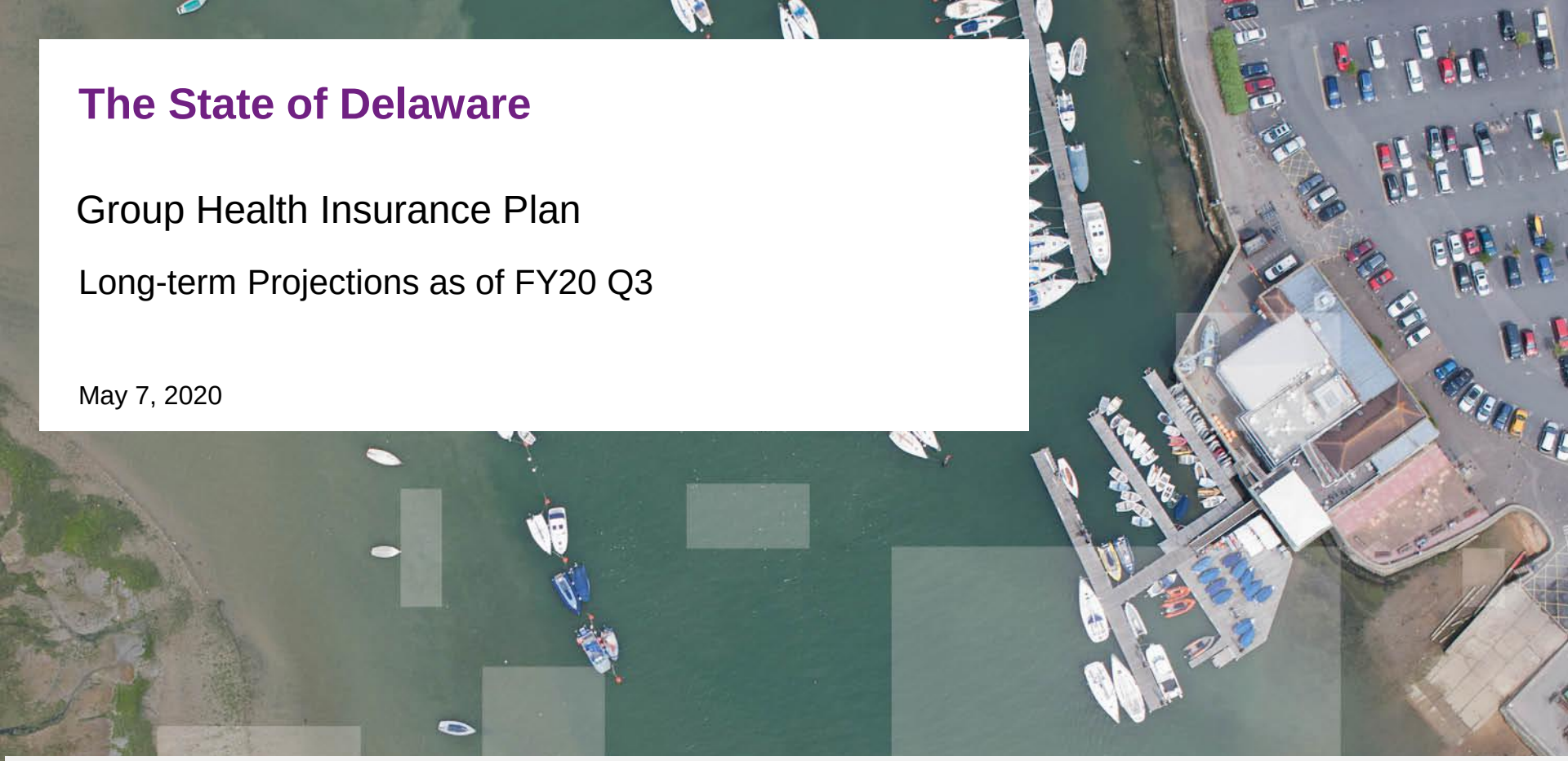

The State of Delaware

Group Health Insurance Plan

Long-term Projections as of FY20 Q3

May 7, 2020

The data and assumptions in this report reflect information available as of 5/72020 and the estimates are specific to the State of Delaware GHIP. Due to the high degree of uncertainty associated with the COVID-19 pandemic, results may vary from the estimates provided.

