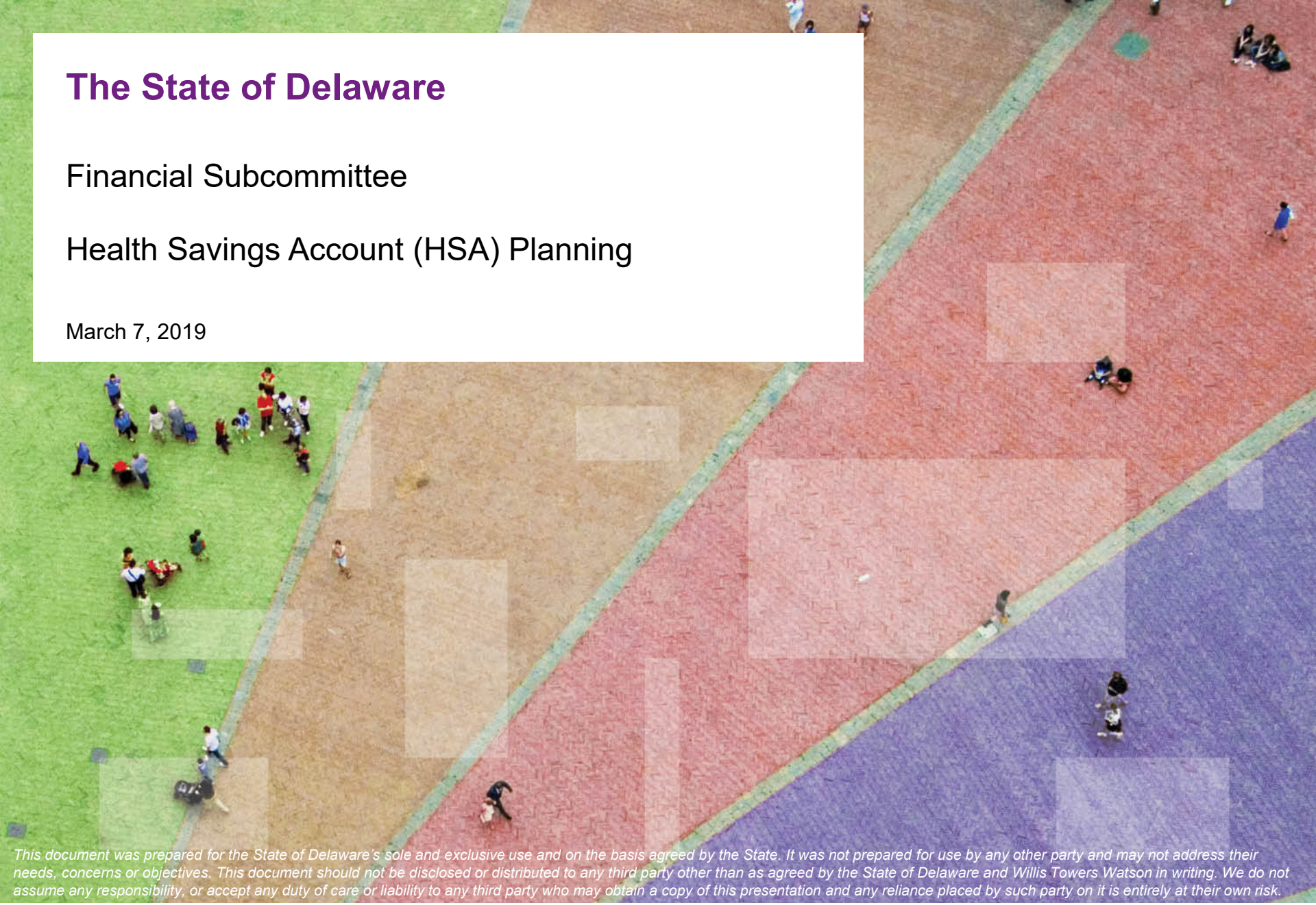


The State of Delaware

Financial Subcommittee

Health Savings Account (HSA) Planning

March 7, 2019

Willis Towers Watson

Today's discussion

- Background and timeline
- Review Health Policy & Planning feedback on topics covered at February 7 meeting
  - HSA plan design alternatives
  - Current GHIP offerings
- Potential financial impact on GHIP and employees
- Oversight of HSA investment options
- Next steps

- Appendix
  - Supplemental information about HSA plans

Background

- A Health Savings Account (HSA) plan is a type of medical plan that meets certain IRS requirements and is offered with a tax-advantaged medical savings account
  - Also called an IRS-qualified high deductible health plan with a HSA
- The SEBC voted on August 20, 2018 to move forward with serious consideration of the adoption of a HSA plan option for the GHIP
  - Viewed as an attraction and retention tool, particularly among millennial GHIP participants
  - Tentative effective date of July 1, 2020 (or later)
- An RFP was released in September 2018 to evaluate Aetna and Highmark's abilities to provide Health Savings Account (HSA) administrative services for the GHIP
  - RFP was conducted as a supplement to the 2016 medical third-party administrator (TPA) RFP in which both Aetna and Highmark participated
  - Narrowed the set of bidding vendors to the State's current medical TPAs only
- Proposal Review Committee (PRC) for this RFP determined that both vendors met the minimum qualifications and criteria outlined in the RFP

Background (continued)

- PRC recommended the following to the SEBC and the Health Policy & Planning and Financial Subcommittees:

1. Evaluate the overall GHIP plan offerings available and goals associated with adding an HSA plan to the GHIP offerings ***(SEBC)***
2. Develop the proposed plan design (including the amount of and schedule for employer funding of the HSA) and premium rates ***(HP&P – design; Financial – premium rates)***
3. Evaluate the current plan offerings and in particular, the feasibility of continuing the existing CDH Gold plan, including how members' account balances would be managed if a proposal included discontinuation of this plan ***(HP&P)***
4. Fully understand the fiduciary responsibilities, if any, by the State for the investment accounts along with any fees to members and how the investment funds are structured ***(Financial)***
5. Determine the intensity of focus needed to communicate and educate members about a HSA plan ***(HP&P)***
6. Re-evaluate how closely aligned each vendor is to the above considerations to determine which vendor may be the best fit to administer a HSA plan ***(HP&P)***
7. Propose whether or not to offer a HSA plan and the effective date, including all of the above considerations as part of a proposal that will include a recommendation on which of the two TPAs is best suited to administer the HSA plan ***(HP&P)***

Note: "Owner" of the final decision about each the above topics is denoted in parentheses at the end of each topic.

Background (continued)

- The following topics were reviewed with the Health Policy & Planning Subcommittee on February 7, 2019:
  - Overview of HSA plans
  - HSA plan design alternatives
  - Considerations for employer contributions to HSAs (“seed”)
  - Current GHIP offerings
- Feedback on these topics was gathered and will be shared with the Financial subcommittee today
- Your input from today’s discussion of HSA plan design alternatives and current GHIP offerings will be shared with the Health Policy & Planning subcommittee this afternoon

Goal **– Review and consider all key decision points associated with an HSA plan in order to be ready to present a complete proposal to the SEBC at the June 10, 2019 meeting**

HSA plan design – *illustrative scenarios*

HP&P Subcommittee Feedback:
No comments were provided on any of the illustrative scenarios below.

Plan Design (In-network)	CDH Gold w/HRA	HSA Scenario 1	HSA Scenario 2	HSA Scenario 3	State Employers Peer Benchmark HDHP+HSA[3]	CY2019 IRS Requirements for HSA Plans[4]
Deductible (Ind./Fam.)	$1,500 / $3,000	$2,000 / $4,000	$1,500 / $3,000	$1,500 / $3,000	$2,100 / $4,200	*Minimum of* $1,350 / $2,700
Account Funding (Ind./Fam.)	$1,250 / $2,500	$1,000 / $2,000	$1,000 / $2,000	$1,000 / $2,000	$700 / $1,400[3]	*Maximum[5] of* $3,500 / $7,000
Coinsurance	90%	80%	80%	90%	80%	
Out-of-Pocket Max (Ind./Fam.)	$4,500 / $9,000	$4,500 / $9,000	$4,500 / $9,000	$4,500 / $9,000	$4,500 / $9,000	*Maximum of* $6,750 / $13,500
PCP Office Visit	90%	80%	80%	90%	80%	
Specialist Office Visit	90%	80%	80%	90%	80%	
Emergency Room	90%	80%	80%	90%	80%	
Inpatient Care	90%	80%	80%	90%	80%	
Prescription Drug[1]						
Out-of-Pocket Max (Ind./Fam.)	$2,100 / $4,200	Combined with medical	Combined with medical	Combined with medical	Combined with medical	Combined with medical
▪ Retail	$8 / $28 / $50	$8 / $28 / $50 after deductible	$8 / $28 / $50 after deductible	$8 / $28 / $50 after deductible	85% / 80% / 75% after deductible	Subject to deductible
▪ Mail Order	$16 / $56 / $100	$16 / $56 / $100 after deductible	$16 / $56 / $100 after deductible	$16 / $56 / $100 after deductible	85% / 80% / 75% after deductible	Subject to deductible
Relative Benefit Value (RBV)[2]	**0.96**	**0.89**	**0.91**	**0.93**	**0.88**	

1 Retail 30 day supply; mail order 90 day supply.
2 RBV estimate includes Health Savings Account seed.
3 See appendix for further details about this benchmark.
4 Announced by the IRS on May 10, 2018.
5 Combined for employer and employee account funding. Does not include catch-up contribution for individuals attaining age 55 by 12/31 until enrolled in Medicare; CY2019 catch-up contribution amount: $1,000.

HSA plan – potential financial impact on GHIP

- Financial impact of an HSA plan will vary based on:
  - Which participant groups are offered this plan
  - Availability of other plan options and/or changes to existing plan options
  - Final plan design and employer HSA contribution ("seed")
  - Employee contributions relative to existing plan options

Estimated FY20 GHIP Savings[1]	HSA Scenario 1	HSA Scenario 2	HSA Scenario 3
Per 5% Migration to HSA plan	$3.0M ($1.9M General Fund)	$2.2M ($1.4M General Fund)	$1.2M ($0.7M General Fund)
Full Replacement (100% enrollment in HSA plan)	$59.2M ($37.2M General Fund)	$43.1M ($27.1M General Fund)	$23.7M ($15.0M General Fund)

- The richest HSA plan design permissible under IRS mandate includes a $1,350/$2,700 deductible (ind./family), followed by 100% plan cost-sharing
  - Relative Benefit Value: 98.7% (assumes $1,000/$2,000 Health Savings Account seed)
  - Estimated GHIP **Cost**[1]: $0.8M ($0.5M General Fund) per 5% migration, up to $16.7M ($10.5M General Fund) at 100% migration

[1] Savings assumes migration from current plans (if offered alongside) or full-replacement of active employees and pre-65 retirees enrolled in the First State Basic, CDH Gold, HMO, and PPO plans; this does not include post-65 retiree Medicfill participants. Savings based on reduction in GHIP claims due to difference in actuarial value between current plan and HSA scenarios 1, 2 and 3.

