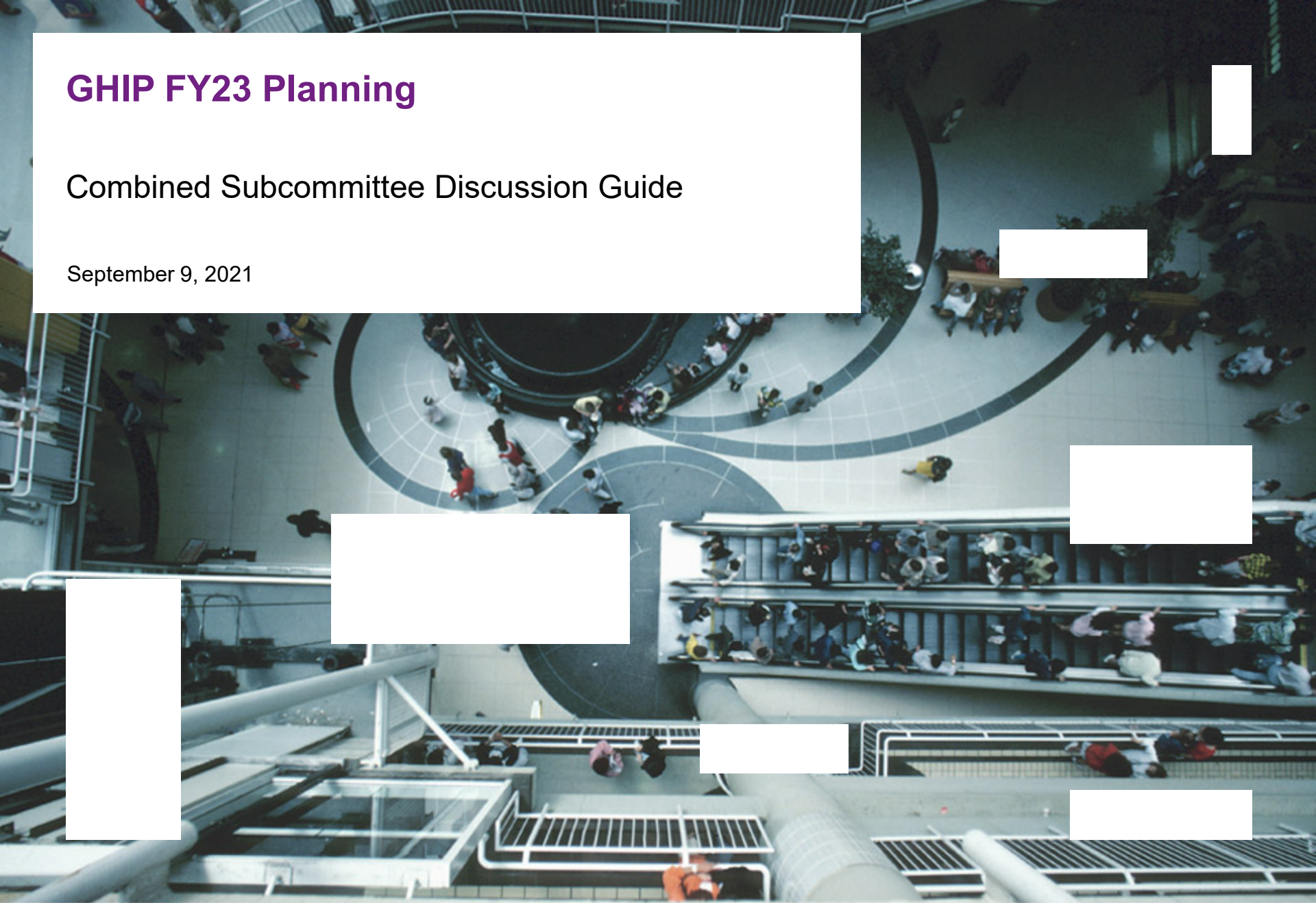
GHIP FY23 Planning

Combined Subcommittee Discussion Guide

September 9, 2021



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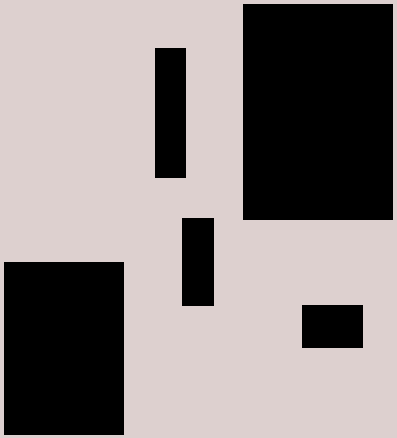
Today's discussion

- GHIP long term health care cost projections – recap
- Savings opportunities for consideration
  - Medical TPA RFP initiatives
  - Plan design changes for active/pre-65 and Medicfill programs
  - Other program design considerations
  - Adoption of proposed CVS Health pharmacy programs
  - Adoption of mandatory bariatric carve-out and incentive modifications with SurgeryPlus
- Next steps

- Appendix

GHIP long term health care cost projections - recap



GHIP long term health care cost projections (FY21 Q4 update)

No premium increases FY22-FY26 (***includes*** $20m supplemental bill funding in FY22)

GHIP Costs ($ millions)	FY20 Actual	FY21 Actual	FY22 Projected[1]	FY23 Projected[1]	FY24 Projected[1]	FY25 Projected[1]	FY26 Projected[1]
Average Enrolled Members	128,531	129,768	130,427	131,731	133,048	134,378	135,722
GHIP Revenue							
Premium Contributions (Increasing with Enrollment)[2]	$830.8	$839.4	$841.8	$850.2	$858.7	$867.3	$876.0
Hold premium rates flat FY21 and beyond	-	-	$0.0	$0.0	$0.0	$0.0	$0.0
Other Revenues[3]	$122.8	$128.9	$190.0	$182.0	$202.0	$219.3	$237.3