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Willis Towers Watson

Today's discussion

- GHIP long term health care cost projections
- COVID-19 update
- Next steps
- Appendix

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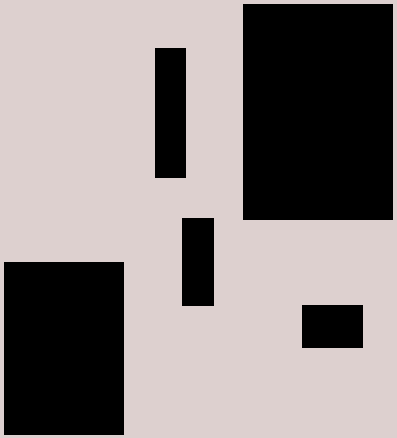
GHIP long term health care cost projections



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GHIP long term health care cost projections (FY20 Q3 update)

FY20 recast and FY21 projected budget

- Willis Towers Watson (WTW) revised GHIP financial projections based on updated claims experience through March 2020 (FY20 Q3):
  - Recast FY20 budget of $849.2M is up 0.2% ($1.6M) from FY20 Q2 update of $847.6M
    - Budget increase mainly driven by unfavorable claims experience (medical and pharmacy) during FY20 Q3
    - Offset by increase in expected rebate payments due to continued spike in pharmacy claims and continued increase in earned rebate percentage
    - FY20 budget includes $1.2M prospective reinsurance true-up received in August 2019 (excludes $5.2M CY2018 financial reconciliation payment received in January 2020)
    - Based on pricing assumptions and methodology consistent with Q2 – ***does not reflect potential impact of COVID-19 pandemic***
  - Projected FY21 budget of $902.5M down slightly ($0.8M) from FY20 Q2 update of $903.3M
    - Projected FY21 budget represents a 6.3% increase over FY20 budget recast

Component ($ millions)	Description	FY20	FY21
FY20 Q2		**$847.6**	**$903.3**
Claims Experience	Claims experience updated through FY20 Q3	$5.9	$2.9
Enrollment	Expected claims and premium increase due to growth in covered population	$0.0	$0.0
Updated Other Revenues	Includes revised EGWP payments, pharmacy rebates and participating group fees (excludes $5.2M EGWP financial reconciliation payment received January 2020)	($4.2)	($3.7)
FY20 Q3		**$849.2**	**$902.5**

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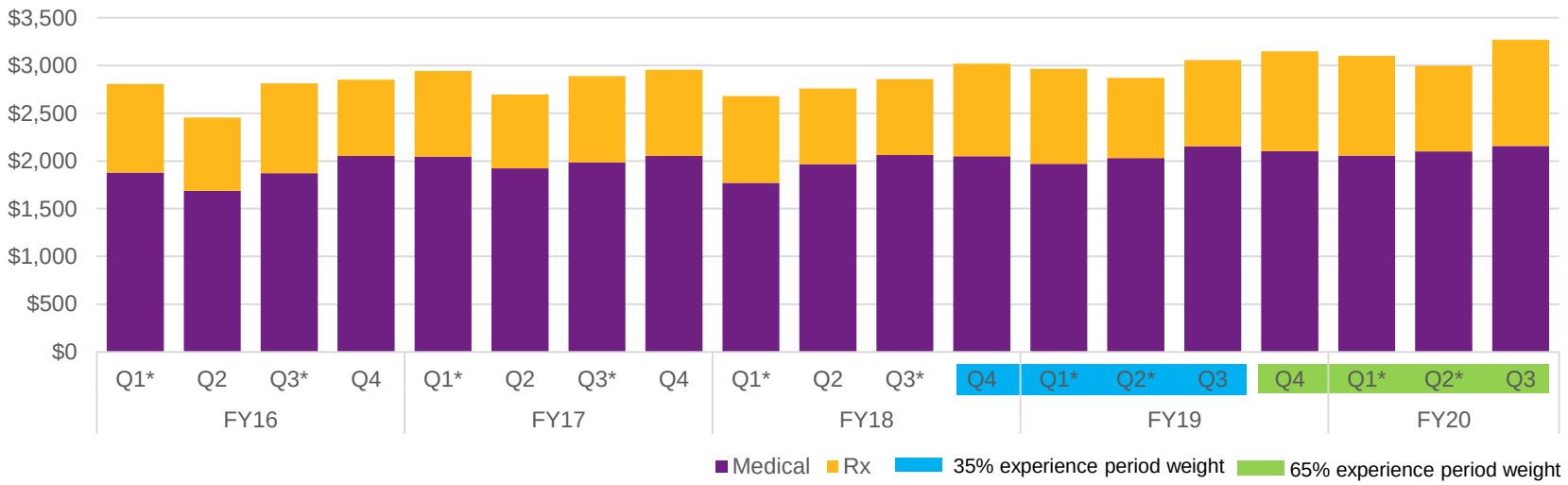
GHIP long term health care cost projections (FY20 Q3 update)

