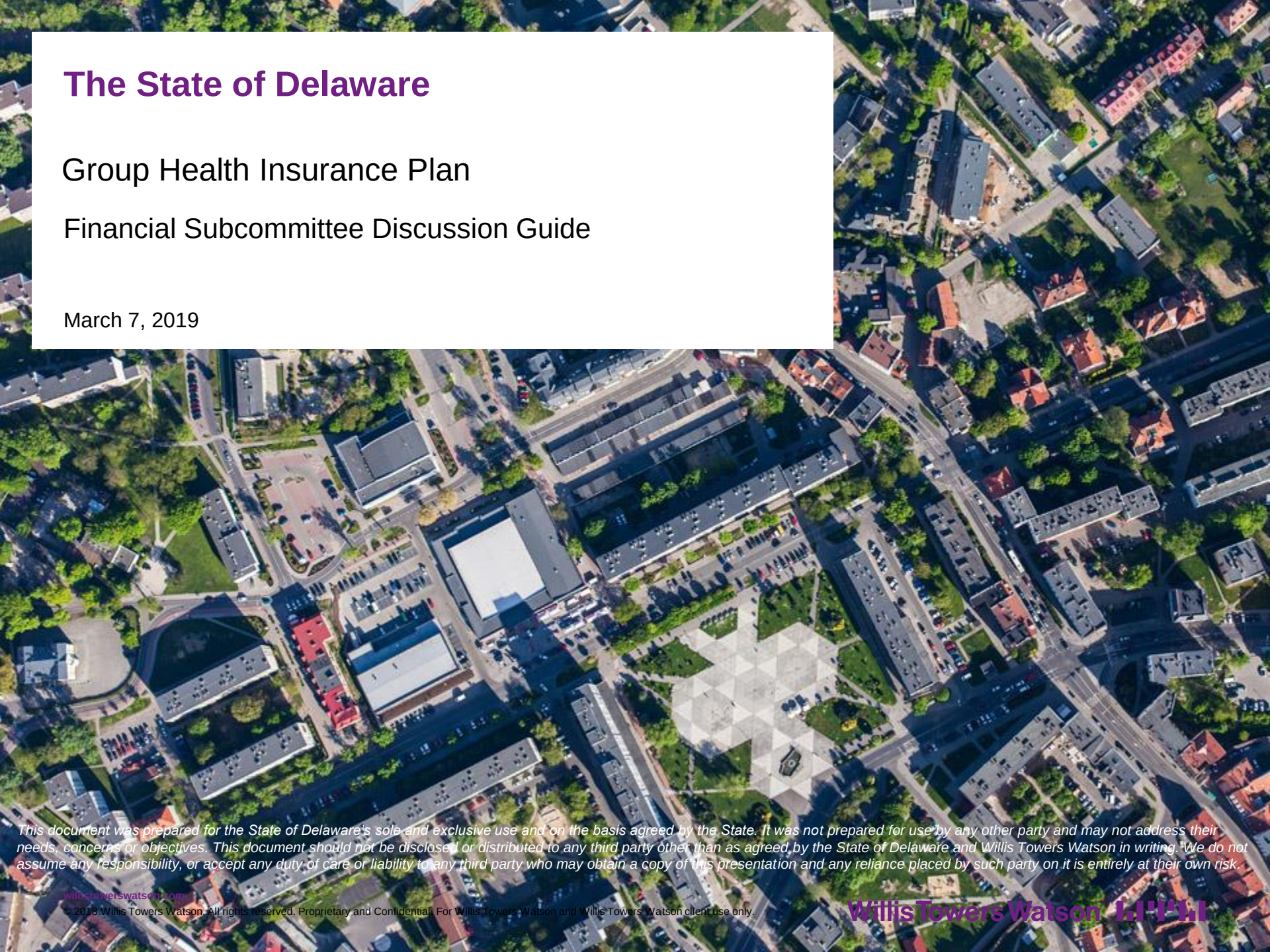


The State of Delaware

Group Health Insurance Plan

Financial Subcommittee Discussion Guide

March 7, 2019

Willis Towers Watson

Today's discussion

- GHIP long-term health care cost projections
  - Revised FY19 recast and FY20 projection
  - ESI pharmacy renewal proposal (final results)
  - Claim liability refresh
- IBM Watson Health reporting discussion
  - Review FY19 Q1 site of care steerage impact analysis
  - Current financial reporting and timing
  - Review High-Cost Claimant analytic and FY19 Q1 incurred modeling reports
- Appendix

GHIP long term health care cost projections (FY19 Q2 update)

Updates to FY19 recast and FY20 projection

- At 2/11/2019 SEBC meeting, Willis Towers Watson (WTW) presented GHIP financial projections based on updated claims experience through December 2018 (FY19 Q2) and the subcommittees' 12/18/2018 recommendations
- FY19 Q2 financial projections have been revised to reflect the following updates:
  - Refreshed lag factors used to determine the GHIP FY19 claim liability as of 12/31/2018
    - Claim liability reduced to $58.8M, down from $61.3M, driven by a reduction in Aetna lag factor
    - Increases GHIP FY19 projected surplus to $54.7M, up from $52.2M
  - ESI's best and final contract renewal proposal, provided 1/29/2019
    - Total savings of $17.1M over current pharmacy contract terms (up from $14.5M based on ESI's preliminary renewal proposal)
- FY20 program changes were approved at the 2/11 SEBC meeting and continue to be reflected in the long-term projection exhibit including:
  - Implementation of SurgeryPlus site-of-care steerage: $500k savings **(approved 10/22)**
  - Implementation of Highmark infusion therapy steerage program: $2.0M savings **(approved 2/11)**
  - Implementation of Livongo diabetes prevention services: $720k savings **(approved 2/11)**
  - Changes to select copay plan design1: $6.9M savings **(approved 2/11)**

Claim liability refresh

Updates to FY19 recast

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	12/31/18
$54.3m	$54.3m	$56.5m	$59.5m	$58.9m	$58.9m	$61.3m	$58.8m

- Recommended Claim Liability target is based on estimated incurred but not paid ("IBNP") liability as of 12/31/2018
  - Medical Claim Liability (Highmark and Aetna): $50.9M
  - Pharmacy Claim Liability (ESI Commercial and EGWP): $7.9M
- IBNP liability is based on paid claims for the period 1/1/2018 – 12/31/2018 and lag factors developed by Willis Towers Watson as of 12/31/2018
  - 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
- Reduction in IBNP as of 12/31/2018 driven by a stabilization of Aetna processing time, which increased in FY18 (likely as a result of plan migration following the TPA RFP effective 7/1/2017)
- Reduction in claims liability increases FY19 projected surplus to $54.7M

