3m

- Recommended Claim Liability target is based on estimated incurred but not paid ("IBNP") liability as of 6/30/2018
  - Medical Claim Liability (Highmark and Aetna): $52.8M
  - Pharmacy Claim Liability (ESI Commercial and EGWP): $8.5M
- IBNP liability is based on paid claims for the period 7/1/2017 – 6/30/2018 and lag factors developed by Willis Towers Watson as of 6/30/2018
  - Lag factors represent the average period of time between when a claim is incurred and then paid by the State, and were developed separately for Aetna, Highmark, and ESI based on data provided by each vendor
  - Lag factors are reviewed and updated (if needed) annually
  - Claim Liability target is updated quarterly based on most recent 12 months of paid claims data
- IBNP liability has been increasing over time, driven by an increase in paid claim levels and an increase in Aetna's lag factor

Any changes needed to the methodology for setting Claims Liability target?

© 2018 Willis Towers Watson. All rights reserved. Proprietary and Confidential. For Willis Towers Watson and Willis Towers Watson client use only.

Reserve and claim liability discussion

Current minimum reserve methodology

FY19 Cost Estimate		
Variability Description	**Lower Bound**	**Upper Bound**
Expected Value (without margin)	$852,367,000	
70% Confidence Interval	$840,788,000	$863,945,000
90% Confidence Interval	$833,991,000	$870,742,000
95% Confidence Interval	$830,471,000	$874,263,000
97% Confidence Interval	$828,124,000	$876,660,000

At the 97% confidence interval level, the upper bound is $24.3M higher than the projected budget

- During March 6, 2017 meeting, SEBC approved a motion to set minimum reserve based on upper bound of 97% confidence interval of Willis Towers Watson health care trend variability tool, set annually based on final fiscal year budget
  - Confidence intervals represent the probability that the budget estimate will fall between an upper and lower bound of a health care claims distribution

The above analysis is based on GHIP data available through FY18 Q4, current enrollment as of July 2018, decisions approved to date by the SEBC, and other pricing assumptions as outlined in this document. The estimated confidence intervals shown are directional and intended to reflect the potential random fluctuation in claim cost given the current size and risk profile of the GHIP. The model does not contemplate potential change in cost due to shifts in enrollment, demographics or morbidity of the population, unexpected changes in provider networks, or significant changes in regulations affecting the health care market.

Source: Willis Towers Watson Trend Variability tool including proprietary Health Care Claims Continuance table based on 2017 data

© 2018 Willis Towers Watson. All rights reserved. Proprietary and Confidential. For Willis Towers Watson and Willis Towers Watson client use only.

Reserve and claim liability discussion

Recommended minimum reserve

FY19 Minimum Reserve Target (Data through June 2018)	**$24.3M**

- From 2005 to 2018, GHIP experienced cost increases ranging from 0.0% to 11.0% per employee/retiree with average annual increase of 5.4% (standard deviation 3.7%)
- Reserving approaches and amounts vary for other state employee benefit programs
  - Some states utilize a factor of IBNP, or a fixed number of months of claims (GHIP minimum reserve is equivalent to 40% of IBNP, while GHIP claim liability and minimum reserve combined are equivalent to 1.15 months of claims)
- Prior GHIP minimum reserve methodology utilized Risk Based Capital (RBC) formula with an RBC ratio set at 2.05 (205% RBC)
  - Equal to approximately 10% of actual expenses from prior fiscal year

Is current methodology still appropriate, or are changes needed to the process for setting minimum reserve target?

© 2018 Willis Towers Watson. All rights reserved. Proprietary and Confidential. For Willis Towers Watson and Willis Towers Watson client use only.