FY20 recast and FY21 projected budget – claims experience

GHIP Quarterly Claims Per Employee/Retiree[1]



- On a rolling 12-month basis, gross per employee claims through FY20 Q3 are 5.1% higher than the prior period
  - Medical trend: 3%; Rx trend: 10%

WTW recommended annual trend assumption from 2/17 SEBC discussion: 5% medical, 8% pharmacy

[1]Based on combined active, pre-65 retiree, and post-65 Medicare retiree gross medical and pharmacy claims provided by Highmark, Aetna, and ESI; does not include offsets from drug rebates and EGWP payments *Denotes quarter with seven ESI invoices

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GHIP long term health care cost projections (FY20 Q3 update)

Premium rate increase scenarios (before reflecting impact of COVID-19)

- To maintain the long-term stability of the Fund, the Financial Subcommittee recommends smoothing any available surplus over a minimum of two years
- A rate increase at any time during FY21 is likely not possible; the Financial Subcommittee will be tasked with recommending the **timing** (e.g., 7/1/2021) and **level of rate increase** for FY22
- The following page shows the revised long term projections reflecting claims data through FY20 Q3 under the following scenario:
  - Hold premium rates flat in FY21 and beyond (**$14.7M projected surplus** through end of FY21, **$95.6M projected deficit** through end of FY22)
  - Scenario does not reflect impact of COVID-19 on GHIP operating expenses
- Absent any impact from COVID-19, the required FY21 rate increase (effective 7/1/2020) needed to smooth the FY20 surplus over two years would be 2.5%
- Absent any impact from COVID-19, delaying rate increases to FY22 would require a 12.1% increase effective 7/1/2021

Reminder: Legislative Constraint

Delaware code establishes the employee cost sharing percentage for each medical plan, and the State premium share cannot be increased without also increasing employee contributions

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GHIP long term health care cost projections (FY20 Q3 update)

No premium increases FY21-FY25 (before reflecting impact of COVID-19)

GHIP Costs ($ millions)	FY19 Actual	FY20 Projected[1,6]	FY21 Projected[6]	FY22 Projected[6]	FY23 Projected[6]	FY24 Projected[6]	FY25 Projected[6]
Average Enrolled Members	126,360	128,147	129,428	130,722	132,029	133,349	134,682
GHIP Revenue							
Premium Contributions (Increasing with Enrollment)[2]	$817.4	$834.2	$842.6	$851.0	$859.5	$868.0	$876.7
Hold premium rates flat FY21 and beyond	-	-	$0.0	$0.0	$0.0	$0.0	$0.0
Other Revenues[3]	$98.5	$121.7	$127.7	$136.0	$144.9	$154.3	$164.3
Total Operating Revenues	**$915.9**	**$955.9**	**$970.3**	**$987.0**	**$1,004.4**	**$1,022.3**	**$1,041.0**
GHIP Expenses (Claims/Fees)							
Operating Expenses[4]	$904.0	$965.7	$1,030.2	$1,099.8	$1,174.1	$1,253.4	$1,338.1
% Change Per Member	*5.1%*	*5.3%*	*5.6%*	*5.7%*	*5.7%*	*5.7%*	*5.7%*
PBM Contract Renegotiation (Year 5)[7]			($7.8)	($8.3)	($8.9)	($9.5)	($10.1)
Adjusted Net Income (Revenue less Expense)	**$11.9**	**($9.8)**	**($52.1)**	**($104.5)**	**($160.8)**	**($221.6)**	**($287.0)**
Balance Forward	$151.8	$163.8	$154.0	$101.9	($2.6)	($163.4)	($385.0)
Ending Balance	$163.8	$154.0	$101.9	($2.6)	($163.4)	($385.0)	($672.0)
- Less Claims Liability[5]	*$58.8*	*$57.5*	*$61.3*	*$65.4*	*$69.8*	*$74.5*	*$79.5*
- Less Minimum Reserve[5]	*$24.3*	*$24.3*	*$25.9*	*$27.6*	*$29.5*	*$31.5*	*$33.6*
GHIP Surplus (After Reserves/Deposits)	**$80.7**	**$72.2**	**$14.7**	**($95.6)**	**($262.7)**	**($491.0)**	**($785.1)**