Total Operating Revenues	**$953.7**	**$968.3**	**$1,031.8**	**$1,032.2**	**$1,060.7**	**$1,086.6**	**$1,113.3**
GHIP Expenses (Claims/Fees)							
Operating Expenses[4]	$927.7	$1,005.7	$1,089.6	$1,163.1	$1,241.7	$1,325.5	$1,415.1
% Change Per Member	*0.9%*	*7.4%*	*7.8%*	*5.7%*	*5.7%*	*5.7%*	*5.7%*
Adjusted Net Income (Revenue less Expense)	**$26.0**	**($37.4)**	**($57.8)**	**($130.9)**	**($181.0)**	**($238.9)**	**($301.8)**
Balance Forward	$163.8	$189.8	$152.3	$94.6	($36.3)	($217.3)	($456.3)
Ending Balance	$189.8	$152.3	$94.6	($36.3)	($217.3)	($456.3)	($758.0)
- Less Claims Liability[5]	*$57.5*	*$57.5*	*$61.0*	*$65.1*	*$69.5*	*$74.2*	*$79.2*
- Less Minimum Reserve[5]	*$24.3*	*$24.3*	*$24.3*	*$25.9*	*$27.6*	*$29.5*	*$31.5*
- Less COVID-19 Reserve[6]	-	-	-	-	-	-	-
GHIP Surplus (After Reserves/Deposits)	**$108.0**	**$70.5**	**$9.3**	**($127.3)**	**($314.4)**	**($560.0)**	**($868.7)**

- FY21 reflects release of COVID-19 reserve and June 2021 Fund balance of $152.3m (includes $23.3m in COVID-19 reimbursement, reflected as offset to FY21 operating expenses)
  - Prior projections assumed COVID-19 reimbursement would be received in July (FY22)

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 the 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.