ESI pharmacy renewal – One year proposal

Overview

- The State engaged Willis Towers Watson to support the evaluation and negotiation of a one-year extension for the ESI Commercial and EGWP pharmacy contracts
  - The State has a traditional pricing arrangement for both contracts with 100% pass-through of rebates
  - The current Commercial contract terminates 6/30/2019
  - The current EGWP contract terminates 12/31/2019
- In December 2018, ESI submitted preliminary one-year renewal offers for both the Commercial and EGWP populations
  - Commercial renewal period: 7/1/2019 – 6/30/2020
  - EGWP renewal period: 1/1/2020 – 12/31/2020
- The preliminary renewal yielded $14.5M savings over the current pharmacy contract terms
- ESI provided a best and final offer on 1/29/2019, yielding an additional $2.6M in savings over the preliminary renewal, for a total savings of $17.1M over the current pharmacy contract terms
  - These savings have been incorporated into the latest GHIP FY20 financial projections

ESI pharmacy renewal – One year proposal

Summary of projected FY20 contract savings (best and final offer)

- Overall, ESI's best and final renewal proposal is projected to reduce pharmacy allowed spend by $25.7M for the respective one-year contract periods compared to the current contract pricing terms
  - Improvements in the commercial offer yield increase in gross allowed savings from $11.6M to $13.8M for the period 7/1/2019 – 6/30/2020
  - Improvements in the EGWP offer yield increase in gross allowed savings from $10.1M to $11.9M for the period 1/1/2020 – 12/31/2020
- Estimated total reduction of $17.1M in GHIP pharmacy plan cost for FY20 ($11.1M Commercial, $6.0M EGWP) or additional $2.6M over initial offer

ESI One Year Renewal Offer ($M)	Commercial Population (FY20)				EGWP Population (CY20)			
	Initial Offer		BAFO		Initial Offer		BAFO	
	$ Savings	% Savings	$ Savings	% Savings	$ Savings	% Savings	$ Savings	% Savings
Rx allowed cost savings before rebates[1] *Reduction in allowed charges*	$4.5	2.7%	$4.9	2.9%	$6.0	4.1%	$6.1	4.2%
Rx allowed cost savings incl. rebates[2] *Reduction in allowed charges + improved rebates*	$11.6	8.6%	$13.8	10.2%	$10.1	8.0%	$11.9	9.4%
FY20 plan cost reduction[3] *FY20 budget impact*	**$9.5**		**$11.1**		**$5.0**		**$6.0**	

[1]Estimated savings for each respective contract period using allowed claims (plan and member cost sharing combined), utilization, and enrollment data for the period 11/1/2017 – 10/31/2018 and composite annual pharmacy trend rate of 6-7% (varying by generic, brand, and specialty drug categories)

[2] Estimated Rx allowed cost savings per footnote 1 plus estimated increase in rebates based on current drug mix; rebate improvements shown are above any anticipated rebate over-performance (true-up) for current contract

[3] Estimated reduction in GHIP pharmacy plan cost (net of member cost sharing) for the period 7/1/2019 – 6/30/2020 based on the pricing assumptions outlined in the Appendix

GHIP long term health care cost projections (revised FY19 Q2 update)

Use of surplus and premium rate increases

- Based on revised financial projections as of Q2 and the updated FY19 claim liability, GHIP is projected to end FY19 with $54.7M surplus
- Maintaining baseline premium increase of 2% effective 7/1/2019 reduces the FY20 projected surplus to $41.5M
- Smoothing the surplus over two years ($27M in FY20, $27M in FY21) suggests a **0.3% premium increase** effective 7/1/2019
- The following pages show the revised long term projections reflecting claims data through Q2, the revised FY19 claim liability, and the best and final ESI FY20 pharmacy renewal under two premium rate increase scenarios:
  - 2.0% increase effective 7/1/2019 ($41.5M projected surplus through end of FY20)
  - Hold premium rates flat effective 7/1/2019 ($24.9M projected surplus through end of FY20)
    - 0.3% increase scenario is worth an additional $2.4M in premium revenue relative to holding rates flat for FY20 (scenario not shown)

GHIP long term health care cost projections (revised FY19 Q2 update[1])

Subcommittee recommendations including FY20 program changes and 2% annual premium increase

Based on negotiated final offer for ESI FY20 pharmacy renewal

FY20 reflects employee contribution increases of $0.56 – $5.46 per month ($6.72 – $65.52 per year) and State subsidy increases of $13.35 – $35.73 per employee per month ($160.20 – $428.76 per year) effective 7/1/2019

GHIP Costs ($ millions)	FY17 Actual	FY18 Actual	FY19 Projected[1]	FY20 Projected[1,8]	FY21 Projected[8]	FY22 Projected[8]	FY23 Projected[8]
Average Enrolled Members	123,132	125,488	126,198	128,722	131,296	133,922	136,600
GHIP Revenue							
Premium Contributions (Increasing with Enrollment)[2]	$799.0	$810.9	$815.7	$830.0	$846.6	$863.5	$880.8
2.0% Premium Increase 7/1/2019	-	-	-	*$16.6*	*$33.9*	*$52.5*	*$72.2*
Other Revenues[3]	$81.6	$92.1	$90.2	$109.7	$117.5	$125.8	$134.7
Total Operating Revenues	**$880.6**	**$903.0**	**$905.9**	**$956.3**	**$998.0**	**$1,041.8**	**$1,087.7**
GHIP Expenses (Claims/Fees)							
Operating Expenses[4]	$816.8	$853.9	$920.0	$975.0	$1,044.2	$1,118.3	$1,197.7
% Change Per Member	*1.8%*	*2.6%*	*7.1%*	*3.9%*	*5.0%*	*5.0%*	*5.0%*
FY20 Program Changes[5]				($9.6)	($10.1)	($10.6)	($11.1)
Excise Tax Liability[6]						$9.1	$16.3
Adjusted Net Income (Revenue less Expense)	**$63.8**	**$49.1**	**($14.1)**	**($9.1)**	**($36.1)**	**($75.0)**	**($115.2)**
Balance Forward	$38.9	$102.7	$151.8	$137.8	$128.7	$92.6	$17.6
Ending Balance	$102.7	$151.8	$137.8	$128.7	$92.6	$17.6	($97.6)
- Less Claims Liability[7]	*$54.0*	*$58.9*	*$58.8*	*$61.7*	*$66.1*	*$71.4*	*$76.9*
- Less Minimum Reserve[7]	*$24.0*	*$24.0*	*$24.3*	*$25.5*	*$27.3*	*$29.5*	*$31.6*
GHIP Surplus (After Reserves/Deposits)	**$24.7**	**$68.9**	**$54.7**	**$41.5**	**($0.8)**	**($83.3)**	**($206.1)**

Note: FY17 actual based on final June 2017 Fund Equity report; FY18 actual based on final June 2018 Fund Equity report; projected operating expenses based on experience through FY19 Q2; FY19 enrollment as of December 2018; 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 and implementation of SurgeryPlus COE effective 7/1/2019; includes financial impact of legislative bills impacting GHIP ($1.2m increase to FY19 budget and $2.4m increase to FY20 projection).