GHIP surplus

Discussion on use of available surplus

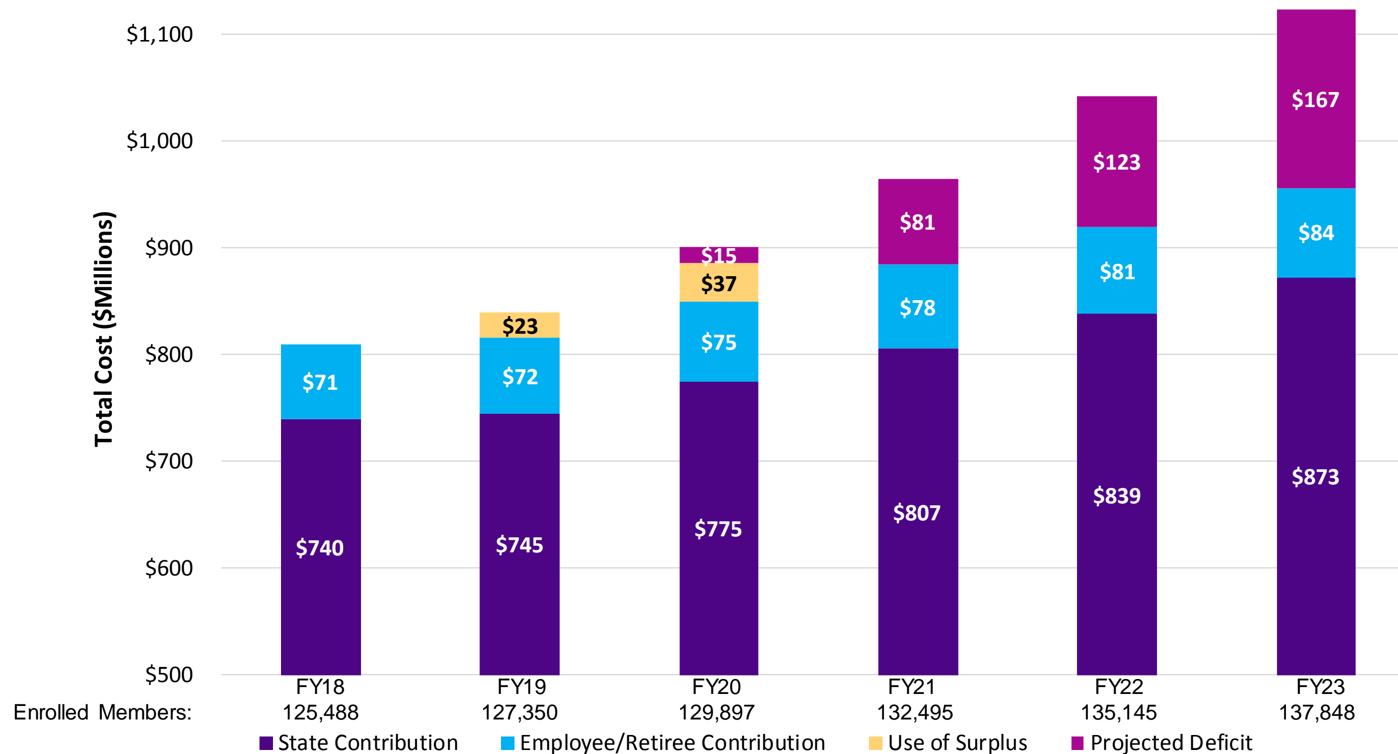
- The long term projection bar chart on the following slide shows the impact of using surplus to offset projected deficit in FY19 and a portion of FY20
- Using surplus to minimize annual premium increases may put a strain on future revenues needed to keep pace with health care cost trend
- $15m projected deficit in FY20 is equivalent to a **1.8% additional premium increase** (+3.8% total); after projected surplus has been depleted, $81m projected deficit in FY21 is equivalent to a **10% additional premium increase** (+12% total) absent other program changes
- Impact on future years is further exacerbated during years with poor claims experience
  - $15M FY20 projected deficit is based on 5% trend target, but GHIP program changes adopted to-date may not be sufficient to maintain long term trend below national average (historical GHIP average: 5.4%)
  - Each 1% of GHIP expense growth (trend) increases the FY20 projected deficit by an additional $8.4M
- Continue targeting short and long-term savings opportunities to minimize future premium increases and plan design changes

What is the Subcommittee's point of view on use of surplus? Options include using all available surplus to offset premium increase in one year, or spread over multiple years to smooth necessary rate action in future years

© 2018 Willis Towers Watson. All rights reserved. Proprietary and Confidential. For Willis Towers Watson and Willis Towers Watson client use only.