Please refer to Appendix for FY17, FY18, and FY19 actual results (slide 15) and detailed projection footnotes (slide 16)

GHIP long term health care cost projections (FY21 Q4 update)

Recap of August 16, 2021 SEBC meeting

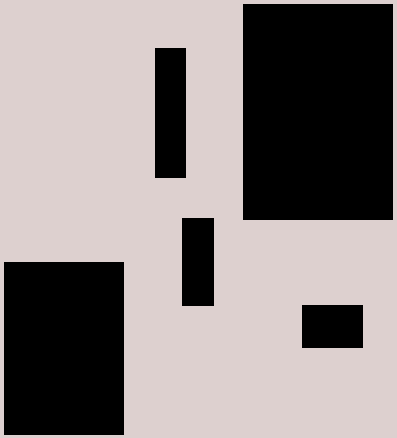
- In order to support the GHIP's strategic framework, Willis Towers Watson (WTW) and the State of Delaware have partnered to identify opportunities to reduce future health care expenditures while creating better health care consumers and ultimately improving the health of the GHIP population
- WTW's latest FY23 budget projection reflects a **$127.3m deficit** that must be solved through a combination of premium rate increases and other levers that can generate substantial plan savings
  - The Financial Subcommittee will be tasked with recommending the timing and level of rate increase in FY23
  - If no other program changes, a 15.0% premium increase will be needed on July 1, 2022 to solve for the projected FY23 deficit of $127.3M
  - A 15.0% premium increase yields $93m in State share revenue and $11m in employee/pensioner revenue for the active/pre-65 retiree population

GHIP long term health care cost projections (FY21 Q4 update)

Recap of August 16, 2021 SEBC meeting

- Due to the looming FY23 deficit, WTW has been asked to review alternatives that will generate GHIP plan savings and reduce the anticipated FY23 premium increase needed to solve for the deficit
- Savings opportunities can come from, but are not limited to, the following alternatives:
  - Medical TPA RFP initiatives
  - Plan design changes for active/pre-65 and Medicfill programs
  - Adoption of proposed CVS Health pharmacy programs
  - Adoption of mandatory bariatric carve-out and incentive modifications with SurgeryPlus
- The following section details the potential savings associated with these alternatives
  - All savings estimates require additional analysis and refining; estimates are intended to highlight the magnitude of program changes needed to solve for the projected FY23 deficit of $127.3m