[2] Includes State and employee/pensioner premium contributions; assumes 2% annual enrollment growth for FY20-FY23.

[3] Includes Rx rebates, EGWP payments, other revenues; FY20 and beyond includes estimated improvements in Rx rebates based on best and final ESI FY20 renewal proposal, provided 1/29/2019; includes fees for participating non-State groups (assumed to increase proportionally with membership growth and health care trend).

[4] FY20 and beyond includes estimated reduction in pharmacy claims as a result of best and final ESI FY20 renewal proposal, provided 1/29/2019.

[5] Includes estimated savings attributable to recommended changes eff. 7/1/2019: site-of-care steerage ($6.9m), Highmark infusion therapy ($2.0m), and Livongo ($0.7m); assumed to increase annually with trend

[6] 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

[7] FY19 Minimum Reserve levels updated with data through June 2018; FY19 Claim Liability updated with data and lag factors as of Dec 2018; future years assumed to increase with overall GHIP expense growth

[8] 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.

FY20 monthly rates and employee/retiree contributions

Illustrative: 2.0% increase effective 7/1/2019

FY20 reflects employee contribution increases of $0.56 – $5.46 per month ($6.72 – $65.52 per year) and State subsidy increases of $13.35 – $35.73 per employee per month ($160.20 – $428.76 per year) effective 7/1/2019

	FY 2019			FY 2020 with 2.0% Increase			$ Change Employee/ Pensioner Contribution		$ Change State Subsidy	
	Rate	Employee Contribution	State Subsidy	Rate	Employee Contribution	State Subsidy	Monthly	Annual	Monthly	Annual
First State Basic										
Employee	$695.36	$27.84	$667.52	$709.27	$28.40	$680.87	$0.56	$6.72	$13.35	$160.20
Employee + Spouse	$1,438.68	$57.52	$1,381.16	$1,467.45	$58.67	$1,408.78	$1.15	$13.80	$27.62	$331.44
Employee + Child	$1,057.02	$42.26	$1,014.76	$1,078.16	$43.11	$1,035.05	$0.85	$10.20	$20.29	$243.48
Family	$1,798.42	$71.92	$1,726.50	$1,834.39	$73.36	$1,761.03	$1.44	$17.28	$34.53	$414.36
CDH Gold										
Employee	$719.68	$35.98	$683.70	$734.07	$36.70	$697.37	$0.72	$8.64	$13.67	$164.04
Employee + Spouse	$1,492.22	$74.58	$1,417.64	$1,522.06	$76.07	$1,445.99	$1.49	$17.88	$28.35	$340.20
Employee + Child	$1,099.56	$54.96	$1,044.60	$1,121.55	$56.06	$1,065.49	$1.10	$13.20	$20.89	$250.68
Family	$1,895.74	$94.78	$1,800.96	$1,933.65	$96.68	$1,836.97	$1.90	$22.80	$36.01	$432.12
Aetna HMO										
Employee	$725.94	$47.16	$678.78	$740.46	$48.10	$692.36	$0.94	$11.28	$13.58	$162.96
Employee + Spouse	$1,530.58	$99.50	$1,431.08	$1,561.19	$101.49	$1,459.70	$1.99	$23.88	$28.62	$343.44
Employee + Child	$1,110.52	$72.18	$1,038.34	$1,132.73	$73.62	$1,059.11	$1.44	$17.28	$20.77	$249.24
Family	$1,909.82	$124.12	$1,785.70	$1,948.02	$126.60	$1,821.42	$2.48	$29.76	$35.72	$428.64
Comprehensive PPO										
Employee	$793.86	$105.18	$688.68	$809.74	$107.28	$702.46	$2.10	$25.20	$13.78	$165.36
Employee + Spouse	$1,647.34	$218.26	$1,429.08	$1,680.29	$222.63	$1,457.66	$4.37	$52.44	$28.58	$342.96
Employee + Child	$1,223.46	$162.08	$1,061.38	$1,247.93	$165.32	$1,082.61	$3.24	$38.88	$21.23	$254.76
Family	$2,059.40	$272.86	$1,786.54	$2,100.59	$278.32	$1,822.27	$5.46	$65.52	$35.73	$428.76

GHIP long term health care cost projections (revised FY19 Q2 update[1])

FY20 approved program changes, **hold premium rates flat FY20+**

Based on negotiated final offer for ESI FY20 pharmacy renewal

GHIP Costs ($ millions)	FY17 Actual	FY18 Actual	FY19 Projected[1]	FY20 Projected[1,8]	FY21 Projected[8]	FY22 Projected[8]	FY23 Projected[8]
Average Enrolled Members	123,132	125,488	126,198	128,722	131,296	133,922	136,600
GHIP Revenue							
Premium Contributions (Increasing with Enrollment)[2]	$799.0	$810.9	$815.7	$830.0	$846.6	$863.5	$880.8
Hold premium rates flat FY20+)	-	-	-	*$0.0*	*$0.0*	*$0.0*	*$0.0*
Other Revenues[3]	$81.6	$92.1	$90.2	$109.7	$117.5	$125.8	$134.7
Total Operating Revenues	**$880.6**	**$903.0**	**$905.9**	**$939.7**	**$964.1**	**$989.3**	**$1,015.5**
GHIP Expenses (Claims/Fees)							
Operating Expenses[4]	$816.8	$853.9	$920.0	$975.0	$1,044.2	$1,118.3	$1,197.7
% Change Per Member	*1.8%*	*2.6%*	*7.1%*	*3.9%*	*5.0%*	*5.0%*	*5.0%*
FY20 Program Changes[5]				($9.6)	($10.1)	($10.6)	($11.1)
Excise Tax Liability[6]						$9.1	$16.3
Adjusted Net Income (Revenue less Expense)	**$63.8**	**$49.1**	**($14.1)**	**($25.7)**	**($70.0)**	**($127.5)**	**($187.4)**
Balance Forward	$38.9	$102.7	$151.8	$137.77	$112.08	$42.1	($85.4)
Ending Balance	$102.7	$151.8	$137.8	$112.08	$42.08	($85.4)	($272.8)
- Less Claims Liability[7]	*$54.0*	*$58.9*	*$58.8*	*$61.7*	*$66.1*	*$71.4*	*$76.9*
- Less Minimum Reserve[7]	*$24.0*	*$24.0*	*$24.3*	*$25.5*	*$27.3*	*$29.5*	*$31.6*
GHIP Surplus (After Reserves/Deposits)	**$24.7**	**$68.9**	**$54.7**	**$24.9**	**($51.3)**	**($186.3)**	**($381.3)**

Note: FY17 actual based on final June 2017 Fund Equity report; FY18 actual based on final June 2018 Fund Equity report; projected operating expenses based on experience through FY19 Q2; FY19 enrollment as of December 2018; 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 and implementation of SurgeryPlus COE effective 7/1/2019; includes financial impact of legislative bills impacting GHIP ($1.2m increase to FY19 budget and $2.4m increase to FY20 projection).

