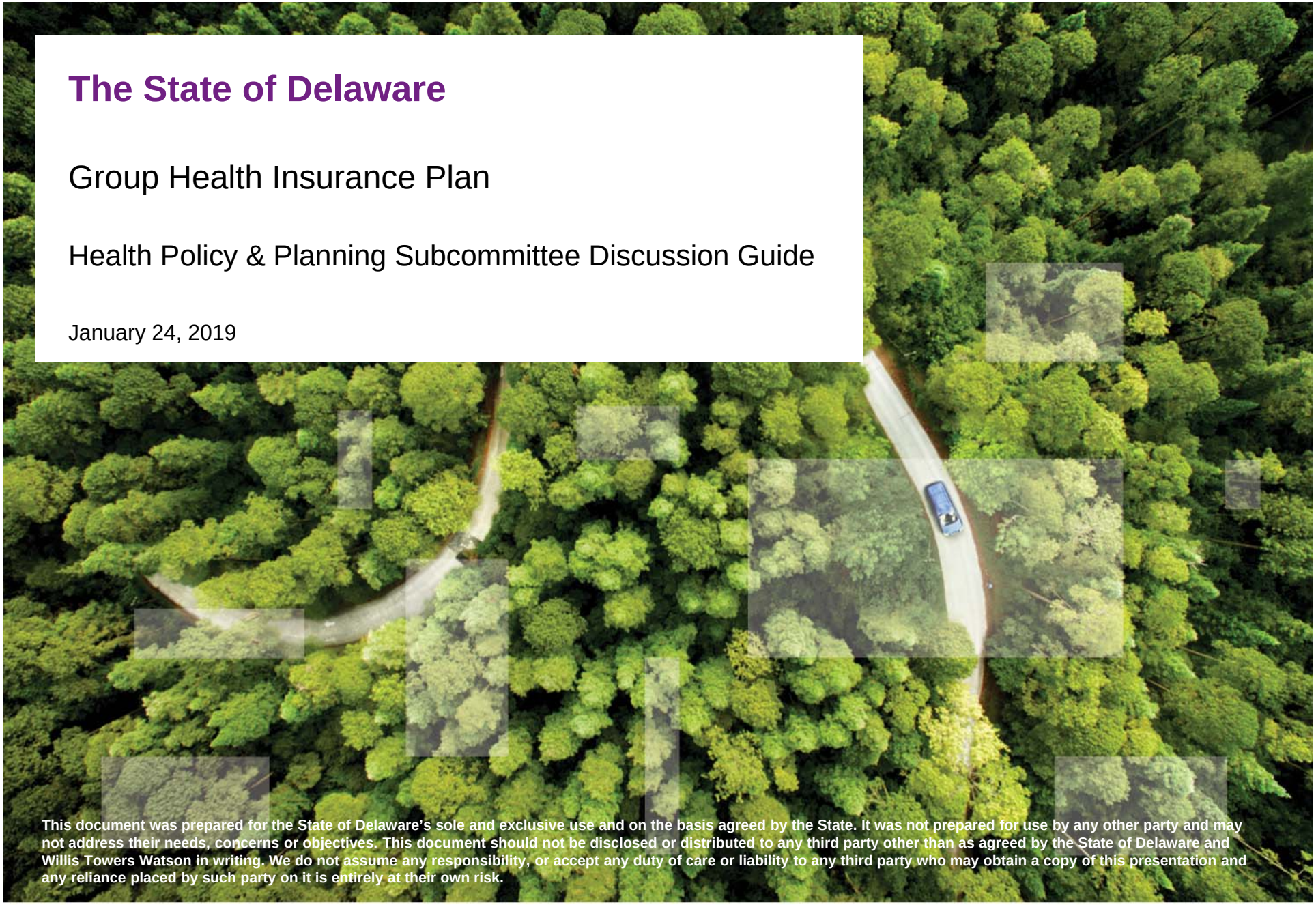
The State of Delaware

Group Health Insurance Plan

Health Policy & Planning Subcommittee Discussion Guide

January 24, 2019



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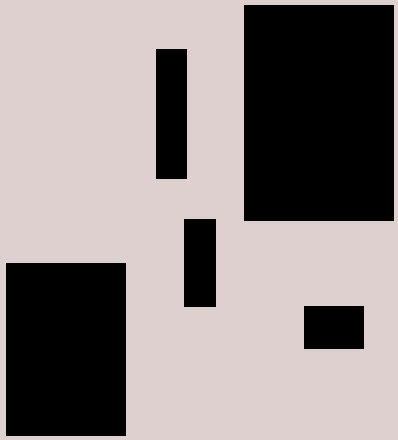
Today's discussion

- Revisiting the GHIP Strategic Framework
- Reference-based pricing
- Next steps

Revisiting the GHIP Strategic Framework



Reviewed with the Health Policy & Planning Subcommittee on 10/25/2018

Multi-year framework

- During the summer of 2016, the SEBC created a multi-year strategic framework aimed at tackling several goals for the GHIP[1]
- Items were organized as potential considerations to attain the stated goals
- Highlighted below are broader categories for which the recent topics were derived for SEBC consideration (Centers of Excellence, Site-of-Care Steerage, etc.)
- This framework will continue to be utilized as a tool to provide guidance for the SEBC, and will be modified to the extent new ideas or approaches are to be considered

Approved and Voted on by SEBC, December 2016

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 ★ Denotes activity through TPA RFP process

Recent Considerations
Site-of-Care Steerage
Centers of Excellence
Reference-Based Pricing

Ongoing/Future Considerations
Further penetration of value-based plans and networks
Plan option evaluation (HSA consideration)
Primary care access and utilization
Third party vendor health and engagement tools

[1]Reduction of medical trend, penetration into value-based care delivery space and increased enrollment in consumer and value-driven plans