HSA plan – employer seed considerations

HP&P Subcommittee Feedback: Several members voiced their preference for delivering HSA seed money as an up-front lump sum.

- The GHIP has flexibility in the amount and timing of HSA seed money

Seed timing	Pros	Cons
Up-front lump sum	▪ Employees have immediate protection against high claims early in plan year ▪ Administrative ease	▪ Employer seed vests immediately and money is portable; employees leaving employer during the year receive full value of the benefit ▪ The GHIP could forfeit $100k in annual seed money for employees terminating during the year[1]
Fixed per-pay contribution	▪ Employer protection against employee turnover ▪ Employees "earn" seed money over course of plan year ▪ Minimizes budget impact	▪ Employees may have to pay for early claims with personal funds ▪ Administrative complexity for employer and employee
Periodic payments (quarterly, semi-annually, etc.)	▪ Employer protection against employee turnover ▪ Employees "earn" seed money over course of plan year, with more money available initially ▪ Less complex than per-pay deposits	▪ Employees may have to pay for early claims with personal funds ▪ Administrative complexity for employer and employee

- Additional considerations:
  - Determination of the amount and timing of HSA seed money must be made as part of plan design and could impact overall plan costs/savings
  - Total deposits (employer + pre-tax employee contributions) are treated as employer contributions, and are subject to nondiscrimination testing
  - How to treat new hires during course of the year (i.e., make "whole" on date of hire, prorate, etc.)?

[1] Per 5% migration to HSA plan; assumes 5% annual turnover with uniform distribution throughout year, $1,000/$2,000 ind./family seed, and 40%/60% ind./family enrollment split

Current GHIP offerings

Plan participant enrollment patterns

- Approximately 1/3 of GHIP enrollees are millennials[1] who are lower paid, more likely to waive/enroll in single coverage, and more likely to elect plans with low contributions (First State Basic, CDH Gold) than other State employees
- Between CY2014 and CY2018, new hires/rehires were more likely to waive coverage or elect First State Basic and CDH Gold options compared to the current GHIP State eligible population overall
  - In more recent years (CY2017-CY2018), new hires are increasingly likely to elect the lowest cost plan (FSB) or waive coverage; fewer new employees elected the HMO and CDH Gold options, though proportion in CDH Gold remains higher than GHIP overall (see Appendix for data table)
- Offering an HSA plan alongside the existing CDH Gold option would erode potential GHIP savings
- For administrative and legislative simplicity, consider replacing CDH Gold plan with an HSA plan
  - Requires strategy for participants with existing Health Reimbursement Account (HRA) balances

HP&P Subcommittee Feedback:
Limited to one member voicing opinion that CDH Gold is "a good plan that encourages consumerism among our insured, as it incentivizes them to spend money for their health care as if it was their own."

CDH Gold – FY19 enrollment and HRA balances

- As of December 2018, there are 2,569 employees enrolled in the Aetna CDH Gold plan
- Total funds remaining in participant HRA balances are $6.5M, with an average remaining balance of $2,537
- If the State were to eliminate the CDH Gold plan and cause HRA balances to be forfeited, there is a potential for members with existing HRA balances to rush to spend remaining funds before forfeiture

HRA Balance (as of December 2018)	# of Participants (% total)
$0	315 (12%)
$1 - $100	34 (1%)
$100 - $249	45 (2%)
$250 - $499	108 (4%)
$500 - $999	279 (11%)
$1,000 - $2,499	845 (33%)
$2,500 - $4,999	602 (23%)
$5,000 - $9,999	286 (11%)
$10,000 and greater	55 (2%)
Total	**2,569 (100%)**

1 EBRI 2017 Consumer Engagement in Health Care Survey defines millennial generation as the demographic cohort with birth years ranging from 1977 to 2000.

CDH Gold plan – options for employees with HRA fund balance

- Because the CDH Gold is a self-insured medical plan with the HRA funded entirely by the State, the SEBC has discretion over:
  - What HRA funds could be used for (e.g., payroll contributions, out-of-pocket expenses for covered services) and for which plans (i.e., medical, dental, vision)
  - How long those funds are available (e.g., 6 months, 1 year)
  - Rules/Restrictions regarding use of funds (e.g., employee must be currently enrolled in the State's dental plan in order to be able to use HRA balance to offset out-of-pocket expenses for covered dental services)

HP&P Subcommittee Feedback:
One member voiced preference for premium holiday HRA until the funds are exhausted.

Another member inquired about the administrative cost of both the limited-purpose HRA and the post-deductible HRA. Administrative fees for either option could be up to $100,000 per year, but may vary by HRA option, scope of allowable expenses, length of time funding is available, vendor selection and potential need for a new or modified eligibility file.