GHIP surplus and long term health care cost projections

Illustrative: Increase premium rates by 2% annually starting in FY20 and full surplus used in FY19/FY20



Every 1% of GHIP expense growth (trend) increases the FY20 projected budget by an additional $8.4M. This would require an additional $7.7M in State Contributions, and an additional $0.7M in EE/pensioner contributions

Notes

- FY18 total cost based on final reported FY18 premium contributions per June 2018 fund equity report, and FY18 budget rates and enrollment.
- FY19 total projected cost based on claims data for the period 7/1/2016-6/30/2018 weighted 35% earlier / 65% later period, estimated savings from expanded COE and site-of-care steerage implemented for 7/1/2018, 7.4% composite health care trend assumption, and enrollment as of July 2018. FY2020-FY2023 projected assuming 5% annual increase (6% long term health care trend less 1% reduction) and 2% annual enrollment increase.
- FY20-FY23 assumes no program changes, 2% annual enrollment growth, and 5% annual health care trend. Includes estimated excise tax liability starting calendar year 2022.

© 2018 Willis Towers Watson. All rights reserved. Proprietary and Confidential. For Willis Towers Watson and Willis Towers Watson client use only.

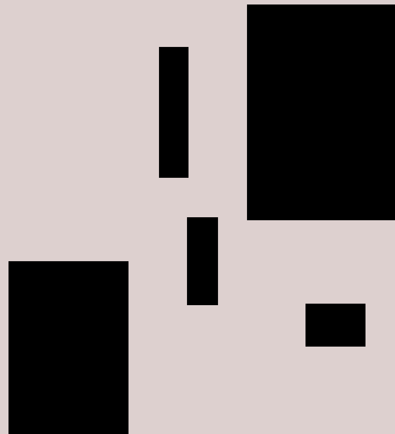
GHIP surplus

Discussion and decision points for Financial Subcommittee

- Claim liability: any changes to current methodology?
- Minimum reserve: any changes to current methodology?
- What is the Financial Subcommittee's point of view regarding use of surplus to offset future premium increases?
- If using surplus to reduce future premium increases, how much surplus should be available?
  - 100%
  - Target % or $ of available surplus
  - Target "cushion" above GHIP reserves
  - Other considerations?

© 2018 Willis Towers Watson. All rights reserved. Proprietary and Confidential. For Willis Towers Watson and Willis Towers Watson client use only.