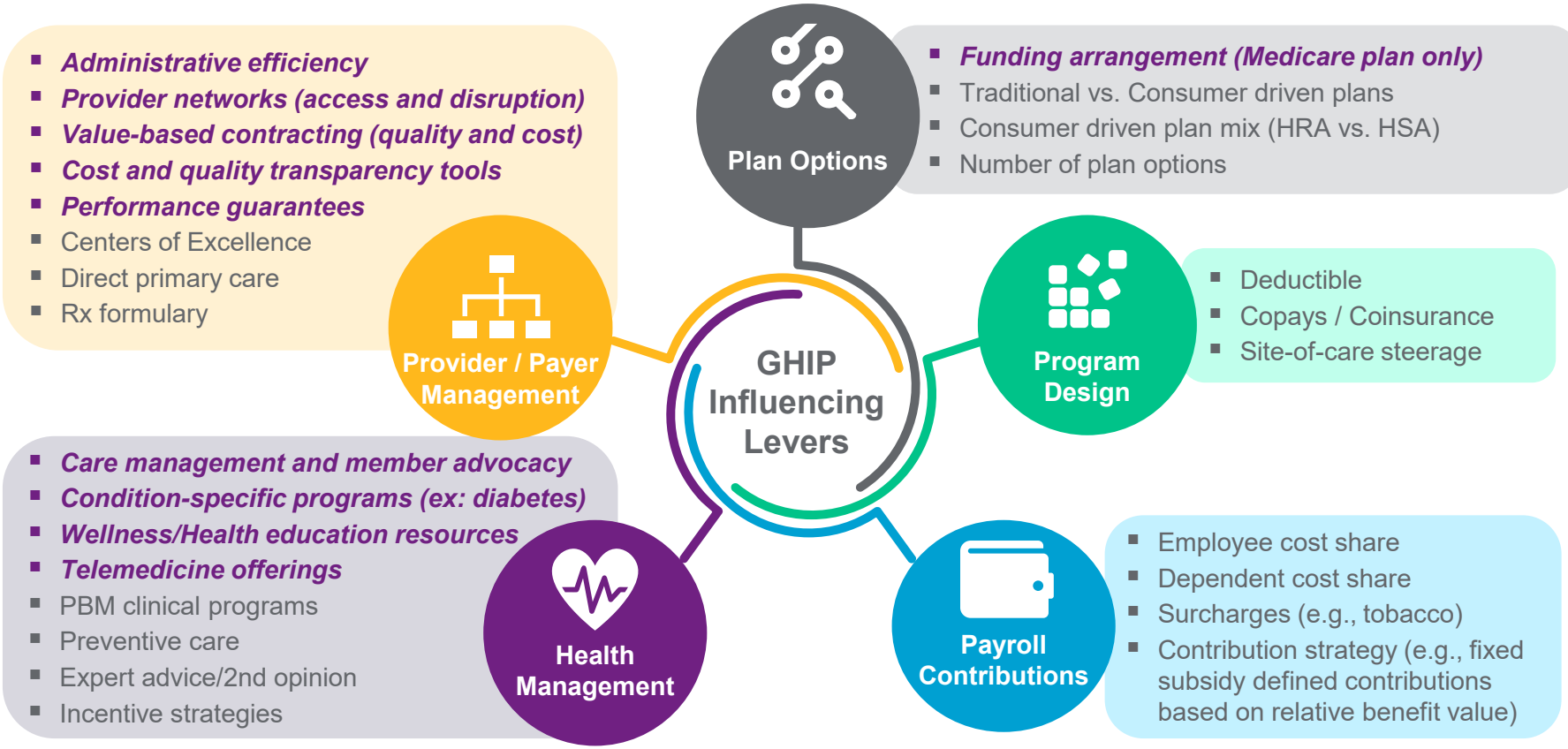
Savings opportunities for consideration



GHIP influencing levers

Tactics for managing health outcomes and cost for participants and the GHIP

- Opportunities that are highlighted ***in purple*** will be evaluated through the Medical TPA RFP
- Most immediate opportunities to impact FY23 plan costs will arise from SEBC decisions related to provider network selection, value-based contracting and Medicare plan funding arrangements



Plan design considerations

Deductible modeling – HMO and Comprehensive PPO plans

- The table below highlights savings attributable to adding various deductibles to the Comprehensive PPO and HMO plans effective 7/1/22

FY23 Deductible (single / family)	$50 / $100	$100 / $200	$150 / $300	$200 / $400	$250 / $500	$500 / $1000
HMO	$0.3 M	$0.7 M	$0.9 M	$1.3 M	$1.5 M	$2.7 M
Comprehensive PPO	$1.1 M	$2.0 M	$3.1 M	$4.2 M	$5.1 M	$9.0 M
Total	**$1.5 M**	**$2.6 M**	**$4.0 M**	**$5.5 M**	**$6.6 M**	**$11.7 M**

- The 15.0% premium increase modeled in August results in the following increase in annual employee/pensioner contributions:
  - HMO: $85 – $223
  - Comprehensive PPO: $189 – $491
- Adding deductibles will have minimal impact on the overall deficit and only generate savings through cost shifting
  - If the State decided to add deductibles to these plans, a premium increase will still be needed to solve for the remaining deficit, creating two layers of member disruption

Plan design considerations

Deductible/copay modeling – Medicfill plan

- Medicare retirees have minimal cost sharing for medical under the current Medicfill plan
- The State can achieve savings through increased cost sharing for the Medicfill plan in the form of deductibles and/or copays on specific services
  - Adding deductibles to the Medicfill plan would generate savings while creating significant member disruption
  - Adding copays for office, emergency department and/or inpatient visits can more effectively achieve savings while mitigating member disruption
- The table below highlights savings attributable to adding various deductibles and copays to the Medicfill plan (savings reflect 12-month plan year)
  - Note: utilization data on Medicare office visits is currently unavailable