[2] Includes State and employee/pensioner premium contributions; assumes 2% annual enrollment growth for FY20-FY23.

[3] Includes Rx rebates, EGWP payments, other revenues; FY20 and beyond includes estimated improvements in Rx rebates based on preliminary ESI FY20 renewal; includes fees for participating non-State groups (assumed to increase proportionally with membership growth and health care trend).

[4] FY20 and beyond includes estimated reduction in pharmacy claims as a result of preliminary ESI FY20 renewal.

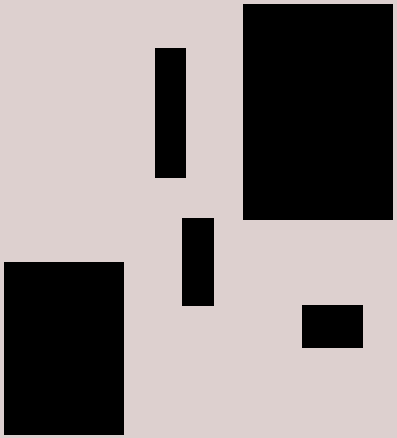
[5] Includes estimated savings attributable to approved changes eff. 7/1/2019: site-of-care steerage ($6.9m), Highmark infusion therapy ($2.0m), and Livongo ($0.7m); assumed to increase annually with trend

[6] 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

[7] FY19 Minimum Reserve levels updated with data through June 2018; FY19 Claim Liability updated with data and lag factors as of Dec 2018; future years assumed to increase with overall GHIP expense growth

[8] 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.

IBM Watson Health Reporting Discussion



IBM Watson Health reporting discussion

Goals of today's discussion

- Review impact of recent plan design changes that promote site-of-care steerage
  - IBM Watson Health site-of-care steerage reporting updated through FY19 Q1
- Review IBM Watson Health high-cost claimant analytic
  - Discuss format and additional metrics the subcommittee would like to see on an ongoing basis to review high-cost claimant experience and identify care management opportunities
- Review IBM Watson Health FY19 Q1 incurred claims report
- Review timing of IBM Watson Health reporting

Recent plan design changes to promote site-of-care steerage

Urgent care – utilization for Q2 FY16 through Q1 FY19

For non-emergent[1] and primary care treatable conditions only

- From Q2 FY16 to Q1 FY19, overall utilization for active employees and early retirees declined (see next page)
  - Goal for number of redirected ER visits was met in both years (FY17 and FY18)
  - PCP visits during this time declined as well, but visits/1,000 remained relatively stable over the same time period
    - Data suggest that some members may utilize urgent care centers for acute conditions that could be treated in a primary care setting
    - However, overall PCP visit rates did not experience a similar decrease during the same time period[2], suggesting that member utilization for non-acute conditions (e.g., maintenance care for chronic conditions) remained stable or increased

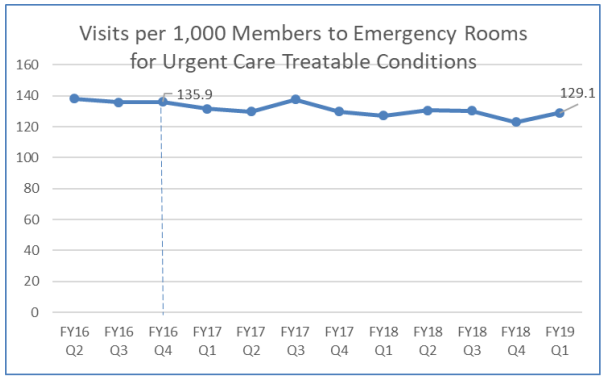
1 Classification of visits provided by IBM Watson Health and based on a New York University study. Non-Emergent = no immediate care required within 12 hours. Primary Care Treatable = treatment required within 12 hours, but could be provided in a primary care setting.
2 Source: Aetna and Highmark Q2 reporting for FY19.

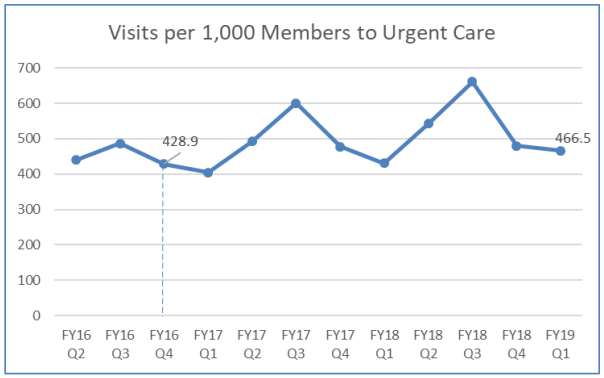
Recent plan design changes to promote site-of-care steerage

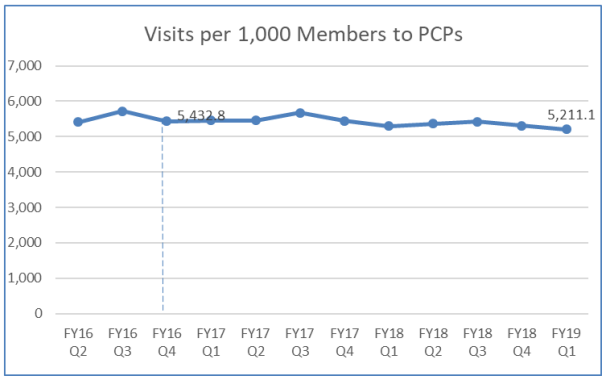
Urgent care – utilization for Q2 FY16 through Q1 FY19 (continued)

Visits[1] *(non-emergent & primary care treatable only)*	Q2 FY16 to Q1 FY17	Q2 FY17 to Q1 FY18	Q2 FY18 to Q1 FY19	Change from Q2 FY16 to Q1 FY18	Change from Q2 FY17 to Q1 FY19	Change from Q2 FY16 to Q1 FY19
Emergency Room	13,208	12,842	12,541	(366)	(301)	(667)
Urgent Care	42,938	49,015	52,548	6,077	3,533	9,610
Primary Care	161,287	154,715	148,414	(6,572)	(6,301)	(12,873)
Total	217,433	216,572	213,503	(861)	(3,069)	(3,930)

1 Represents a subset of the total number of visits to emergency rooms, urgent care centers and primary care physicians during each period. Classification of these types of visits provided by IBM Watson Health and based on a New York University study. Non-Emergent = no immediate care required within 12 hours. Primary Care Treatable = treatment required within 12 hours, but could be provided in a primary care setting.