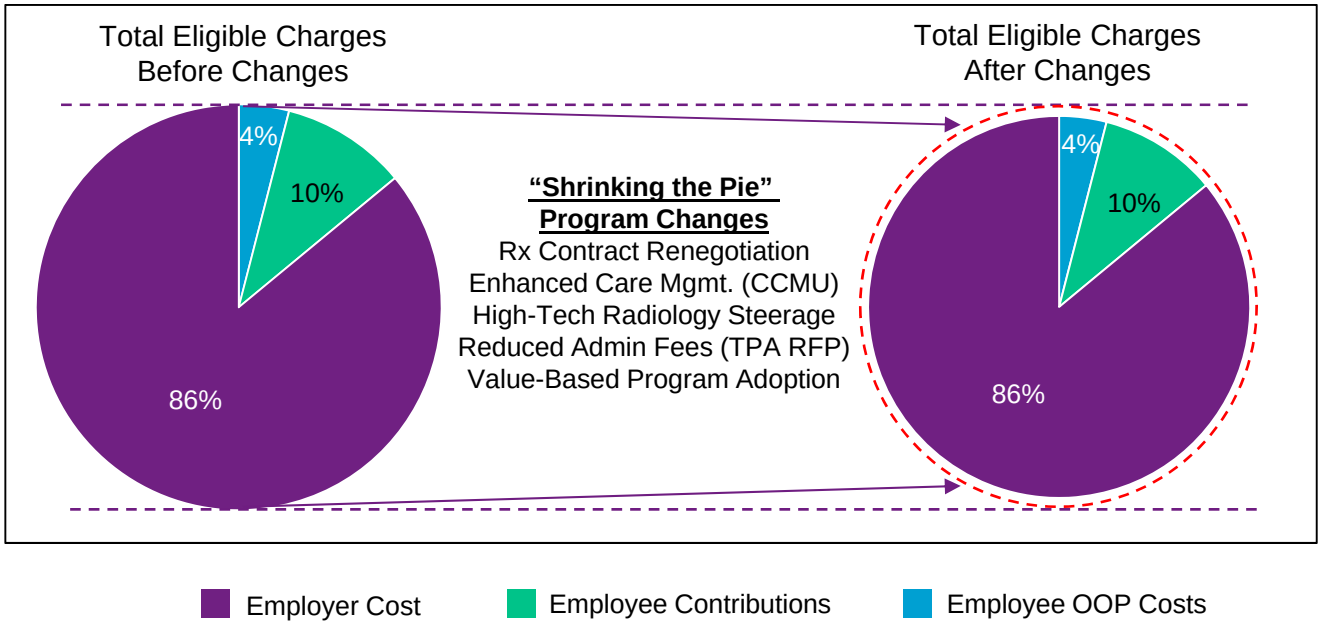
Range of Health Care Delivery Solutions

Treatment Support Solutions	Telemedicine	Navigation Solutions	Near-Site and Onsite Health Centers	Centers of Excellence	Network Products and Solutions	Direct Contracting Solutions
▪ Decision support tools through carriers ▪ Carve-out solutions ▪ Expert medical or second opinion providers	▪ Available through carrier partnerships or directly with carve-out vendors ▪ Range of services expanding	▪ Digital point solutions for navigation, engagement and concierge ▪ Single point-of-contact solutions that integrate all member needs	▪ Near-site centers or onsite centers^^ ▪ Range of services ▪ Employer sponsored, local health systems, or carve-out vendors	▪ Carrier-solutions; primarily focused on quality but have limited integration ▪ Carve-out vendor solutions; typically focused on quality with bundled case rate pricing	▪ Carrier-solutions (e.g., site-of-care steerage, reference based pricing, high-performance networks, value-based contract product ACOs/JVs) ▪ Carve-out high-performance networks	▪ ACOs ▪ Custom networks ▪ Custom Centers of Excellence ▪ Targeted quality/ efficiency health system arrangements