Plan design change	Gross savings
$50 Deductible[1]	$0.8 M
$250 Deductible[1]	$3.9 M
$10 OV Copay	$3.4 M
$150 ER Copay	$2.1 M
$100 IP Copay[2]	$0.9 M

[1] Deductibles apply to hospital benefits only (Part A)
[2] $100 copay per day to a maximum of $200

Plan design considerations

Rx copay modeling

- To evaluate potential copay changes to Rx plan design, WTW reviewed benchmarking information from its Benefit Data Source database
- Benchmarking reflects 272 organizations with 10,000+ employees
- Majority of organizations offer copays for generic drugs (retail and mail-order), and coinsurance for brand drugs (preferred and non-preferred, retail and mail-order)
- The illustrative design changes below target copay amounts aligned with the copays offered by the majority of organizations in BDS for each category of drug

	Current Design	Benchmark Design
Prescription Drug[2] – (Retail / Mail-Order)		
Generic	$8 / $16	$12 / $24
Brand Formulary	$28 / $56	$42 / $84
Brand Non-Formulary	$50 / $100	$75 / $150

- Illustrative savings[1]:
  - Commercial plans: $3.9m
  - Medicfill plan: $2.3m

[1] Savings estimates utilize Rx copay data provided by IBM Watson Health; reflects Rx scripts and copays paid in FY21 separately for generics, preferred brands and non-preferred brands for retail and mail-order drugs; applies ratio of average paid copay per script relative to maximum current copay to the illustrative benchmark copays for each drug category; actual savings may vary

Plan design considerations

COVID-19 benefit enhancements

- Since the onset of COVID-19, the GHIP has continued to evaluate and extend certain benefit enhancements related to the pandemic, including:
  - EAP coverage for all SOD employees (annual GHIP cost ~$70k)
  - No member cost sharing for any telehealth visit
    - GHIP cost impact varies, and has grown with the substantial increase in telehealth utilization with "other" telehealth providers, including PCP's and specialists
  - Benefit enhancements currently extended for no more than thirty days following the end of the public health emergency
- In the 12-months ended in July 2021, the GHIP paid approx. $19m in telehealth claims associated with these "other" providers with essentially no member cost sharing
  - Based on cost sharing for pre-pandemic telehealth claims[1], the GHIP could save up to $4m by waiving the extension of no member cost sharing for any telehealth visit[2]
    - Assumes future utilization mirrors pre-pandemic utilization

[1] 10% coinsurance for CDH and FSB plans, $0 copay for PPO/HMO visits with select telehealth providers (i.e., Teladoc, Doctor on Demand, Amwell), and office visit copays for appointments with community-based providers (i.e., PCPs, specialists) and for behavioral health counseling services through certain telehealth providers (MDLive, Array AtHome Care, Bright Heart Health)

[2] Savings estimates based on IBM Watson reporting of telehealth utilization with other providers (excludes Doctor on Demand, Teladoc and Amwell) for the periods August 2020 – July 2021 and November 2018 – October 2019; savings based on % member cost share for pre-pandemic telehealth visits applied to most recent 12 months of paid telehealth claims

Other program design considerations

- The SEBC has previously adopted a variety of initiatives that improve health outcomes and support management of cost for members and the GHIP
- WTW has periodically updated the Subcommittees on the utilization and outcomes of these initiatives (most recently in November-December 2020 for site of care steerage and clinical management programs)
- WTW is in the process of refreshing those analyses and will share with the Subcommittee at an upcoming meeting this fall