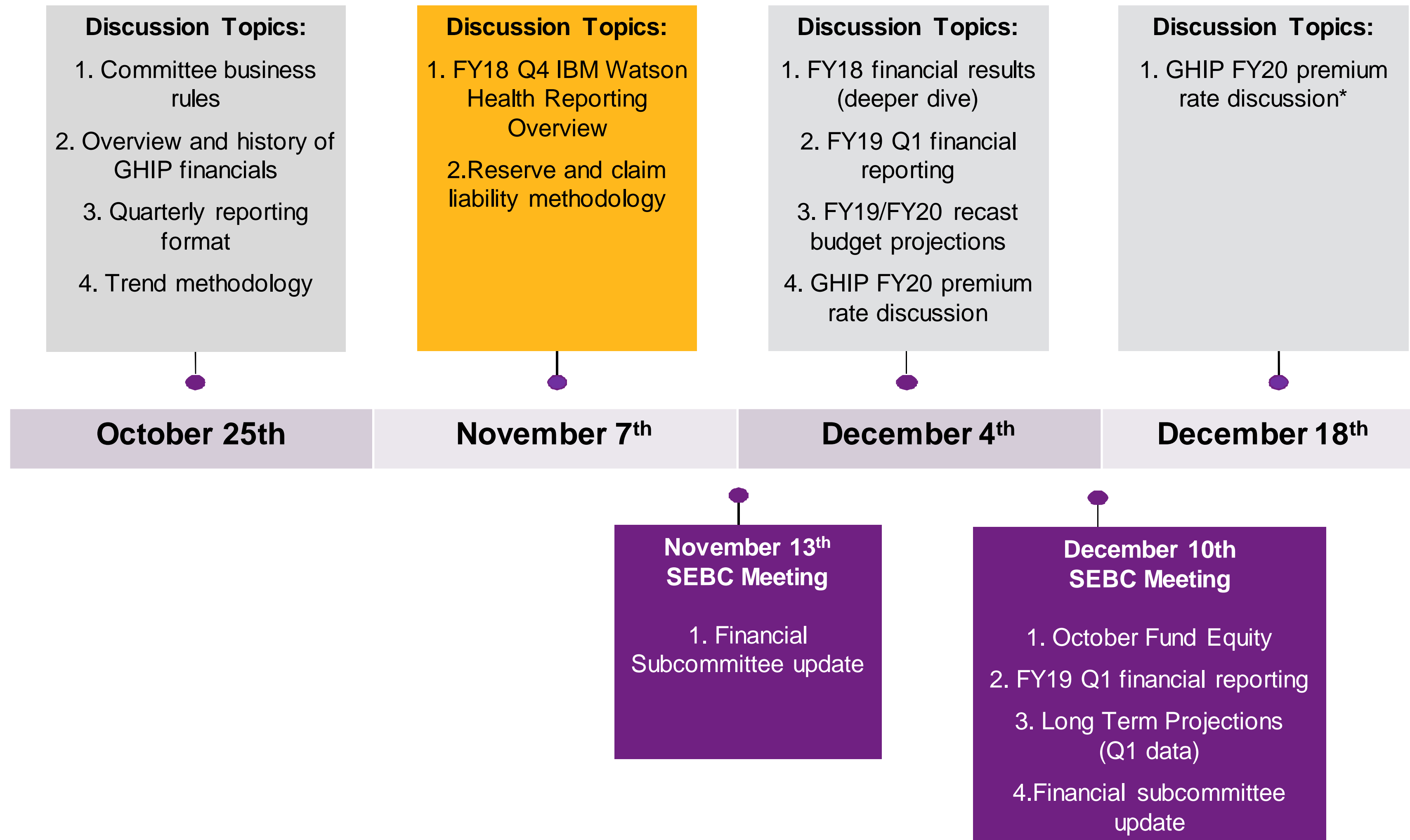
Next Steps



© 2018 Willis Towers Watson. All rights reserved. Proprietary and Confidential. For Willis Towers Watson and Willis Towers Watson client use only.

Next steps

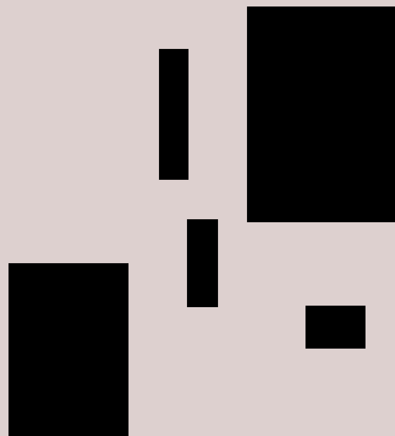
Financial Subcommittee topics through December 2018



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

© 2018 Willis Towers Watson. All rights reserved. Proprietary and Confidential. For Willis Towers Watson and Willis Towers Watson client use only.