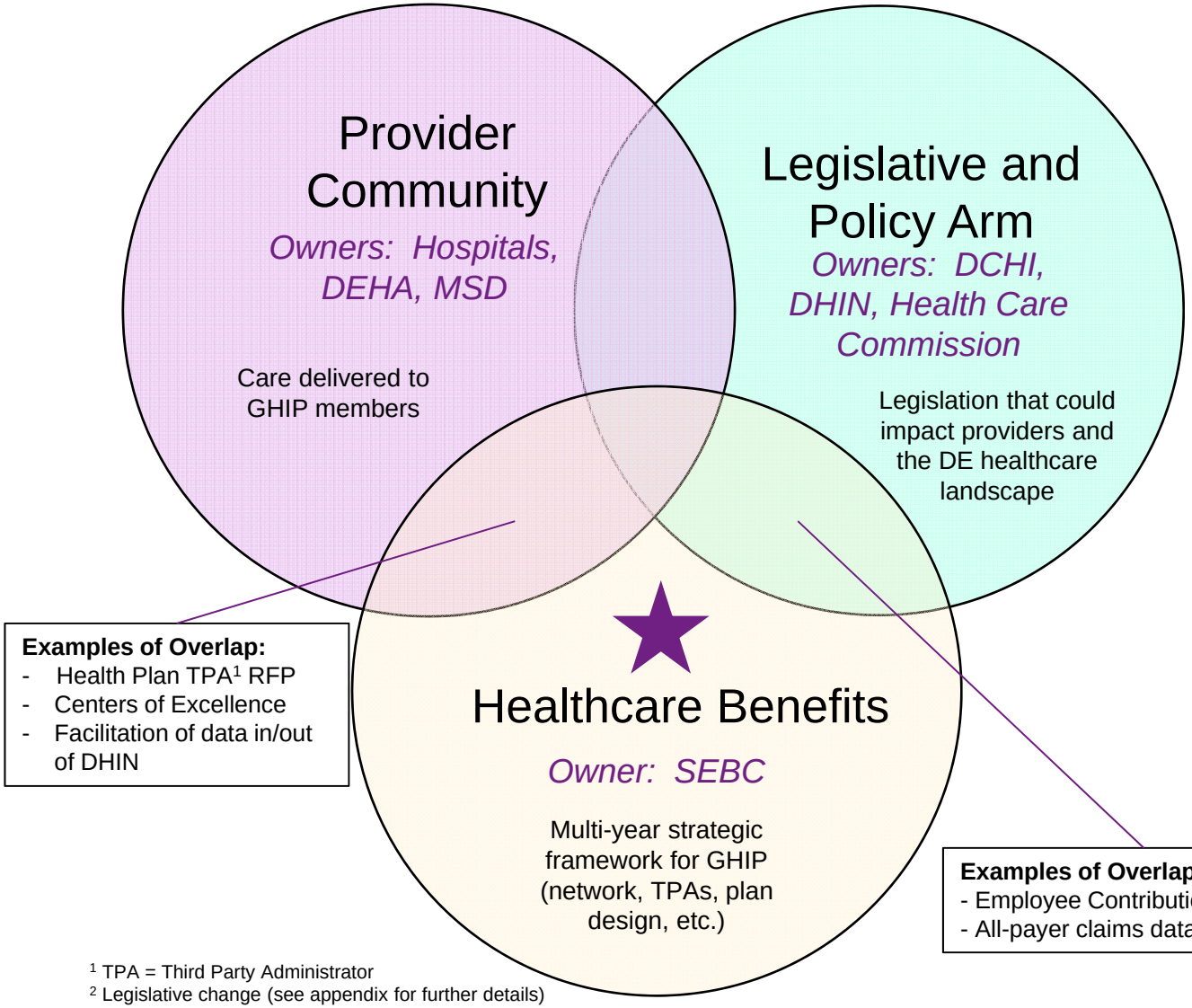
^ *Typically requires 500+ employees*
^^ *Typically requires 1,000+ employees in a geography*
^^^*Typically requires 3,000+ employees in a geography and a higher degree of provider readiness*

“Shrinking the pie”

- The SEBC developed a mission statement that identified several tenets, including an emphasis on providing adequate access to high quality healthcare at an **affordable cost**
- To that end, 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
- The SEBC should continue to look for opportunities to improve program efficiency and further shrink the pie



Key influencers on the GHIP



Examples of Overlap:
- Health Plan TPA[1] RFP
- Centers of Excellence
- Facilitation of data in/out of DHIN

Examples of Overlap:
- Employee Contributions (HB81)[2]
- All-payer claims database

- 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

Acronym key:

DCHI – Delaware Center for Health Innovation

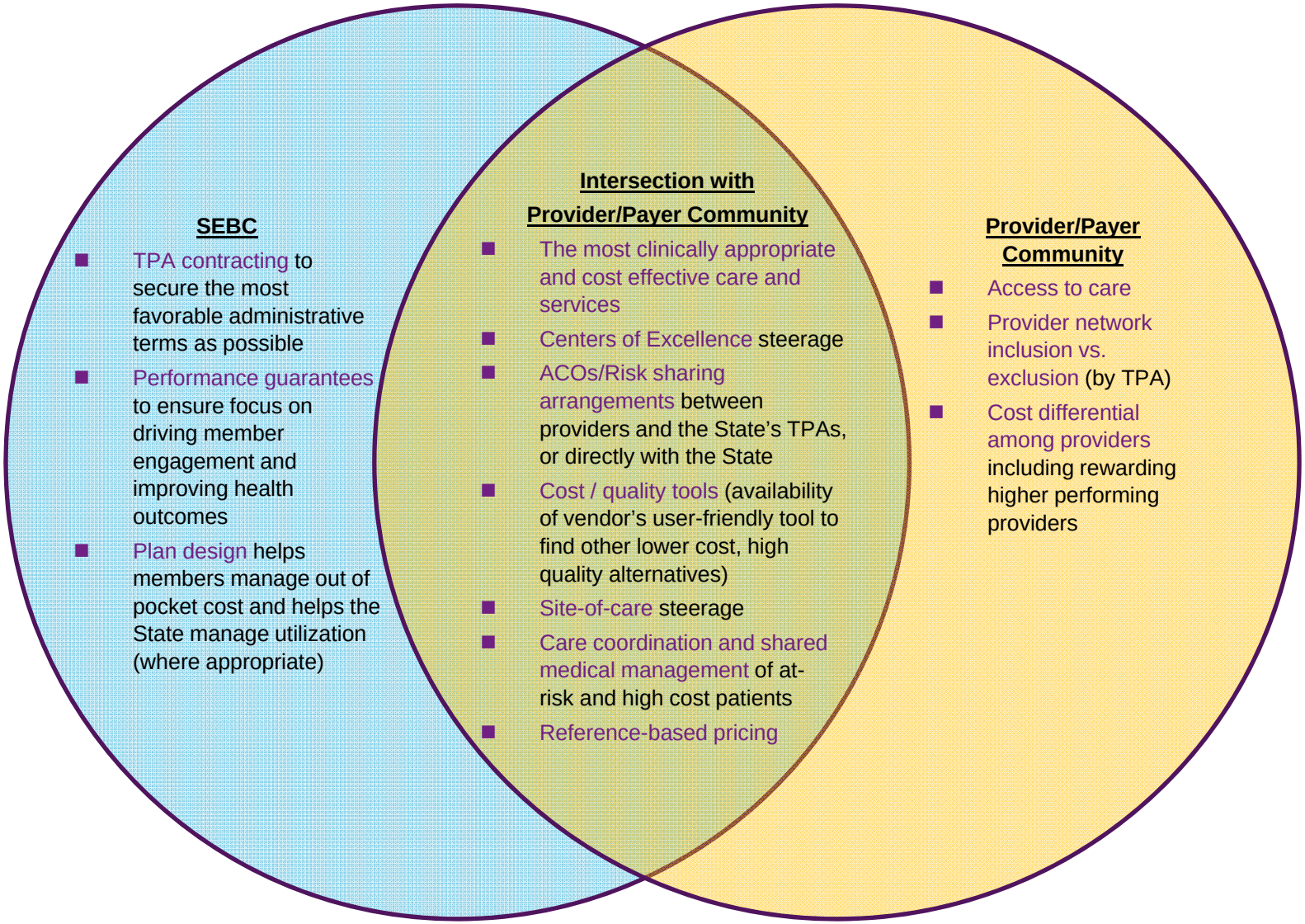
DEHA – Delaware Healthcare Association

DHIN – Delaware Health Information Network

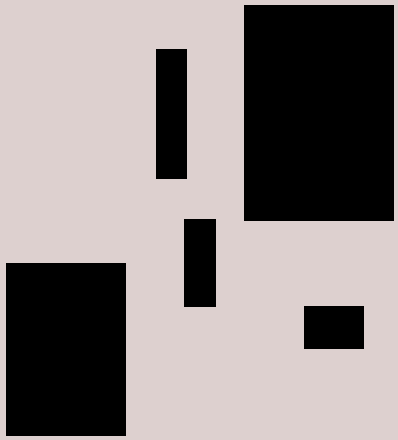
MSD – Medical Society of Delaware

[1] TPA = Third Party Administrator
[2] Legislative change (see appendix for further details)