	FY17 *(Effective 7/1/16)*	FY18 *(Effective 7/1/17)*	FY19 *(Effective 7/1/18)*	FY20 *(Effective 7/1/19)*	FY21 *(Effective 7/1/20)*	FY22 *(Effective 7/1/21)*
Site of Care Steerage	▪ ***Already in place***: Aetna infusion therapy site-of-care steerage ▪ Copay changes for urgent care, high-tech imaging ▪ Third-party telemedicine programs added	(no changes)	▪ Copay changes for basic imagining, high-tech imaging, outpatient labs	▪ Copay changes for basic imaging, high-tech imaging, outpatient labs, emergency room, and telemedicine ▪ Implemented Highmark infusion therapy site-of-care steerage program	(no changes)	(no changes)
Clinical Management Programs	(no changes)	▪ Implemented Aetna/Carelink and Highmark CCMU care management programs	▪ Implemented diabetes prevention programs (Retrofit, YMCA)	▪ Implemented Livongo for diabetes management	(no changes)	(no changes)
Other Initiatives and Changes	(no changes)	▪ Implemented Aetna Enhanced Clinical Review program for select high tech imaging services	▪ HB203 Diabetes monitoring and prevention	▪ Implemented SurgeryPlus surgeons of excellence program ▪ ***Effective 8/1/19:*** Implemented enhanced fertility benefits	(no changes)	(no changes)

Proposed CVS Health pharmacy programs

- CVS has presented the following pharmacy programs that could produce meaningful savings for the GHIP
- ***Drug Savings Review:*** Program reviews Rx utilization to ensure that prescriptions/dosage follows evidence-based medical guidelines
  - Program savings are highly dependent on the responsiveness and engagement of the medical provider community, as CVS would be reaching out to physicians with patient safety and savings opportunities
  - Monthly administrative fee applies
- ***Next Generation Transform Diabetes Care (ngTDC):*** Engages members with diabetes on actionable steps to address gaps in care, evaluate medical needs and facilitate overall wellness
  - Potential replacement for Livongo, which will be discontinued for plan participants in the Aetna and Medicfill plans effective 6/30/22 and 12/31/22, respectively
  - Potential for disruption through moving members away from their current glucose meters (including those currently engaged with Livongo)
  - ngTDC would use medical/Rx data to tailor recommended type of glucose meter for individual participants
  - Monthly administrative fee applies (though is less than current fee with Livongo)
- ***PrudentRx:*** Program leverages manufacturer assistance with specialty medications that could produce meaningful savings but would require significant engagement from members
  - No upfront administrative fees but savings is shared with program administrator
- If the Subcommittee is interested in exploring any of these programs further, then additional analysis would be conducted to validate the savings estimates provided by CVS along with any potential member impact

SurgeryPlus mandatory carve-out for bariatric and incentive modifications

Background

- Members have the option to access surgical Centers of Excellence (COEs) through SurgeryPlus
  - Participants' utilization of this benefit has gradually increased since program inception in the beginning of FY20 (7/1/2019)
  - Members can still access the same services through the medical TPAs (without the same level of incentives to do so), so utilization of the program for certain types of surgeries is still low
- In February 2021, an update on FY20 program outcomes was provided to the SEBC[1]
  - Program produced savings of approximately $370,000 (net of program costs and incentives)
  - While more procedures were completed than expected (81 actual vs. 53 estimated), net savings was lower than expected by approximately $130,000 due to:
    - Greater variety and cost variation among the scope of procedures actually offered vs. originally anticipated
    - Incentive design was developed after FY20 budget was finalized and was not factored into savings estimate
- At the same time, the combined Subcommittees were considering the implications of mandating use of the SurgeryPlus benefit for bariatric surgery
  - As shared with the SEBC in March 2021[2], no action was taken at the time given continued concerns from Subcommittee members about the bariatric provider network under a carve-out approach
  - Since then, SBO and WTW have continued to monitor outcomes of the SurgeryPlus benefit and are preparing a summary of FY21 outcomes for an upcoming Subcommittee meeting