HRA Options	Description	Pros	Cons
Premium Holiday HRA	Allow employees to use HRA funds to pay for coverage in lieu of payroll contributions in year one	▪ Could offer only if employee enrolls in HSA plan to encourage enrollment ▪ Offers the most benefit to employees, especially if not limited to employees electing an HSA plan	▪ May be expensive for the State, particularly if not limited to employees electing an HSA plan ▪ Could be an administrative burden for the State to maintain
Limited-purpose HRA	Use HRA money to pay for "permitted insurance" (e.g., dental, vision)[1]	▪ Offers a small benefit to employees ▪ Minimal cost to the State (relative to HRA use for medical expenses), especially if limited to out-of-pocket costs for "permitted insurance"	▪ Communication could be difficult ▪ If State allows HRA funds to offset dental and vision premiums, may need to review with those insurers for potential impact on premiums for those fully-insured plans
Post-deductible HRA	Pays for medical expenses after HSA plan deductible met	▪ Encourages HSA plan enrollment ▪ Potential for moderate cost to the State	▪ Would shield employees from some health care cost until HRA balance ran out
Retirement HRA	HRA used to pay for medical expenses[2] in retirement	▪ Little cost to the State in the near-term ▪ The State could chose to allow employees to keep HRA funds if they terminate before retirement	▪ No immediate value to the employee ▪ Could be an administrative burden for the State to maintain

1 Potential compliance considerations related to allowing HRA use toward expenses not covered by the plan, and allowing employees continued access to HRA if they drop medical coverage.
2 For non-Medicare eligible retirees enrolled in an IRS-qualified high deductible health plan, would need to be post-deductible medical expenses only to maintain eligibility for HSA contributions.

HSA plan – potential financial impact on employee contributions

- Illustrative HSA plan rates shown below based on actuarial relativity to FY19 rate for CDH Gold[1] with employee contributing 5% of the total premium
  - Per the Delaware Code, the State must pay 95% of the premium for a consumer-directed health plan

Monthly Rates	FY19 CDH Gold		HSA Plan (Scenario 1)[2]		
Coverage Tier	Rate	EE Contrib	Rate[2]	EE Contrib	EE Savings (Annual)
Employee Only	$719.68	$35.98	$665.12	$33.26	-$32.64
EE + Spouse	$1,492.22	$74.58	$1,379.10	$68.96	-$67.44
EE + Child(ren)	$1,099.56	$54.96	$1,016.21	$50.81	-$49.80
Family	$1,895.74	$94.78	$1,752.03	$87.60	-$86.16

Monthly Rates	Employee Contribution Impact				
Coverage Tier	HSA Plan[2]	FY19 HMO	EE Savings (Annual)	FY19 PPO	EE Savings (Annual)
Employee Only	$33.26	$47.16	-$166.80	$105.18	-$863.04
EE + Spouse	$68.96	$99.50	-$366.48	$218.26	-$1,791.60
EE + Child(ren)	$50.81	$72.18	-$256.44	$162.08	-$1,335.24
Family	$87.60	$124.12	-$438.24	$272.86	-$2,223.12

- The GHIP has flexibility in setting the HSA plan design (subject to IRS-qualified HDHP provisions) and budget rates to increase appeal of this plan relative to existing plan options

1 CDH Gold RBV of 96.3% (including HRA seed).
2 HSA plan scenario 1 reflects a $2,000/$4,000 single/family deductible, $1,000/$2,000 HSA seed and an RBV of 0.89.

Oversight of HSA investment options

Considerations for the State

- Most HSAs include an option for accountholders to invest their savings once it reaches a certain dollar threshold
- HSA administrators and/or their banking partners normally determine the investment options available to accountholders
- During the HSA Administrator RFP, the PRC expressed interest in understanding any potential fiduciary responsibilities for HSA investment accounts
  - The PRC's interest in further understanding any fees to members and how investment funds are structured will be addressed at a future Financial Subcommittee meeting
- HSAs are generally considered IRS trust accounts that are exempt from ERISA, even in cases where the employer makes contributions to employee accounts, provided further employer involvement is limited
- While the Department of Labor has stated that an HSA under which the employer makes or influences the investment choices will be subject to ERISA, it is unlikely that this would be the case for the State since governmental plans are not subject to ERISA
- Nevertheless, providing direct oversight of HSA investments may carry other risks
  - State laws would still apply, to the extent that Delaware has passed any investment or banking statutes that require the employer to meet certain standards when playing a role in overseeing any investment options offered to employees
  - Non-compliance with those requirements could put the State at risk of participant lawsuits due to improper selection of investment choices, improper oversight, excessive fees claims and potential conflict of interest charges
- Willis Towers Watson recommends the SEBC consult with legal counsel to evaluate potential risk associated with direct oversight of HSA investment options

Disclaimer: Willis Towers Watson is providing this information to the State of Delaware solely in our capacity as consultants with knowledge and experience in the industry and not as legal advice. The issues presented here have legal implications, and we recommend discussing this matter with the State's legal counsel prior to choosing a course of action.