Source: IBM Watson Health.

Recent plan design changes to promote site-of-care steerage

High tech imaging – utilization for Q2 FY16 through Q1 FY19

- From Q2 FY16 to Q1 FY19, overall utilization of outpatient hospital site of service for high tech imaging services increased 8%, while use of freestanding imaging centers remained relatively unchanged
  - Results suggest that these design changes were only effective in changing behavior in the first year following implementation (FY17); Q2 FY18 to Q1 FY19 results largely resemble FY16 utilization before the design changes were put into place
  - Additional communications and further design changes may be necessary to sustain improved utilization over time

High tech imaging services	Q2 FY16 to Q1 FY17	Q2 FY17 to Q1 FY18	Q2 FY18 to Q1 FY19	Change from Q2 FY16 to Q2 FY17	Change from Q2 FY17 to Q2 FY18	Change from Q2 FY16 to Q1 FY19
Hospital-based Facility	11,948	11,332	12,851	(616)	1,519	903
Freestanding Facility	7,435	7,769	7,525	334	(244)	90
Total	19,383	19,101	20,376	(282)	1,275	993

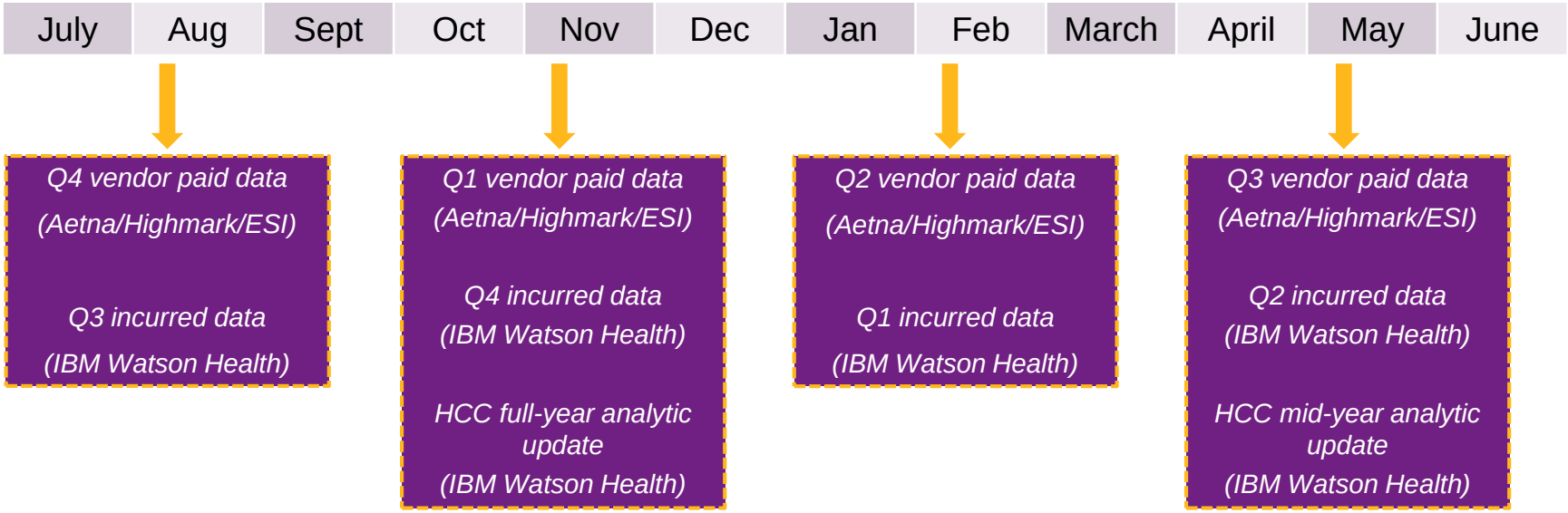
Source: IBM Watson Health.

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)
  - IBM Watson Site-of-Care Steerage Report – quarterly measure of plan design change impact (incurred basis)
  - IBM Watson High-Cost Claimant (HCC) Analytic – HCC deep dive (incurred basis) - ***NEW***
  - Quarterly financial and utilization reports from Aetna, Highmark, and ESI (paid basis)

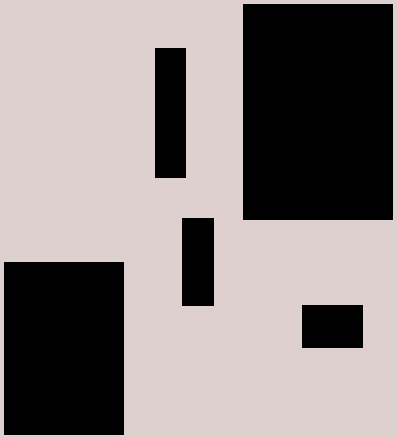
Fiscal Year



IBM Watson Health reporting discussion

- Review IBM Watson Health high-cost claimant analytic and FY19 Q1 incurred claims reported (included in meeting packets)

Appendix



GHIP long term health care cost projections (original FY19 Q2 update[1])

FY20 approved program changes and **2% annual premium increase**

FY20 reflects employee contribution increases of $0.56 – $5.46 per month ($6.72 – $65.52 per year) and State subsidy increases of $13.35 – $35.73 per employee per month ($160.20 – $428.76 per year) effective 7/1/2019

GHIP Costs ($ millions)	FY17 Actual	FY18 Actual	FY19 Projected[1]	FY20 Projected[1,8]	FY21 Projected[8]	FY22 Projected[8]	FY23 Projected[8]
Average Enrolled Members	123,132	125,488	126,198	128,722	131,296	133,922	136,600
GHIP Revenue							
Premium Contributions (Increasing with Enrollment)[2]	$799.0	$810.9	$815.7	$830.0	$846.6	$863.5	$880.8
2.0% Premium Increase 7/1/2019	-	-	-	*$16.6*	*$33.9*	*$52.5*	*$72.2*
Other Revenues[3]	$81.6	$92.1	$90.2	$107.4	$115.1	$123.3	$132.1
Total Operating Revenues	**$880.6**	**$903.0**	**$905.9**	**$954.0**	**$995.6**	**$1,039.3**	**$1,085.1**
GHIP Expenses (Claims/Fees)							
Operating Expenses[4]	$816.8	$853.9	$920.0	$975.4	$1,044.7	$1,118.9	$1,198.3
% Change Per Member	*1.8%*	*2.6%*	*7.1%*	*3.9%*	*5.0%*	*5.0%*	*5.0%*
FY20 Program Changes[5]				($9.6)	($10.1)	($10.6)	($11.1)
Excise Tax Liability[6]						$9.1	$16.3
Adjusted Net Income (Revenue less Expense)	**$63.8**	**$49.1**	**($14.1)**	**($11.7)**	**($39.0)**	**($78.1)**	**($118.4)**
Balance Forward	$38.9	$102.7	$151.8	$137.77	$126.02	$87.0	$8.9
Ending Balance	$102.7	$151.8	$137.8	$126.02	$87.02	$8.9	($109.4)
- Less Claims Liability[7]	*$54.0*	*$58.9*	*$61.3*	*$64.4*	*$69.0*	*$74.5*	*$80.2*
- Less Minimum Reserve[7]	*$24.0*	*$24.0*	*$24.3*	*$25.5*	*$27.3*	*$29.5*	*$31.6*
GHIP Surplus (After Reserves/Deposits)	**$24.7**	**$68.9**	**$52.2**	**$36.1**	**($9.3)**	**($95.1)**	**($221.2)**