1. Source: https://dhr.delaware.gov/benefits/sebc/documents/2021/0222-open-enrollment-fy22-planning.pdf
2. Source: https://dhr.delaware.gov/benefits/sebc/documents/2021/0308-new-program-outcomes-planning.pdf

SurgeryPlus mandatory carve-out for bariatric and incentive modifications

Opportunities for Subcommittee consideration

- Bariatric surgery carve-out:
  - Since early 2021, SurgeryPlus has made progress with addressing earlier concerns from the Subcommittee about the bariatric provider network
  - Prior savings estimates[1] for carving out bariatric surgery ranged from $355,000 to $1.4m, depending on number of procedures performed during the plan year
  - Further analysis would be required to update the estimated savings along with quantifying the cost of bariatric surgery through the medical carriers
  - Subcommittee could also consider mandating SurgeryPlus for other surgeries beyond bariatric, such as joint replacements and spine surgery

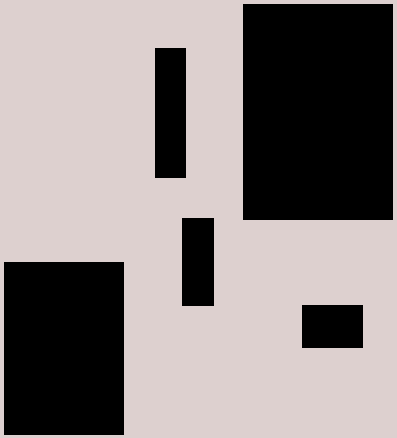
- Incentive modifications:
  - Mandating use of the SurgeryPlus benefit for any surgeries would create an opportunity to revisit the incentive amounts paid to members who utilize the program for care
  - Incentives would no longer be necessary for mandated services
  - For remaining surgeries in which members would still have a choice of providers (i.e., SurgeryPlus or the medical carrier's network), there would still be opportunity to consider scaling back the incentives offered

1. Source: https://dhr.delaware.gov/benefits/sebc/documents/sub-comm-2021/0304-new-program-outcomes-planning.pdf

Recommended next steps

- Discuss which savings opportunities should be explored further by Subcommittee
- 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

Appendix



FY23 monthly rates and employee/retiree contributions

Illustrative: 15.0% increase effective 7/1/2022

FY22 reflects employee contribution increases of $4.18 - $40.93 per employee per month ($50.16 - $491.16 per year) and State subsidy increases of $100.12 - $270.14 per employee per month ($1,201.44 - $3,241.68 per year) effective 7/1/2022

	Current Rates			FY 2023 with 15.0% Increase (effective 7/1/2022)			$ 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	$799.66	$32.02	$767.64	$4.18	$50.16	$100.12	$1,201.44
Employee + Spouse	$1,438.68	$57.52	$1,381.16	$1,654.48	$66.15	$1,588.33	$8.63	$103.56	$207.17	$2,486.04
Employee + Child	$1,057.02	$42.26	$1,014.76	$1,215.57	$48.60	$1,166.97	$6.34	$76.08	$152.21	$1,826.52
Family	$1,798.42	$71.92	$1,726.50	$2,068.18	$82.71	$1,985.47	$10.79	$129.48	$258.97	$3,107.64
CDH Gold										
Employee	$719.68	$35.98	$683.70	$827.63	$41.38	$786.25	$5.40	$64.80	$102.55	$1,230.60
Employee + Spouse	$1,492.22	$74.58	$1,417.64	$1,716.05	$85.77	$1,630.28	$11.19	$134.28	$212.64	$2,551.68
Employee + Child	$1,099.56	$54.96	$1,044.60	$1,264.49	$63.20	$1,201.29	$8.24	$98.88	$156.69	$1,880.28
Family	$1,895.74	$94.78	$1,800.96	$2,180.10	$109.00	$2,071.10	$14.22	$170.64	$270.14	$3,241.68
Aetna HMO										
Employee	$725.94	$47.16	$678.78	$834.83	$54.23	$780.60	$7.07	$84.84	$101.82	$1,221.84
Employee + Spouse	$1,530.58	$99.50	$1,431.08	$1,760.17	$114.43	$1,645.74	$14.93	$179.16	$214.66	$2,575.92
Employee + Child	$1,110.52	$72.18	$1,038.34	$1,277.10	$83.01	$1,194.09	$10.83	$129.96	$155.75	$1,869.00
Family	$1,909.82	$124.12	$1,785.70	$2,196.29	$142.74	$2,053.55	$18.62	$223.44	$267.85	$3,214.20
Comprehensive PPO										
Employee	$793.86	$105.18	$688.68	$912.94	$120.96	$791.98	$15.78	$189.36	$103.30	$1,239.60
Employee + Spouse	$1,647.34	$218.26	$1,429.08	$1,894.44	$251.00	$1,643.44	$32.74	$392.88	$214.36	$2,572.32
Employee + Child	$1,223.46	$162.08	$1,061.38	$1,406.98	$186.39	$1,220.59	$24.31	$291.72	$159.21	$1,910.52
Family	$2,059.40	$272.86	$1,786.54	$2,368.31	$313.79	$2,054.52	$40.93	$491.16	$267.98	$3,215.76