Feedback request

Thoughts from Financial Subcommittee members on…

- HSA plan design scenarios
- HSA seed timing
- Feasibility of continuing the existing CDH Gold plan
- Options for managing members' account balances if CDH Gold were discontinued
- HSA plan budget rates and employee contributions
- Role that the State should play in evaluating HSA investment options

Next steps

- Subcommittee member feedback discussed today will be shared with the Health Policy & Planning Subcommittee this afternoon

- WTW to incorporate this feedback into the materials for the April 4 meeting of the Health Policy & Planning Subcommittee

Timeline

○ Review options and provide feedback
■ Discuss other subcommittee's feedback
◈ TPA capabilities presentations
✓ Finalize recommendations

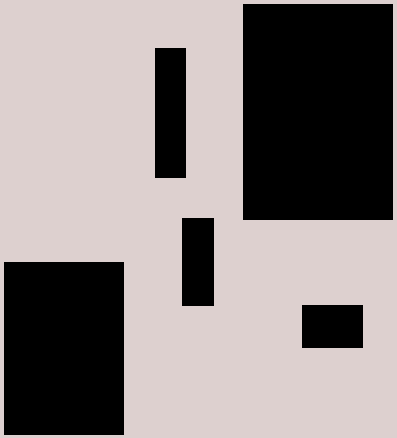
***Goal* – Review and consider all key decision points associated with an HSA plan in order to be ready to present a complete proposal to the SEBC at the June 10, 2019 meeting**

Task (PRC recommendation #)	Owner	February 7		March 7		April 4		May 2		June 6	
		Financial	Health P&P	Financial	Health P&P	Financial	Health P&P	Financial	Health P&P	Financial	Health P&P
Develop HSA plan design (2)	Health P&P		○	○ ■	■ ✓						
Develop premium rates (2)	Financial			○	○ ■	■ ✓					
Evaluate current plan offerings and feasibility of continuing CDH Gold plan (3)	Health P&P		○	○ ■	○ ■	○ ■	✓				
Review fiduciary responsibilities (4)	Financial			○		○		✓			
Determine intensity of focus for communication and education (5)	Health P&P				○		○		○		✓
Review TPA capabilities (6)	Health P&P						◈ ○		○		✓
Finalize HSA plan proposal and recommendations to SEBC (7)	Health P&P							○	○ ■	■ ✓	■ ✓

Topics will be moved to May meeting if April is cancelled

Appendix

Supplemental information about HSA plans



HDHP with HSA plan design benchmarking

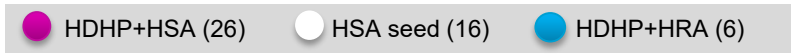
State employers peer group[1]

Key Provisions (In-Network)	GHIP CDH Gold with HRA	State Employers Peer Benchmark HDHP+HSA[1,2]
Deductible (Ind./Fam.)	$1,500 / $3,000	$2,100 / $4,200
Account Funding (Ind./Fam.)	$1,250 / $2,500	$700 / $1,400[3]
Coinsurance	90%	80%, after ded.
Out-of-Pocket Max (Ind./Fam.)	$4,500 / $9,000	$4,500 / $9,000
PCP Office Visit	90% after ded.	80%, after ded.
Specialist Office Visit	90% after ded.	80%, after ded.
Emergency Room / Urgent Care	90% after ded.	80%, after ded.
Inpatient Hospital	90% after ded.	80%, after ded.
Prescription Drug[4,5]	After ded.	After ded.[6]
▪ Retail	$8/$28/$50	85% / 80% / 75%
▪ Mail Order	$16/$56/$100	85% / 80% / 75%
▪ OOP Max (Ind./Fam.)	$2,100 / $4,200	Combined
Relative Benefit Value	0.96[7]	0.88[8]

Note: Refer to the appendix for a list of the state employers evaluated

1. 26 state employers; 37 HDHP+HSA plans; 12 state employers provide account funding to 16 HSA-qualified plans; excludes the State of Delaware's Group Health Insurance Program (GHIP) CDH Gold plan
2. Provisions shown are averages of 37 HDHP+HSA plans in place in 2018 (CY2018 and FY2019) corresponding to 26 state employers evaluated
3. KS, NV and SD HSA seed incentives for wellness participation not included in the account funding individual/family averages (see footnote #9. The State of Kansas (KS) provides HSA funding to plans C and N, however, funding for plan C is contingent on employee contributions to HSA
4. Deductible must be satisfied before coinsurance applies; coinsurance waived for preventive drugs and services
5. Retail 30 day supply; mail order 90 day supply
6. For prescription drug purchase, 15 of the 37 HDHP+HSA plans benchmarked apply a copayment in addition to coinsurance, after the deductible has been met; retail generic avg. copay: $10, formulary avg. copay: $40, non-formulary avg. copay: $80; mail-order avg. copays approximately 2x retail; Indiana, Utah and Wisconsin drug plans are coinsurance-based with minimum and/or maximum copays in place
7. CDH Gold plan RBV of 96.3% (including HRA seed)
8. RBVs shown are rough estimates developed using WTW proprietary actuarial tools and provided for reference only
9. KS provides additional $500 employee or $1,000 employee+spouse annual HSA funding for completing wellness-related activities; NV provides additional $200 in HSA contributions to employees only (regardless of coverage level), $100 for participating in preventive care exams and $100 more for completing registration with Doctor on Demand and a guided tour using the Healthcare Blue Book (HCBB) program; in FY19, SD provides additional $250 individual / $500 family HSA contributions if employee or employee and spouse complete a health screening, a health assessment and earn 100 wellness points during plan year (by March 31, 2018); methodology for earning points not outlined in plan documents or website . Additional plan sponsor HSA contributions excluded from average account funding.