It is probable that the COVID-19 pandemic will have an impact on health care costs. In performing this analysis to develop health care cost estimates for GHIP, we have not explicitly reflected adjustments due to the impact of COVID-19. Due to the high degree of uncertainty associated with this pandemic, results may vary from the estimates provided.

Please refer to Appendix for FY17 and FY18 actual results (slide 16) and detailed projection footnotes (slide 17)

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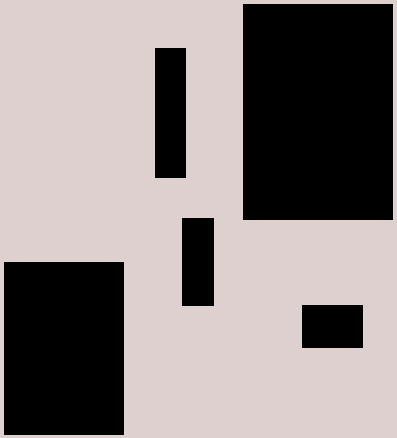
COVID-19 considerations



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COVID-19 considerations

- COVID-19 is placing growing pressure on the health care system
- Employers with older populations, more tobacco users, or populations with more chronic disease, could see higher increases
- Assumptions that impact cost projections include:
  - How much of the population is infected, and how quickly
  - Severity of illness (level of morbidity)
  - Ability of health care delivery system to increase supply of intensive care
  - How much elective and semi-elective care is delayed or prevented
- Some health care services deferred during this initial wave of COVID-19 will return once treatment and movement restrictions are eased and as the public regains confidence in the safety of care delivery settings
- Due to system capacity, it may take many months to satisfy this pent-up demand; there will also be some deferred services that may never return to the system

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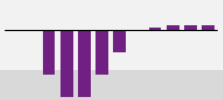
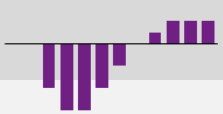
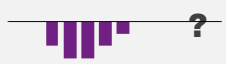
COVID-19 considerations

- Naturally, both the volume of deferred care and the likelihood it returns will vary based upon the type of care; the table below offers insights as to the types of care for which demand is building and the possibility of its return to the system:

Type of Care	Reduction in Utilization	Illustrative Utilization Curve	Pent-up Demand	Comments
Pharmacy	None►		◄None	Most maintenance prescriptions are still being filled, although more are transitioning to mail order. Fewer office visits could reduce new prescriptions
Office Visits/ Dental Care	High►		◄Low	Only highly urgent care is being delivered; most preventive care will resume but lost volume will not be recovered
Acute Emergency Care	Low►		◄None	Those with less serious emergencies are avoiding care now; these cases will have resolved when current restrictions are lifted
Accidents	High►		◄None	Less travel means fewer accidents. There is no reason to believe that there will be an increase in accidents to make up for this
Non-Urgent Procedures	High►		◄High	Many non-urgent procedures are very important to patient health and will be performed later. Some in queue will have resolved and will not be performed
Cancer Care	Moderate►		◄Moderate	Most care will eventually be delivered. Delay could mean some patients will no longer be candidates for intensive interventions
Transplants	High►		◄Low	Many transplants have been deferred. Cadaver organ supply is lower with decreased movement. Some on waiting lists will have died
Cardiac care	Moderate►		◄Unknown	Hospitals are seeing fewer heart attacks and strokes; it is unclear what the long-term consequences will be

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COVID-19 considerations

- Willis Towers Watson has updated and expanded its analysis of the estimated impact of COVID-19 on 2020 self-funded employer health care spend
- We have utilized more recent estimates of ultimate infection levels in the U.S., which vary significantly by geography and suggest that this first wave of COVID-19 will infect fewer Americans than initially expected
- Additionally, the updated results reflect revised assumptions related to non-infected care deferral:

Estimated Change in 2020 Self-Funded Employer Health Care Spend*			
	Level of Care Deferred to Future Year		
Infection Level	**Low Deferral**	**Medium Deferral**	**High Deferral**
1% (e.g., rural area)	-0.3%	-1.5%	-2.7%
5%	0.4%	-0.7%	-1.9%
10%	1.5%	0.4%	-0.7%
15% (e.g., metro area)	2.6%	1.4%	0.4%
20%	3.5%	2.0%	1.0%

* *Reflects GHIP active and pre-65 retiree population only; Impacts reflect average morbidity levels for those people who are infected based on active employee populations in the IBM MarketScan® Commercial Database.*

- In most scenarios, the cost reductions due to care deferral completely offset projected cost increases associated with COVID-19 infections
- Further, the applicability of any scenario remains geographically specific since spike infections to date have occurred in certain geographical hot spots, while care deferral is, at least initially, more evenly spread across the states

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COVID-19 considerations

- Through March, GHIP medical and pharmacy claims were 3.4% above budget ($22.6m), contributing to an $8.2m fund deficit YTD
- Delaware stay-at-home order was implemented on March 24th; impact of deferred care due to COVID-19 has begun to emerge in the April claims experience
  - April medical claims projected to be $14.5m ***below*** April budget
  - April pharmacy claims projected to be $1.7m ***above*** April budget
- Unlikely that claims will return to budgeted levels during the remainder of FY20
- Deferred care savings expected to outpace COVID-19 expenses for GHIP
  - YTD COVID-19 claims approximately $350k based on weekly COVID-19 reports from Highmark and Aetna; reflects COVID-19 tested and confirmed cases
- Impact on the GHIP Fund beyond FY20 depends on many factors, including:
  - Effectiveness of policies to mitigate spread and timing of easement of social distancing measures
  - Level of FY20 care deferral that returns in FY21
  - Cost of new vaccine or therapeutic agents
  - Potential for new waves of COVID infection

Consider impact on GHIP long term cost projections, trend assumptions, minimum reserve, rate action planning, and other factors

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COVID-19 considerations

Current minimum reserve methodology

FY20 Cost Estimate		
Variability Description	**Lower Bound**	**Upper Bound**
Expected Value (without margin)	$838,495,000	
70% Confidence Interval	$826,934,000	$850,056,000
90% Confidence Interval	$820,147,000	$856,843,000
97% Confidence Interval	$814,288,000	$862,802,000

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

- During March 6, 2017 meeting, SEBC approved a motion to set minimum reserve based on upper bound of 97% confidence interval of Willis Towers Watson health care trend variability tool, set annually based on final fiscal year budget
  - Confidence intervals represent the probability that the budget estimate will fall between an upper and lower bound of a health care claims distribution
- The estimated confidence intervals shown are directional and intended to reflect the potential random fluctuation in claims given the current size and risk profile of the GHIP

The model does not contemplate changes in costs due to systemic events; consider holding additional minimum reserve to cover potential uptick in FY21 budget due to COVID-19

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COVID-19 considerations

GHIP long term health care cost projections (FY20 Q3 update) with potential COVID-19 impact

GHIP Costs ($ millions)	FY19 Actual	FY20 Projected[1,6]	FY21 Projected[6]	FY22 Projected[6]
Average Enrolled Members	126,360	128,147	129,428	4 130,722
GHIP Revenue				
Premium Contributions (Increasing with Enrollment)[2]	$817.4	$834.2	$842.6	$851.0
Hold premium rates flat FY21 and beyond	-	-	$0.0	$0.0
Other Revenues[3]	$98.5	$121.7	$127.7	$136.0
Total Operating Revenues	**$915.9**	**$955.9**	**$970.3**	**$987.0**
GHIP Expenses (Claims/Fees)				
Operating Expenses[4]	$904.0	1 $940.4	2 $1,049.0	$1,099.8
% Change Per Member	*5.1%*	*2.6%*	*10.4%*	4 *3.8%*
PBM Contract Renegotiation (Year 5)[7]			($7.8)	($8.3)
Adjusted Net Income (Revenue less Expense)	**$11.9**	**$15.5**	**($70.9)**	**($104.5)**
Balance Forward	$151.8	$163.8	$179.3	$108.4
Ending Balance	$163.8	$179.3	$108.4	$3.9
- Less Claims Liability[5]	*$58.8*	*$57.5*	*$64.1*	*$67.2*
- Less Minimum Reserve[5]	*$24.3*	*$24.3*	3 *$52.4*	*$28.4*
GHIP Surplus (After Reserves/Deposits)	**$80.7**	**$97.5**	**($8.1)**	**($91.7)**

It is evident that the COVID-19 pandemic will have an impact on health care costs. We have used available information and reasonable estimation techniques to develop health care cost estimates for GHIP that reflect the impact of COVID-19. However due to the high degree of uncertainty associated with this pandemic, results may vary from the estimates provided.