Note: FY17 actual based on final June 2017 Fund Equity report; FY18 actual based on final June 2018 Fund Equity report; projected operating expenses based on experience through FY19 Q2; FY19 enrollment as of December 2018; 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 and implementation of SurgeryPlus COE effective 7/1/2019; includes financial impact of legislative bills impacting GHIP ($1.2m increase to FY19 budget and $2.4m increase to FY20 projection).

[2] Includes State and employee/pensioner premium contributions; assumes 2% annual enrollment growth for FY20-FY23.

[3] Includes Rx rebates, EGWP payments, other revenues; FY20 and beyond includes estimated improvements in Rx rebates based on preliminary ESI FY20 renewal; includes fees for participating non-State groups (assumed to increase proportionally with membership growth and health care trend).

[4] FY20 and beyond includes estimated reduction in pharmacy claims as a result of preliminary ESI FY20 renewal.

[5] Includes estimated savings attributable to approved changes eff. 7/1/2019: site-of-care steerage ($6.9m), Highmark infusion therapy ($2.0m), and Livongo ($0.7m); assumed to increase annually with trend

[6] 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

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

[8] 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.

ESI pharmacy renewal – One year proposal

Summary of projected FY20 contract savings (initial offer)

- Overall, ESI's initial renewal proposals are projected to reduce pharmacy allowed spend by $21.7M for the respective one-year contract periods compared to the current contract pricing terms
  - Commercial renewal offer is projected to reduce allowed pharmacy claims by $4.5M (2.7%) and increase rebates by $7.1M, yielding $11.6M gross savings for the period 7/1/2019 – 6/30/2020
  - EGWP renewal offer is projected to reduce allowed pharmacy claims by $6.0M (4.1%) and increase rebates by $4.1M, yielding $10.1M gross savings for the period 1/1/2020 – 12/31/2020
- Estimated total reduction of $14.5M in GHIP pharmacy plan cost for FY20 ($9.5M Commercial, $5.0M EGWP)

ESI One Year Renewal Offer ($M)	Commercial Population FY20		EGWP Population CY20	
Initial Proposal	**$ Savings**	**% Savings**	**$ Savings**	**% Savings**
Rx allowed cost savings before rebates[1] *Reduction in allowed charges*	$4.5	2.7%	$6.0	4.1%
Rx allowed cost savings incl. rebates[2] *Reduction in allowed charges + improved rebates*	$11.6	8.6%	$10.1	8.0%
FY20 plan cost reduction[3] *FY20 budget impact*	$9.5		$5.0	

[1]Estimated savings for each respective contract period using allowed claims (plan and member cost sharing combined), utilization, and enrollment data for the period 11/1/2017 – 10/31/2018 and composite annual pharmacy trend rate of 6-7% (varying by generic, brand, and specialty drug categories)

[2] Estimated Rx allowed cost savings per footnote 1 plus estimated increase in rebates based on current drug mix; rebate improvements shown are above any anticipated rebate over-performance (true-up) for current contract

[3] Estimated reduction in GHIP pharmacy plan cost (net of member cost sharing) for the period 7/1/2019 – 6/30/2020 based on the pricing assumptions outlined in the Appendix

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

Health care budget development

Assumption and pricing analysis details

- **Claims experience** provided by vendors (Highmark, Aetna, and ESI) reflect paid claims and enrollment for the most recent available 24 months, or two experience periods (1/1/2017 – 12/31/2018)
- Claims experience adjusted for **claim offsets** from pharmacy rebates and EGWP funding
- **Incurred But Not Reported (IBNR)** adjustments convert paid claims to an incurred basis based on the lag between when a claim is incurred and when it is paid
- **Exposure** adjustments convert claims experience into a *per adult* equivalent claims cost
- **Inflation and trend** adjustments increase the claims costs to reflect expected year-over-year increases to the cost of services
- **Plan Design** adjustments applied to the claims costs to reflect any plan design changes or movement across plans, and are based on the relative difference in *actuarial value* of the plans
- **Vendor adjustments** reflect results from medical TPA RFP and other adopted vendor initiatives
- **Self-insured fixed costs** are added to the adjusted claims cost to develop the **total budget**; this includes administrative service fees and operational expenses

WTW projected total budget is based on a best estimate of projected GHIP expenses (claims, fees, etc.) and does not assume any surplus offset or deficit recoup based on current Fund balance

Policy subcommittee recommendations for FY20 changes

- Implement the following changes for FY20:

Service *For PPO and HMO plans only*	FY19 Current	FY20 Proposed Change
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	 ▪ $10 copay ▪ $50 copay
Emergency / Urgent Care ▪ Urgent Care (HMO/PPO copay) ▪ Emergency Room	 ▪ $15/$20 copay ▪ $150 copay	 ▪ $15/$20 copay ▪ $200copay
Telemedicine	▪ $15/$20 copay (HMO/PPO)	▪ $0 copay (HMO/PPO)

Combined annual claim cost avoidance opportunity: $6.9m ($4.6m to General Fund)

- Implement Highmark's infusion therapy site-of-care steerage program ($2.0m claim savings potential, $1.3m to General Fund)
- Implement Livongo through Aetna, Highmark and Express Scripts ($720k claim savings potential, $500k to General Fund)
- ***Total annual claim cost avoidance opportunity: $9.6m ($6.4m to General Fund)***

GHIP claim liability and reserve methodology

Subcommittee recommends maintaining current methodology (12/18/2018 meeting)

Alternatives for consideration (details in Appendix)

- Financial Subcommittee reviewed current methodology for setting the claim liability

Methodology	Description	FY19 Claim Liability
Current	Estimated incurred but not paid ("IBNP") liability based on Aetna, Highmark, and ESI lag factors	$61.3M

- Financial Subcommittee also reviewed alternative methodologies for setting the minimum reserve level for GHIP