Addressing cost and access with Delaware healthcare providers



Reference-based pricing



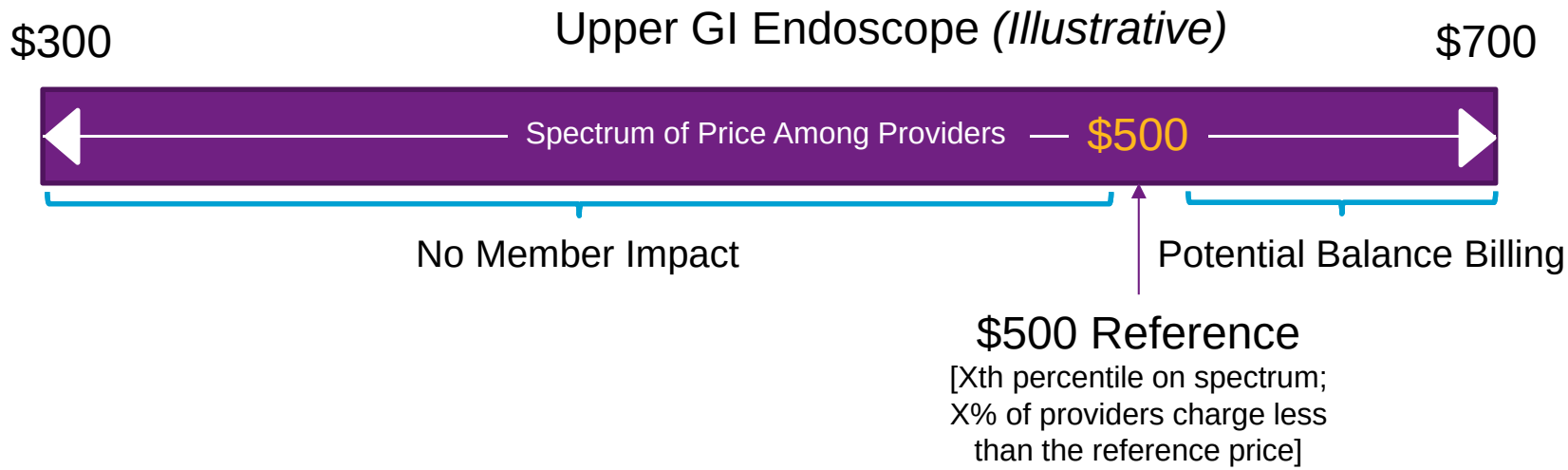
Reference-based pricing – overview

How is it defined?

- Plan sponsors pay a fixed amount or "reference" price toward the cost of a specific health care service, instead of a discounted rate off the billed provider charge.
- Health plan members must pay the difference in price if they select a more costly health care provider or service.

Plan design	Works best with coinsurance-based plan design (e.g., First State Basic or CDH Gold) where members are already exposed to differentials in underlying cost.
Covered procedures	Typically limited to a small number of elective procedures, usually those with high cost and local competition.
Price	Based on what can be negotiated in the free market. Usually a multiple of Medicare pricing (e.g., 150%).
Third party administrator (TPA)	Can be traditional medical TPA (e.g., Aetna, Highmark) that maintains its own provider network or a non-traditional TPA with access to a rented/leased network.
Network contracts	TPA may arrange for access to providers who have agreed to accept reference-based price, which may be more limited set of providers than in a broad PPO network. However, when contracting with network providers, some TPAs may not build in contractual requirements for network providers to accept a reference price up to a specified amount.
Patient balance billing	Balance billing likely if patient obtains care outside of the designated providers that have agreed to reference-based price. May be difficult to avoid depending upon the scope of the designated provider network. All billing should occur following claim adjudication, not at point-of-care.
Advocacy, navigation and education	Substantial advocacy services and an intensive communication and member education program are critical to success.