10.8% rate increase (7/1/21) to eliminate $91.7m deficit

1. FY20 operating expenses reduced to reflect impact of deferred care on FY20 surplus; reduction based on actual claim levels in April with reduction in deferred care assumed for May and June
2. FY21 operating expenses assumed to increase above normal trend levels as some care deferred in FY20 expected to return in FY21; operating expenses FY22 and beyond assumed to return to status quo projection
3. Reduction in FY20 claims assumed to be held as additional minimum reserve in FY21 to offset potential FY21 cost increases due to COVID-19
4. No change in long-term trend assumptions (5% medical, 8% Rx) or assumed membership growth

Please refer to Appendix for FY17 and FY18 actual results (slide 16) and detailed projection footnotes (slide 17)

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Recommended next steps

- Continue to monitor emerging plan experience for COVID-19 testing and treatment, care deferral by type of care, and GHIP overall
- Continue to monitor emerging utilization and cost savings for the GHIP initiatives adopted to date
- Continue to discuss timing and level of future rate action

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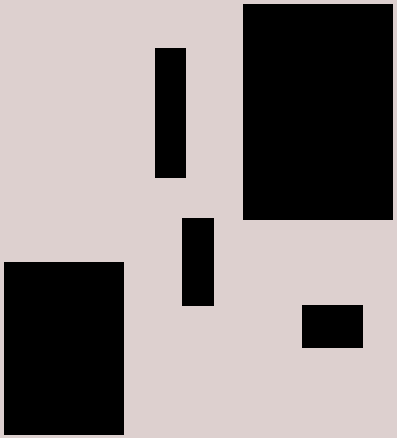
Appendix



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GHIP historical health care fund information

FY17-FY18

GHIP Costs ($ millions)	FY17 Actual	FY18 Actual
Average Enrolled Members	123,132	125,488
GHIP Revenue		
Premium Contributions (Increasing with Enrollment)[2]	$799.0	$810.9
Hold premium rates flat FY21+)	-	-
Other Revenues[3]	$81.6	$92.1
Total Operating Revenues	**$880.6**	**$903.0**
GHIP Expenses (Claims/Fees)		
Operating Expenses[4]	$816.8	$853.9
% Change Per Member		*2.6%*
Excise Tax Liability[5]		
Adjusted Net Income (Revenue less Expense)	**$63.8**	**$49.1**
Balance Forward	$38.9	$102.7
Ending Balance	$102.7	$151.8
- Less Claims Liability[6]	*$54.0*	*$58.9*
- Less Minimum Reserve[6]	*$24.0*	*$24.0*
GHIP Surplus (After Reserves/Deposits)	**$24.7**	**$68.9**

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GHIP long term health care cost projection footnotes

Note: FY17, FY18, and FY19 actual based on final June 2017, June 2018, and June 2019 Fund Equity reports; projected operating expenses and enrollment based on experience through FY20 Q3; assumed 1% annual enrollment growth; numbers in table may not add up due to rounding

1. Includes approved design changes effective 7/1/2019 including implementation of SurgeryPlus COE ($0.5m annual savings), site-of-care steerage ($6.9m), Highmark infusion therapy program ($2.0m) and implementation of Livongo ($0.7m), as well as cost impact of passed legislation ($2.875m cost increase)
2. Includes State and employee/pensioner premium contributions; assumes 1% annual enrollment growth for FY20-FY25
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 and premium growth); FY20 includes $5.2m CY2018 CMS financial reconciliation payment received January 2020.
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. FY21 reflects implementation of Highmark radiation therapy authorization program ($633k annual savings per Highmark). Assumes no other program changes in FY21 and beyond.
5. FY20 Minimum Reserve levels updated with data through June 2019; FY20 Claim Liability updated with lag factors as of Dec 2019 and claims data through December 2019; future years assumed to increase with overall GHIP expense growth. Consider one-time increase in Minimum Reserve for FY21 to account for additional uncertainty associated with COVID-19 pandemic
6. FY20-FY25 projections based on 5% medical, 8% pharmacy baseline trend (before potential impact of COVID-19 pandemic); assumes 1% annual growth in GHIP membership (before potential impact of COVID-19 pandemic).
7. Reflects FY21 plan savings based on ESI year 5 traditional pharmacy BAFO renewal; assumed to increase with trend FY22 and beyond