- 26 (53%) of 49[3] state employers offer one or more health savings account (HSA) qualified high deductible health plan (HDHP) options
  - 4 (8%) state employers provide access to both HDHP+HSA and HDHP+HRA plan options
  - Of the 26 states benchmarked, none offers an HDHP+HSA as their only medical plan option
- Of the 26 State employers in the HDHP+HSA peer group, 12 (38%) provide HSA funding[1,3]
  - 37 HSA-qualified plans evaluated; subscribers in 16 HDHP+HSA plans receive plan sponsor account funding
  - The individual and family deductibles in the average HDHP+HSA peer benchmark design is higher than the FY19 CDH Gold plan, however, OOPMs align
  - Dependent HSA plan sponsor funding is generally 2-times individual funding across all peers
  - Prevalent coinsurance-only medical and Rx cost sharing, after deductible; however, 15 of the 37 plans evaluated include pharmacy coverage with combined copayment plus coinsurance design
  - On average, non-formulary prescription drugs are covered at a lower coinsurance
  - Prescription drug individual and family deductibles and out-of-pocket maximums are combined with medical across all HDHP+HSA plans evaluated
- Kansas (KS), Nevada (NV) and South Dakota (SD) state employers provide wellness incentives through HSA contributions[9]



HDHP with HSA plan design benchmarking

Peer list - State employers[1]

Peer #	Peer State Employer Name	Region[2]	Plan Year Effective Date	Account-Based High Deductible Health Plans (HDHPs)[1]	HSA Employer Funding[3] Ind./Fam.
1	Arizona (AZ)	West	1/1/2018	●	No
2	Arkansas (AR)	South Central	1/1/2018	●●●●	No[4]
3	Colorado (CO)	South Central	7/1/2018	○○	HDHP UHC & HDHP Kaiser: $720 / $720
4	Florida (FL)	South East	1/1/2018	○○	HDHP PPO & HDHP HMO: $500 / $1,000
5	Georgia (GA)	South East	1/1/2018	●●●●	No
6	Indiana (IN)	North Central	1/1/2018	●●	No
7	Kansas (KS)	North Central	1/1/2018	○○●●	Plan C: $1,000 / $1,250[5,6] Plan N: $500 / $625[5]
8	Louisiana (LA)	South Central	1/1/2018	●●	No
9	Mississippi (MS)	South East	1/1/2018	●	No[4]
10	Missouri (MO)	North Central	1/1/2018	○	HSA Plan: $300 / $600
11	Nebraska (NE)	North Central	7/1/2018	●	No
12	Nevada (NV)	West	7/1/2018	○	CDHP: $700 / $900[5,7]
13	New Jersey (NJ)	North East	1/1/2018	○	HD1500: $300 / $300[8]
14	North Dakota (ND)	North Central	7/1/2018	●	No
15	Oklahoma (OK)	South Central	1/1/2018	●	No
16	Rhode Island (RI)	North East	1/1/2018	○	Choice Plus: $1,500 / $3,000
17	South Carolina (SC)	South East	1/1/2018	●	No
18	South Dakota (SD)	North Central	1/1/2018	○	HDHP: $250 / $500[5,9]
19	Tennessee (TN)	South East	1/1/2018	○●	CDHP State & Higher Educ.: $250 / $500[10]
20	Texas (TX)	South Central	9/1/2018	○	Consumer Direct: $540 / $1,080
21	Utah (UT)	South Central	7/1/2018	○○	STAR: $792 / $1,584 Basic Plus: $1,825 / $3,650
22	Virginia (VA)	South East	7/1/2018	●●	No
23	Washington (WA)	West	1/1/2018	○●	UMP CDHP: $700 / $1,400[11]
24	West Virginia (WV)	South East	7/1/2018	●	No
25	Wisconsin (WI)	North Central	1/1/2018	●●	No
26	Wyoming (WY)	North Central	1/1/2018	●	No

1. 26 of 49 U.S. state employers offer one or more health savings account (HSA) qualified high deductible health plans (HDHP) options; 37 HSA-qualified plans evaluated. 6 of 49 state employers offer access to health reimbursement arrangement (HRA) HDHP plans (AK, GA, KS, KY, LA and VA), however, only 4 provide access to both HDHP+HSA and HDHP+HRA plan types
2. HDHP+HSA plans distribution by region (# of state employers / # of plans): North Central – 8 / 11; North East – 2 / 2; South Central – 6 / 11; South East – 7 / 9; West – 3 / 4
3. Of the 26 State employers in the HDHP+HSA peer group, 12 provide HSA funding to a total of 16 plans. AR, ID, IN, MN, MS, ND, VA, WA, WI and WY, assumed do not provide HSA funding to one or all of their plans as HSA funding information was not publicly available
4. State employer does not offer/administer HSA accounts, however, subscribers are advised to secure an account independently
5. KS, NV and SD state employers provide wellness incentives through HSA contributions
6. KS state employer provides HSA funding to plans C and N, however, funding for plan C is contingent on employee contributions to HSA; KS state employer also provides additional $500 employee or $1,000 employee+ spouse annual HSA funding for completing wellness-related activities
7. NV state employer provides $500 base HSA funding for employee only coverage and additional $200 for each dependent
8. NJ state employer offers an HDHP+HSA (HD4000) to Local Government and State employees and an HDHP without account option (HD1500) to all Local government, Education and State employees
9. SD state employer provides base account contribution amounts based on coverage level and additional FY 2019 $250 individual / $500 family HSA contribution, if the employee and covered spouse complete a Health Screening, a Health Assessment, and earn 100 Wellness Points during FY18; plan sponsor contribution rules and methodology for point assessment not disclosed in plan documents or website
10. TN state employer offers 2 HDHP+HSA plans. CDHP State and Higher Education subscribers receive $250 ind./$500 fam. annual account funding. Plan sponsor account funding is not available for CDHP Local Education and Local Government subscribers
11. WA state employer offers 2 HDHP+HSA plans. Plan sponsor account funding is not available for Kaiser CDHP subscribers