Mechanics of setting the reference price



- Reference price set at percentile of all provider charges
- The plan sponsor may set the reference price, in conjunction with the vendor partner, based on a sliding scale that has a correlation between savings and member impact
  - Higher percentile – less savings, less member impact
  - Lower percentile – more savings, more member impact
- The bulk of savings are generated by member cost shifting, and may also drive utilization to lower cost providers

Medical vendor capabilities to administer reference-based pricing

- Both Aetna and Highmark can administer reference-based pricing
- Each vendor's capabilities differ slightly in terms of covered procedures and network breadth
  - Some network contracts stipulate provider may balance bill up to the contracted allowance, while others do not
- Both vendors have limited data/analysis to conclude whether or not changes in member utilization patterns have occurred as a result of reference-based pricing being implemented

Vendor	Procedures Available[1]	Customers with RBP[2]	Administration Cost	Additional Considerations
Aetna	7 Outpatient procedures 4 Outpatient imaging	9	None	Uses bundles to group related procedures together
Highmark	21 Outpatient procedures 7 Outpatient imaging	0	No cost for implementation; ongoing administration is $0.50 PEPM	6 month roll-out required

[1] Full list available in appendix
[2] Data as of January 2019.

Member impact

Illustrative example #1 – copay-based plan

- In this example, an employee needs an Upper GI endoscope
- Employee is in PPO plan
  - Current PPO plan copay for specialist visit is $30 at a freestanding facility
  - Under the Illustrative Offering, the “reference price” for this procedure is $500

Cost Breakdown	Current PPO Offering (no reference-based pricing)	Illustrative Offering With Reference Based Pricing
Provider Billed Amount	**$1,200**	**$1,200**
Reference Price	N/A	**$500** (based on Medicare Allowable)
Plan Allowed Amount (“Negotiated Rate”)	**$700 —** Agreed upon price after PPO discount. Provider agrees not to balance bill member.	N/A
State Pays	**$670** ($700 - $30 copay)	**$500** (Reference Price)
Member Pays	**$30** Copay	**$30** Copay plus up to **$670** *($1,200 - $500 - $30)* if provider chooses to balance bill

Member impact

Illustrative example #2 – coinsurance-based plan

- In this example, an employee needs back surgery and chooses an in-network provider for the procedure
- Employee is in the CDH Gold plan with Employee Only coverage
  - Current CDH Gold plan coinsurance is 90% for in-network providers after $1,500 individual deductible
  - Under the Illustrative Offering, the “reference price” for this procedure is $15,000

Cost Breakdown	Current CDH Gold Offering (no reference-based pricing)	Illustrative Offering With Reference Based Pricing
Provider Billed Amount	**$75,000**	**$75,000**
Reference Price	NA	**$15,000** (Medicare Allowable Cost)
Plan Allowed Amount (“Negotiated Rate”)	**$45,000 —** Agreed upon price after PPO discount. Provider agrees not to balance bill member	**$22,500** (150% of Medicare) There is no agreement around member balance billing
Coinsurance	10%	10%
Employer Pays	**$40,500** Maximum ($45,000 – $4,500)	**$18,000** Maximum ($22,500 – $4,500)
Member Pays	**$4,500** Out of Pocket Maximum ($1,500 deductible plus $3,000 coinsurance, assumes individual has no other medical claims for the plan year)	**$4,500** Out of Pocket Maximum plus up to **$52,500** *($75,000 - $18,000 - $4,500)* if provider chooses to balance bill

Compliance considerations for reference price ceiling plans

- ACA limits cost-sharing for essential health benefits in a non-grandfathered group health plan to $7,350 for self-only coverage and $14,700 for other than self-only coverage (2018)
- Employers offering a reference-based plan should ensure adequate and timely access to high quality providers accepting the reference-based price
- Employers should exclude emergency services from reference-based plans, as members do not have the opportunity to shop
- Employers should have an easily accessible exceptions process when access to a provider that accepts the reference price is unavailable, or would compromise the quality of services for a particular individual
- Plans should fully disclose information about the pricing structure, including the services to which it applies and the exceptions process. In addition, plans should provide the following specified information upon request: a list of providers that will accept the reference price for each service; a list of providers that will accept a negotiated price above the reference price for each service; and information on the process and underlying data used to ensure that an adequate number of providers accepting the reference price meet reasonable quality standards.