Methodology	Description	FY19 Reserve
★ **Current**	Upper bound of 97% confidence for WTW claim variability tool	$24.3M
Alternative 1	Upper bound of 98.5% confidence for WTW claim variability tool	$27.1M
Alternative 2	Upper bound of 98.5% confidence for WTW claim variability tool ***plus*** 1% load for potential population health risk volatility	$35.1M

- Continue to review claim liability on a quarterly basis and minimum reserve on an annual basis

Subcommittee recommends smoothing available surplus over 2 years (12/18/2018 meeting)

GHIP surplus modeling

Scenarios for consideration

- Using surplus to minimize annual premium increases may put a strain on future revenues needed to keep pace with health care cost trend
- GHIP surplus projected to be $48.1M by the end of FY19, based on assumptions outlined on page 2
- Financial Subcommittee discussed spreading the FY19 surplus level ($48.1M) over multiple years, rather than using the full amount to offset costs in FY20
  - Each scenario reviewed included a corresponding premium contribution increase to "balance" the fund ($0 surplus) by FY21 or FY22
  - Avoid the need for a more significant increase in a future year, which could be further exacerbated in a year of poor claims experience
- The following scenarios were considered:
  - ★ Spread $48.1M surplus over 2 years (use $24.0M surplus in FY20 by increasing premiums 4.5%* effective 7/1/2019)
  - Spread $48.1M surplus over 3 years (use $16.0M surplus in FY20 by increasing premiums 5.4%* effective 7/1/2019)
- Recommendation intended to address both current fund surplus, and available surplus in future years – Subcommittee may choose to revisit smoothing duration in the future

* Required premium increase assuming no program changes for FY20; if SEBC approves recommended FY20 program changes yielding $9.6M in savings, required premium increases drop to 3.2% (2 year smoothing) and 4.2% (3 year smoothing)

= *WTW recommended change*

Site-of-care steerage opportunities for FY20

Estimated savings potential – basic and high tech imaging services

Carrier	Modeled Designs	Annual Claim Cost Avoided (%)	Annual Claim Cost Avoided ($)	Annual Claim Cost Avoided, General Fund ($)
Aetna	**Option 1:** Non-preferred basic imaging increases +$5/visit, high tech increases +$10/visit	0.23%	$0.4m	$0.3m
Highmark		0.10%	$0.4m	$0.3m
	Total Cost Avoidance Opportunity – Option 1:		**$0.8m**	**$0.5m**
Aetna	**Option 2:** Non-preferred basic imaging increases +$15/visit, high tech increases +$15/visit	0.43%	$0.7m	$0.5m
Highmark		0.20%	$0.9m	$0.6m
	Total Cost Avoidance Opportunity – Option 2:		**$1.6m**	**$1.1m**
Aetna	**Option 3:** Non-preferred basic imaging increases +$15/visit, high tech increases +$25/visit	0.49%	$0.8m	$0.5m
Highmark		0.20%	$0.9m	$0.6m
	Total Cost Avoidance Opportunity – Option 3:		**$1.7m**	**$1.1m**
Aetna	*Illustrative: Max opportunity (100% of services steered to preferred site)*	*1.27%*	$2.1m	$1.4m
Highmark		*1.40%*	$6.1m	$4.0m
	Maximum Cost Avoidance Opportunity (illustrative only):		**$8.3m**	**$5.5m**

- The design options modeled above assume design changes are adopted to promote site-of-care steerage for basic and high-tech imaging services only
  - Consistent with existing site-of-care steerage design, modeling assumes that these changes would only apply to the Comprehensive PPO and the HMO plans
  - CDH Gold and First State Basic plans already have member cost differential built into design (via coinsurance for most plan provisions) to incentivize utilization of lower cost providers
  - Additional utilization assumptions have been provided in the Appendix
- Member disruption will vary based on procedure, education and specific provider

The percentage of cost paid by the State subsidy from the general fund and non-general fund based on FY 2018 premium contributions and revenue as reported by DHR Financial Services/OMB PHRST.
Savings for active and pre-65 retiree populations only; based on each vendor's best estimate of the expected utilization at the desired site of care.
Savings largely attributable to copay differential rather than changes in member behavior.

= *WTW recommended change*

Site-of-care steerage opportunities for FY20

Estimated savings potential – outpatient lab services

Carrier	Modeled Designs	Annual Claim Cost Avoided (%)	Annual Claim Cost Avoided ($)	Annual Claim Cost Avoided, General Fund ($)
Aetna	**Option 1:** Non-preferred lab copay increases +$10/visit	0.19%	$0.3m	$0.2m
Highmark		0.30%	$1.3m	$0.9m
	Total Cost Avoidance Opportunity – Option 1:		**$1.6m**	**$1.1m**
Aetna	**Option 2:** Non-preferred lab copay increases +$20/visit	0.36%	$0.6m	$0.4m
Highmark		0.40%	$1.8m	$1.2m
	Total Cost Avoidance Opportunity – Option 2:		**$2.4m**	**$1.6m**
Aetna	**Option 3:** Non-preferred lab copay increases +$30/visit	0.51%	$0.9m	$0.6m
Highmark		0.40%	$1.8m	$1.2m
	Total Cost Avoidance Opportunity – Option 3:		**$2.6m**	**$1.7m**
Aetna	*Illustrative: Max opportunity (100% of services steered to preferred site)*	*0.62%*	$1.0m	$0.7m
Highmark		*1.10%*	$4.8m	$3.2m
	Maximum Cost Avoidance Opportunity (illustrative only):		**$5.9m**	**$3.9m**

- The design options modeled above assume design changes are adopted to promote site-of-care steerage for outpatient lab services only
  - Consistent with existing site-of-care steerage design, modeling assumes that these changes would only apply to the Comprehensive PPO and the HMO plans
  - CDH Gold and First State Basic plans already have member cost differential built into design (via coinsurance for most plan provisions) to incentivize utilization of lower cost providers
  - Additional utilization assumptions have been provided in the Appendix
- Member disruption will vary based on procedure, education and specific provider

The percentage of cost paid by the State subsidy from the general fund and non-general fund based on FY 2018 premium contributions and revenue as reported by DHR Financial Services/OMB PHRST.
Savings for active and pre-65 retiree populations only; based on each vendor's best estimate of the expected utilization at the desired site of care.
Savings largely attributable to copay differential rather than changes in member behavior.
Preferred labs for both Aetna and Highmark: Quest and Labcorp.