Health Savings Account plan designs – surrounding states[1]

2018 Plan Design (In-network)	NJ HD4000[2]	NJ HD1500[2]
Deductible (Ind./Fam.)	$4,000 / $8,000	$1,500 / $3,000
Account Funding (Ind./Fam.)	N/A	$300 / $300
Coinsurance	80%	80%
Out-of-Pocket Max (Ind./Fam.)	$5,000 / $10,000	$2,500 / $5,000
PCP Office Visit	80%	80%
Specialist Office Visit	80%	80%
Emergency Room	80%	80%
Inpatient Care	80%	80%
Prescription Drug[3]		
Out-of-Pocket Max (Ind./Fam.)	Combined with medical	Combined with medical
▪ Retail	80% after deductible	80% after deductible
▪ Mail Order		
Relative Benefit Value (RBV)[4]	**0.78**	**0.88 [5]**

- The State of NJ provides two HSA-qualified high deductible health plans (HDHPs) alongside several other traditional plan options (5 PPOs, 5 HMOs with RBVs ranging from 0.87 – 0.98) with varying levels of eligibility
  - The State of NJ $300 annual Health Savings Account funding is available to HD1500 plan subscribers only
- The State of PA offers an CDHP with a Health Reimbursement Account for permanent part-time and temporary employees
- MD has not implemented an HSA-qualified HDHP from 2016 through 2018
- From 2016 through 2018, none of the states evaluated, implemented and then eliminated HSA-qualified HDHPs

1. Maryland (MD), Pennsylvania (PA) and New Jersey (NJ) state medical programs evaluated; MD and NJ 2016 through 2018 medical programs; PA 2017 and 2018 medical programs
2. HD1500 plan available to all Local government, Education and State employees; HD4000 plan available to Local Government and State employees only
3. Retail 30 day supply; mail order 90 day supply
4. RBVs shown are rough estimates developed using WTW proprietary actuarial tools and provided for reference only
5. NJ HD1500 plan RBV estimate shown includes HSA funding (annual funding dollars are $300 Individual/$300 Family); NJ HD1500 estimated RBV without seed is 0.86

State employer peer benchmarking

HSA seed amounts[1] and overall plan relative benefit values[2]

State employer peer HSA plans	Minimum	25th Percentile	Median	75th Percentile	Maximum	Average
Individual HSA Seed	$250	$450	$620	$738	$1,825	$694
Family HSA Seed	$300	$619	$950	$1,288	$3,650	$1,177
Relative Benefit Value (Without Seed)	0.65	0.78	0.83	0.84	0.88	0.80
Relative Benefit Value (With Seed[3])	0.73	0.86	0.90	0.92	0.95	0.88

1 KS, NV and SD HSA seed incentives for wellness participation not included in the account funding individual/family seed amounts or RBV average with seed.
2 RBVs shown are rough estimates developed using WTW proprietary actuarial tools and provided for reference only. RBVs with seed based on averaged individual and family seed amounts.

Current GHIP offerings

New hire enrollment patterns

- The below exhibit summarizes the distribution of plan elections made by new hires or rehired employees, at time of hire/rehire eligibility date
- New hires/rehires were more likely to waive coverage or elect First State Basic and CDH Gold options compared to the current GHIP State eligible population overall
  - In more recent years, new hires are increasingly likely to elect the lowest cost plan (FSB) or waive coverage; fewer new employees elected HMO and the CDH Gold options, though proportion in CDH Gold remains higher than GHIP overall

	% Original Election by Plan[1]				
Hire Year	**PPO**	**Aetna/Highmark HMO**	**Aetna/Highmark CDH**	**FSB**	**Waive**
CY 2014	37.8%	26.8%	7.6%	5.4%	22.3%
CY 2015	36.0%	28.2%	7.5%	6.1%	22.3%
CY 2016	32.6%	25.6%	8.4%	10.9%	22.5%
CY 2017	34.1%	20.8%	6.9%	13.9%	24.3%
CY 2018	32.7%	14.4%	5.1%	17.3%	30.4%
Overall GHIP[2] (current election)	55.2%	24.6%	4.5%	5.6%	10.1%

[1] Based on all full-time benefits eligible employees of the State hired or rehired between 2014 and 2018 per 'PHRST_Hires_Rehires_ConHires_FY15-18_medical election_6.20.2018' provided to WTW by OMB on June 20, 2018

[2] Based on all full-time benefits eligible employees of the State per 'Ben Elig Ees April2018 wEarnings thru 041518' report provided to WTW by OMB on May 14, 2018. Includes 31,107 active State employees enrolled in GHIP. Excludes participating groups (waiver data not available)

New hire enrollment patterns

Distribution by age

- Average age for new hires/rehires is typically in the mid to late 30s
- Difference in age of new hires/rehires who enroll in a medical plan compared to those who waive coverage is minimal (on average, less than 1 year)
- Largest proportion of new hires/rehires is consistently from the 26-34 age band