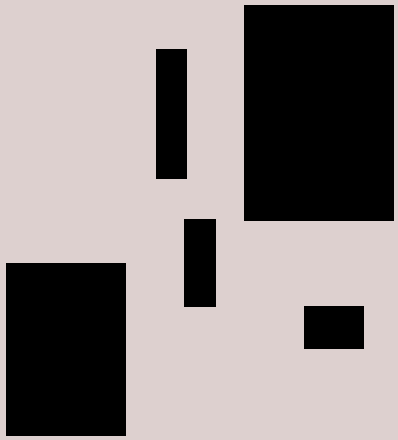
If a plan sets such a low reference price that few (if any) providers would be willing to accept the reference price as payment in full, the plan must count a participant's payments above the reference price toward the plan's overall cost-sharing limit. - ACA FAQs Part 31),

Willis Towers Watson Point of View

- Organizations considering reference-based pricing should seek substantial information regarding potential member liability, operations, and compliance
- The market is evolving rapidly, and hybrid plans are emerging that have some network contracting along with reference-based designs
- Organizations considering reference-based pricing should seek opinion from their counsel to be sure that plan complies with all appropriate laws and regulations
- Reference-based pricing will likely lead to more queries and complaints to Human Resources, which will need to be staffed and prepared for this

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

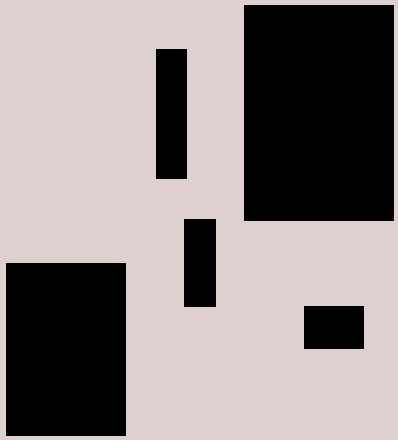
Next steps



Next steps

- Next meeting of the Health Policy & Planning Subcommittee – February 7
  - Further discussion of SB139
  - HSA plan design considerations

Appendix



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.

Procedures eligible for reference-based pricing

Aetna

Outpatient Procedures	Outpatient Imaging
Colonoscopy (preventive and screening) Upper GI Endoscopy Carpal Tunnel Release Cataract Removal Tonsillectomy/Adeniodectomy Inguinal Herniorrhaphy Sleep Study	CT Scan with Contrast CT Scan without Contrast MRI with Contrast MRI without Contrast

Note: Aetna has four “standard bundles” for reference-based pricing. These include, GI Scope, Complex Radiology, GI Scopes and Complex Radiology and Comprehensive

Procedures eligible for reference-based pricing

Highmark

Outpatient Procedures	Outpatient Imaging
Cataract Removal Knee arthroscopy with cartilage repair ACL repair by arthroscopy Upper GI endoscopy Upper GI endoscopy with biopsy Carpal tunnel Shoulder arthroscopy Shoulder arthroscopy with rotator cuff repair Colposcopy with removal of lesion(s) Colonoscopy with biopsy Back surgery – laminectomy Bladder repair for incontinence (sling) Bunionectomy Endoscopy – sinus surgery Insertion of tubes in ears Umbilical hernia repair – age 5+ Release trigger finger Inguinal hernia repair – laproscopic Inguinal hernia repair – age 5+ non laparoscopic Esophagoscopy Hammertoe correction	MRI (includes Orbit/face/neck, brain, neck spine, lumbar spine, spine, arm joint, arm (other than joint), abdomen, pelvis, leg, leg with joint Ultrasound of pelvis Ultrasound of abdomen CAT scan (includes head/brain, mount/jaw/neck, angiography of head with and without contrast, abdomen, chest, pelvis, abdomen and pelvis, angiography of abdomen with and without contrast) PET scan skull base to mid-thigh PET scan image whole body