It is probable that the COVID-19 pandemic will have an impact on health care costs. In performing this analysis to develop health care cost estimates for GHIP, we have not explicitly reflected adjustments due to the impact of COVID-19. Due to the high degree of uncertainty associated with this pandemic, results may vary from the estimates provided.

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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 (1/1/2018 – 12/31/2019)
- 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

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ESI pharmacy renewal – FY21 (Year 5)

Summary of projected FY21 contract savings (best and final offer)

- ESI provided a traditional and transparent one-year renewal BAFO offers for both the Commercial and EGWP populations on January 21, 2019
- ESI's traditional BAFO offer provides pricing guarantee improvements of 4% for the Commercial population and 5% for EGWP for a combined contract improvement of $12.2M over the current terms and $5.1M over the initial offer
- ESI's transparent BAFO offer provides pricing guarantee improvements of 2.1% for the Commercial population and 3.4% for the EGWP population for a combined contract improvement of $7.4M over the current terms and $5.4M improvement over the initial offer
  - The transparent offer has higher costs before rebates due to added fees and lower minimum guarantees, but has potential upside for retail pass-through

ESI One Year Renewal Offer - Traditional	Commercial FY20 Initial	EGWP CY21 Initial	Commercial FY20 BAFO	EGWP CY21 BAFO
Savings before rebates[1]	-0.1% ($0.2M)	-0.1% ($0.1M)	-0.3% ($0.5M)	-0.2% ($0.3M)
Savings after rebates[2]	-3.0% ($4.3M)	-2.1% ($2.8M)	-4.0% ($5.6M)	-5.0% ($6.7M)
Plan cost reduction in FY20[3]	$4.8M		$7.8M	
ESI One Year Renewal Offer - Transparent	**Commercial FY20 Initial**	**EGWP CY21 Initial**	**Commercial FY20 BAFO**	**EGWP CY21 BAFO**
Savings before rebates[1]	+1.4% (+$2.5M)	+1.4% (+$2.2M)	+1.2% (+$2.2M)	+1.2% (+$1.8M)
Savings after rebates[2]	-1.1% ($1.6M)	-0.4% ($0.5M)	-2.1% ($2.9M)	-3.4% ($4.5M)
Plan cost reduction in FY20[3]	$1.5M		$4.6M	

[1]Estimated savings for each respective contract period using allowed claims (plan and member cost sharing combined), utilization, and enrollment data for the period 10/1/2018 – 9/30/2019 and composite annual pharmacy trend rate of 6-8% (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 7/1/2020 – 6/30/2021 based on the pricing assumptions outlined in the Appendix

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COVID-19 impact modeling assumptions

As of 5/7/2020

Costs by Severity Level		
Severity	Services	Estimated Gross Cost
Mild	Office visit + test	$250
Moderate	ER + test	$2,500
Severe	ER, 5-day IP stay + test	$30,000
Catastrophic	ER, 14-day ICU stay + test	$100,000

Severity	Mild	Moderate	Severe	Catastrophic
Morbidity	**Est % of members by severity level**			
Low	93%	4%	2%	0.4%
Medium	87%	8%	4%	0.7%
High	81%	12%	6%	1.0%

Change in Utilization			
Service Type	Low Deferral	Medium Deferral	High Deferral
PCP	-5%	-10%	-15%
Specialist	-5%	-10%	-15%
ER	-5%	-10%	-15%
Urgent Care	-5%	-10%	-15%
OP surgery	-5%	-10%	-15%
Telehealth	+200%	+200%	+200%

- The number of units and unit costs associated with office visits, emergency room visits, and outpatient and inpatient encounters reflect an average commercial population profile underlying the IBM MarketScan® Commercial Database

- Supply-side constraints are built into modeling, reflecting the limited capacity of health care resources (e.g., available hospital beds)
- The model also reflects a "substitution" effect, where costs of some current inpatient and ICU utilization go away and are replaced with COVID-19 cases

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