Hire Year	Average Age by Plan					
	PPO	HMO	CDH	FSB	All Plans	Waive
CY 2014	38.2	38.1	39.0	35.6	38.1	37.6
CY 2015	41.2	38.9	41.1	36.9	40.0	38.8
CY 2016	39.4	37.8	38.2	36.0	38.3	37.5
CY 2017	38.5	37.7	39.3	35.3	37.8	36.6
CY 2018	39.3	39.1	38.2	36.6	38.5	38.2
Average	**39.3**	**38.3**	**39.1**	**36.1**	**38.5**	**37.7**

Hire Year	% of New Hires/Rehires by Age Band						
	Less than 26	26-34	35-44	45-54	55-64	65+	Total
CY 2014	3%	45%	25%	17%	9%	0%	100%
CY 2015	8%	36%	23%	18%	12%	2%	100%
CY 2016	13%	37%	22%	18%	9%	1%	100%
CY 2017	18%	33%	22%	17%	9%	1%	100%
CY 2018	17%	29%	22%	19%	11%	1%	100%
Average	**12%**	**36%**	**23%**	**18%**	**10%**	**1%**	**100%**

[1] Based on all full-time benefits eligible employees of the State hired or rehired between 2014 and 2018 per 'PHRST_Hires_Rehires_ConHires_FY15-18_medical election_6.20.2018.xls' provided to WTW by OMB on June 20, 2018

New hire enrollment patterns

Enrollment by age and by plan

- Nearly half of new hires/rehires under age 26 waive coverage
- Of those who enroll in coverage, new hires/rehires under age 35 are more likely to enroll in FBS compared to older new hires, and less likely to enroll in PPO and HMO plans

	% Original Election by Plan				
Hire Year	**PPO**	**HMO**	**CDH**	**FSB**	**Waive**
Under Age 26					
CY 2014	33.3%	7.4%	3.7%	7.4%	48.1%
CY 2015	19.6%	25.6%	5.4%	7.1%	42.3%
CY 2016	23.8%	19.5%	5.4%	9.0%	42.2%
CY 2017	27.7%	12.5%	4.2%	13.2%	42.4%
CY 2018	23.3%	10.3%	3.9%	16.4%	46.1%
Age 26-34					
CY 2014	37.8%	26.1%	8.0%	6.3%	21.9%
CY 2015	34.9%	29.3%	7.3%	7.6%	21.0%
CY 2016	29.6%	27.6%	10.2%	15.1%	17.5%
CY 2017	32.7%	23.5%	6.4%	18.7%	18.6%
CY 2018	34.6%	15.1%	5.6%	23.3%	21.3%
Age 35+					
CY 2014	38.1%	28.8%	7.6%	4.5%	21.0%
CY 2015	39.2%	27.8%	7.9%	4.9%	20.3%
CY 2016	37.0%	25.7%	7.9%	8.3%	21.1%
CY 2017	37.5%	22.1%	8.2%	10.8%	21.4%
CY 2018	34.8%	15.4%	5.2%	14.4%	30.3%

[1] Based on all full-time benefits eligible employees of the State hired or rehired between 2014 and 2018 per 'PHRST_Hires_Rehires_ConHires_FY15-18_medical election_6.20.2018.xls' provided to WTW by OMB on June 20, 2018

Indicates millennial population based on EBRI survey

HSA plan – demographic considerations

- Employees enrolling in HSA plans tend to be younger and healthier than those electing other types of plans; millennials are the generation most likely to be enrolled in an HSA plan
  - Millennials are more likely to engage in consumerism behaviors targeted by HSA plans when seeking medical care, and are more interested in the tax-advantages and investment features of these plans than other generations[1]
  - HSAs are important employer tools for attracting and retaining young talent
- Approximately 1/3 of GHIP enrollees are millennials[2] who are lower paid, more likely to waive/enroll in single coverage, and more likely to elect plans with low contributions (FSB, CDH) than other State employees

Demographics by Age Band

Age Band	Average Salary	% Single Coverage	% Waive Coverage
< 26	$36,724	51.2%	37.1%
26 - 29	$41,879	65.9%	7.5%
30 - 39	$51,402	32.0%	8.6%
40 - 49	$59,423	19.1%	10.2%
50 - 59	$55,108	29.2%	9.5%
60 - 69	$54,766	40.7%	8.6%
70 and over	$51,889	43.1%	12.5%

Plan Election by Age Band

Age Band	CDH	PPO	FSB	HMO	Total Enrolled
< 26	9.0%	47.8%	19.2%	24.0%	**676**
26 - 29	7.1%	50.9%	14.6%	27.4%	**2,250**
30 - 39	5.4%	60.5%	7.2%	26.9%	**7,277**
40 - 49	4.5%	61.7%	4.7%	29.1%	**8,269**
50 - 59	4.8%	62.0%	4.7%	28.5%	**8,467**
60 - 69	3.9%	68.5%	4.2%	23.3%	**3,839**
70 and over	2.4%	79.9%	2.1%	15.5%	**329**

GHIP Millennials (10,203 enrolled, 33% of total)

- Offering a HSA plan will be more attractive to GHIP millennials than other State employees, allowing them to build HSA balances and save for retirement during lean utilization years

1 Source: EBRI 2017 Consumer Engagement in Health Care Survey.
2 EBRI 2017 Consumer Engagement in Health Care Survey defines millennial generation as the demographic cohort with birth years ranging from 1977 to 2000.