GHIP historical health care fund information

FY17-FY19

GHIP Costs ($ millions)	FY17 Actual	FY18 Actual	FY19 Actual
Average Enrolled Members	123,132	125,488	126,360
GHIP Revenue			
Premium Contributions (Increasing with Enrollment)[2]	$799.0	$810.9	$817.4
Hold premium rates flat FY21+)	-	-	-
Other Revenues[3]	$81.6	$92.1	$98.5
Total Operating Revenues	**$880.6**	**$903.0**	**$915.9**
GHIP Expenses (Claims/Fees)			
Operating Expenses[4]	$816.8	$853.9	$904.0
% Change Per Member		*2.6%*	*5.1%*
Excise Tax Liability[5]			
Adjusted Net Income (Revenue less Expense)	**$63.8**	**$49.1**	**$11.9**
Balance Forward	$38.9	$102.7	$151.8
Ending Balance	$102.7	$151.8	$163.8
- Less Claims Liability[6]	*$54.0*	*$58.9*	*$58.8*
- Less Minimum Reserve[6]	*$24.0*	*$24.0*	*$24.3*
GHIP Surplus (After Reserves/Deposits)	**$24.7**	**$68.9**	**$80.7**

GHIP long term health care cost projection footnotes

Note: FY17-FY21 actuals based on final June Fund Equity reports for respective fiscal year; FY22+ projected operating expenses and enrollment based on experience through FY21 Q4 with adjustments due to COVID-19 financial impact; 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); FY21 reflects implementation of Highmark radiation therapy authorization program ($633k annual savings per Highmark); FY22-FY26 projections based on 5% medical, 8% pharmacy baseline trend; assumes 1% annual growth in GHIP membership; FY22 projection reflects impact of COVID-19; assumes no other program changes in FY22 and beyond.
2. Includes State and employee/pensioner premium contributions; assumes 1% annual enrollment growth for FY22-FY26
3. Includes Rx rebates, EGWP payments, other revenues based on when revenues will be received; FY22 and beyond includes estimated improvements in Rx rebates based on result of PBM award to CVS Health; rebates assumed to be paid 60 days after the quarter adjudicated; includes fees for participating non-State groups (assumed to increase proportionally with membership and premium growth); FY22 includes projected $8.4m CY2020 CMS financial reconciliation payment to be received Jan. 2022.
4. FY22 and beyond includes estimated reduction in pharmacy claims as a result of PBM award to CVS Health
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; FY21 reserves assumed to remain at FY20 levels; FY22 claim liability and future years assumed to increase with overall GHIP claims growth; FY22 minimum reserve assumed to remain at FY21 level.
6. One-time COVID-19 reserve as approved by SEBC on July 27th, 2020; released at the end of FY21

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 the 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.