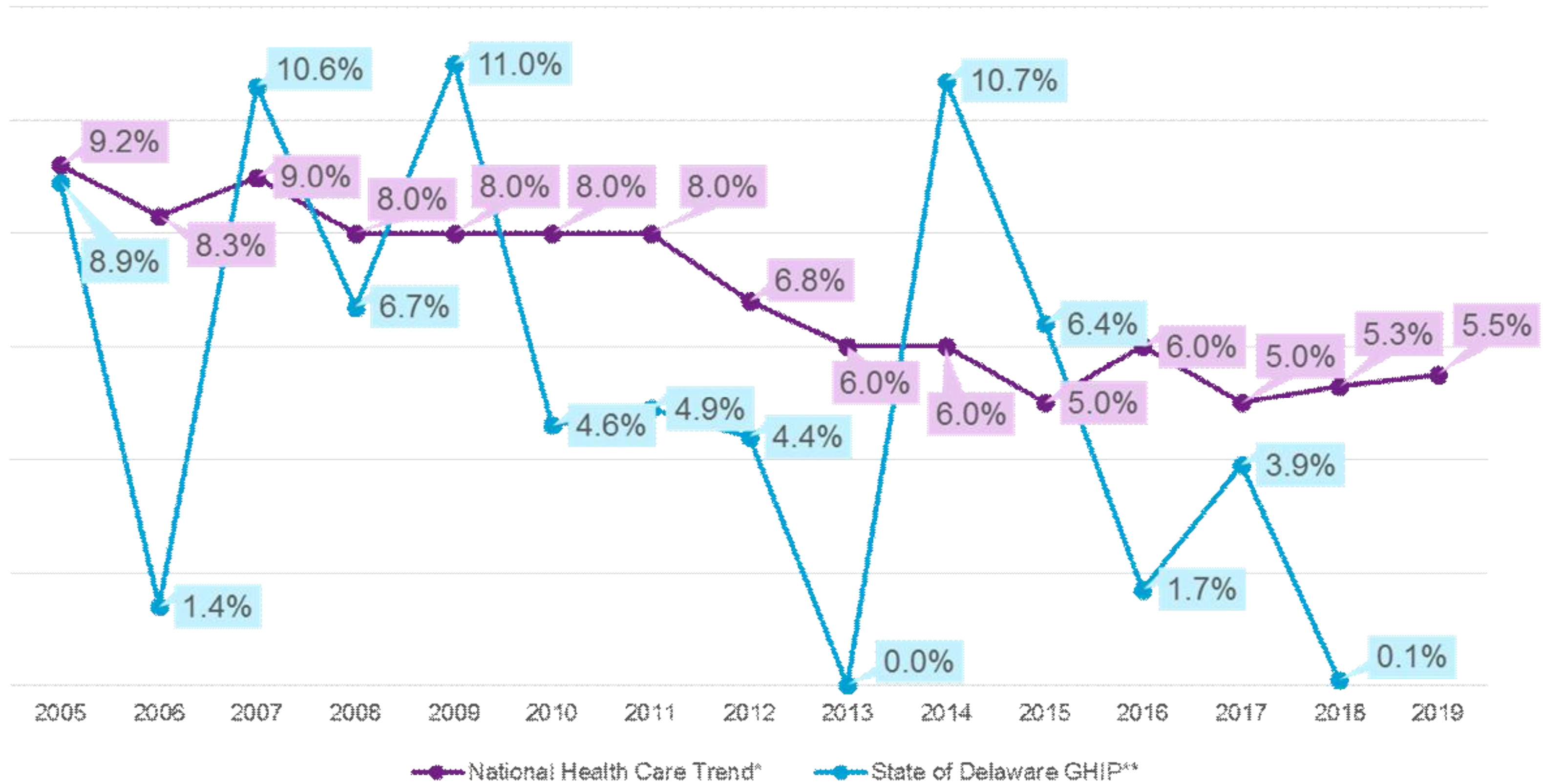
Appendix



© 2018 Willis Towers Watson. All rights reserved. Proprietary and Confidential. For Willis Towers Watson and Willis Towers Watson client use only.

Historical GHIP cost increases

Actual GHIP increases vs. WTW survey data



*National Benchmark Source: Willis Towers Watson Best Practices in Healthcare survey. Based on respondents with at least 1,000 employees and median trends for medical and drug claims for active employees including both employer and employee contributions but excludes employee OOP costs. 2018 and 2019 benchmark data is projected.
**2007-2015 GHIP Trend data estimated based on Segal's State_of_Delaware_-_Trend_History_thru_Q2_FY16 030416.pdf
**2016-18 GHIP trend based on WTW financial reporting for corresponding fiscal year (includes net paid claims and fees) on a per employee per year basis

© 2018 Willis Towers Watson. All rights reserved. Proprietary and Confidential. For Willis Towers Watson and Willis Towers Watson client use only.