= *WTW recommended change*

Site-of-care steerage opportunities for FY20

Estimated savings potential – emergency / urgent care

Carrier	Modeled Designs	Annual Claim Cost Avoided (%)	Annual Claim Cost Avoided ($)	Annual Claim Cost Avoided, General Fund ($)
Aetna	**Option 1:** ER copay increases +$25/visit	0.30%	$0.5m	$0.3m
Highmark		0.20%	$0.9m	$0.6m
	Total Cost Avoidance Opportunity – Option 1:		**$1.4m**	**$0.9m**
Aetna	**Option 2:** ER copay increases +$50/visit	0.51%	$0.9m	$0.6m
Highmark		0.40%	$1.8m	$1.2m
	Total Cost Avoidance Opportunity – Option 2:		**$2.6m**	**$1.7m**
Aetna	*Illustrative: Max opportunity (100% of services steered to preferred site)*	*1.61%*	$2.7m	$1.8m
Highmark		*0.60%*	$2.6m	$1.7m
	Maximum Cost Avoidance Opportunity (illustrative only):		**$5.3m**	**$3.5m**

- The design options modeled above assume design changes are adopted to promote site-of-care steerage for emergency / urgent care only
  - Consistent with existing site-of-care steerage design, modeling assumes that these changes would only apply to the Comprehensive PPO and the HMO plans
  - CDH Gold and First State Basic plans already have member cost differential built into design (via coinsurance for most plan provisions) to incentivize utilization of lower cost providers
  - Additional utilization assumptions have been provided in the Appendix
- Member disruption will vary based on procedure, education and specific provider

The percentage of cost paid by the State subsidy from the general fund and non-general fund based on FY 2018 premium contributions and revenue as reported by DHR Financial Services/OMB PHRST.
Savings for active and pre-65 retiree populations only; based on each vendor's best estimate of the expected utilization at the desired site of care.
Savings largely attributable to copay differential rather than changes in member behavior.

Site-of-care steerage opportunities for FY20

Aetna and Highmark recommendations for potential plan design changes

Aetna

- For imaging and lab services, would not recommend any copays greater than option 3
- For emergency / urgent care, would not recommend any copays greater than option 2

Highmark

- Recommendations for designs are mostly covered in the scenarios outlined by WTW
- Regarding imaging, would not recommend $0 for any non-routine service, so consider a nominal copay (especially high tech imaging)
- For lab services, Options 2-3 seem high for non-preferred labs, in light of average total allowed cost for those
- Minimum ER copays for fully-insured customers is $150/visit (consistent with FY19 current design)

Site-of-care steerage opportunities for FY20

Additional assumptions for estimated cost avoidance – imaging services

Service ***For PPO and HMO plans only***	**FY19 Current**	**FY20 Design Options**			
		Option 1	**Option 2**	**Option 3**	**Max Opportunity *(illustrative)***
Basic Imaging ▪ Freestanding Facility (preferred) ▪ Hospital-based Facility	▪ $0 copay ▪ $35 copay	▪ $0 copay ▪ $40 copay	▪ $0 copay ▪ $50 copay	▪ $0 copay ▪ $50 copay	n/a
High Tech Imaging ▪ Freestanding Facility (preferred) ▪ Hospital-based Facility	▪ $0 copay ▪ $50 copay	▪ $0 copay ▪ $60 copay	▪ $0 copay ▪ $65 copay	▪ $0 copay ▪ $75 copay	
Estimated number and percent of services steered toward preferred site of care		▪ Basic: 1,515 (3%) ▪ High Tech: 515 (3%)	▪ Basic: 2,781 (5%) ▪ High Tech: 707 (4%)	▪ Basic: 2,781 (5%) ▪ High Tech: 1,052 (6%)	▪ Basic: 56,130 (100%) ▪ High Tech: 18,407 (100%)
Estimated cost avoidance opportunity		$0.8m annual claim savings ($0.5m to General Fund)	$1.6m annual claim savings ($1.1m to General Fund)	$1.7m annual claim savings ($1.1m to General Fund)	$8.3m annual claim savings ($5.5m to General Fund)

The percentage of cost paid by the State subsidy from the general fund and non-general fund based on FY 2018 premium contributions and revenue as reported by DHR Financial Services/OMB PHRST.
Savings for active and pre-65 retiree populations only; based on each vendor's best estimate of the expected utilization at the desired site of care.
Savings largely attributable to copy differential rather than changes in member behavior.

Highlights potential FY20 design change.

Site-of-care steerage opportunities for FY20

Additional assumptions for estimated cost avoidance – outpatient lab services

Service *For PPO and HMO plans only*	FY19 Current	FY20 Design Options			
		Option 1	Option 2	Option 3	Max Opportunity *(illustrative)*
Outpatient Lab ▪ Preferred Lab ▪ Other Lab	▪ $10 copay ▪ $20 copay	▪ $10 copay ▪ $30 copay	▪ $10 copay ▪ $40 copay	▪ $10 copay ▪ $50 copay	n/a
Estimated number and percent of services steered toward preferred site of care		2,642 (1%)	5,212 (2%)	7,715 (4%)	216,206 (100%)
Estimated cost avoidance opportunity		$1.6m annual claim savings ($1.1m to General Fund)	$2.4m annual claim savings ($1.6m to General Fund)	$2.6m annual claim savings ($1.7m to General Fund)	$5.9m annual claim savings ($3.9m to General Fund)

The percentage of cost paid by the State subsidy from the general fund and non-general fund based on FY 2018 premium contributions and revenue as reported by DHR Financial Services/OMB PHRST.
Savings for active and pre-65 retiree populations only; based on each vendor's best estimate of the expected utilization at the desired site of care.
Savings largely attributable to copay differential rather than changes in member behavior.
Preferred labs for both Aetna and Highmark: Quest and Labcorp.
Highlights potential FY20 design change.

Site-of-care steerage opportunities for FY20

Additional assumptions for estimated cost avoidance – emergency / urgent care

Service ***For PPO and HMO plans only***	**FY19 Current**	**FY20 Design Options**		
		Option 1	**Option 2**	**Max Opportunity *(illustrative)***
Emergency / Urgent Care ▪ Urgent Care (HMO/PPO copay) ▪ Emergency Room	▪ $15/$20 copay ▪ $150 copay	▪ $15/$20 copay ▪ $175 copay	▪ $15/$20 copay ▪ $200 copay	n/a
Estimated number and percent of services steered toward preferred site of care		288 (2%)	454 (2%)	18,976 (100%)
Estimated cost avoidance opportunity		$1.4m annual claim savings ($0.9m to General Fund)	$2.6m annual claim savings ($1.7m to General Fund)	$5.3m annual claim savings ($3.5m to General Fund)

The percentage of cost paid by the State subsidy from the general fund and non-general fund based on FY 2018 premium contributions and revenue as reported by DHR Financial Services/OMB PHRST.
Savings for active and pre-65 retiree populations only; based on each vendor's best estimate of the expected utilization at the desired site of care.
Savings largely attributable to copay differential rather than changes in member behavior.

Highlights potential FY20 design change.