GHIP FY23 Planning

Combined Subcommittee Discussion Guide

October 7, 2021

Willis Towers Watson

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Today's discussion

- Recap of FY23 opportunities for consideration presented in September
- Other opportunities for consideration
  - Adoption of proposed CVS Health pharmacy programs
  - Adoption of mandatory bariatric carve-out and incentive modifications with SurgeryPlus
- Program design considerations
  - Site of care utilization
  - Clinical management programs
- Next steps

- Appendix
  - Plan design changes for active/pre-65 and Medicfill programs

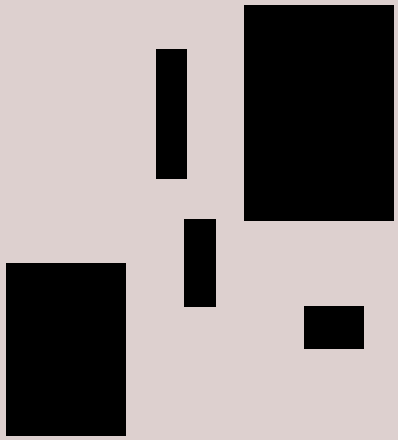
FY23 opportunities for consideration

- Chart outlines impact of several FY23 opportunities for consideration presented at the September Combined Subcommittee meeting
- Other opportunities for consideration for further discussion today include:
  - Adoption of proposed CVS Health pharmacy programs
  - Adoption of mandatory bariatric carve-out and incentive modifications with SurgeryPlus

FY23 Opportunity	Description	Estimated # Members Impacted*	Estimated FY23 Savings / Cost Avoidance	Impact to required premium increase of 15.0% for FY23
Add deductibles to the Comprehensive PPO and HMO plans	WTW modeled deductibles for single / family coverage ranging from $50 / $100 to $500 / $1,000	89,000 members enrolled in PPO and HMO plans	Ranges from **$1.5M** to **$11.7M** depending on deductible level	**0.2%** – **1.4%** reduction in required increase based on range of cost avoided
Deductible/copay changes to the Medicfill plan	WTW modeled deductibles of $50 and $250 as well as copays for office visits, ER visits and hospital stays	28,600 members enrolled in Medicfill plan	Each change ranges from **$0.8M** to **$3.9M** (max: **$10.3M**)	**0.1%** – **0.5%** (max: **1.2%**) reduction in required increase based on range of cost avoided
Rx copay changes	WTW modeled impact of increasing Rx copays for Commercial and EGWP populations	Commercial: 102,100 members EGWP: 28,000 members	Commercial: **$3.9M** EGWP: **$2.3M** Total: **$6.2M**	Reduction in required increases: Commercial: **0.5%** EGWP: **0.3%** Total: **0.7%**
Telemedicine copay changes	WTW modeled reinstatement of member cost sharing for telehealth visits with community providers	102,100 members	**$4.0M**, assuming future utilization mirrors pre-pandemic utilization	**0.5%** reduction in required increase

*Based on enrollment as of August 2021.

Other opportunities for consideration



Proposed CVS Health pharmacy programs

- CVS has presented the following pharmacy programs that could produce meaningful savings for the GHIP, which were discussed briefly at the September Combined Subcommittee meeting:
  - ***Drug Savings Review:*** Program reviews Rx utilization to ensure that prescriptions/dosage follows evidence-based medical guidelines
  - ***PrudentRx:*** Program leverages manufacturer assistance with specialty medications that could produce meaningful savings but would require significant engagement from members
  - ***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
- Further information on each of these programs follows

Proposed CVS Health pharmacy programs

Drug Savings Review

- Identifies opportunities for improved prescribing and utilization based on 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
  - CVS outreach consists of a request to the provider to consider making a change in a member's prescription therapy
  - Provider retains discretion over the member's prescription therapy; if the provider does not wish to make a change, CVS will honor their clinical opinion
- Minimal impact to member outside of possible change in prescription(s)
- Program has a 3:1 minimum Return on Investment (ROI) guarantee
  - Monthly administrative fee applies
  - CVS-estimated annual gross savings range: $1.1M – $3.0M (includes savings for members)
- Program can only be implemented at the beginning of a quarter; for a 1/1/2022 effective date, CVS must be notified by October 15, 2021

Proposed CVS Health pharmacy programs

PrudentRx specialty copay card program

- PrudentRx is an independent third-party organization that CVS Health has partnered with to offer this program
- Program leverages changes to member cost sharing for specialty drugs to optimize savings from manufacturer copay cards and reduce plan and member costs
  - Applies to all specialty medications on the CVS Caremark® specialty drug list, including highly utilized classes such as autoimmune, hepatitis C, multiple sclerosis and oncology
  - Would be applicable for Commercial (non-Medicare) plan participants only; not applicable to EGWP
- All members on a specialty medication that is exclusively filled by the CVS specialty pharmacy would be contacted by PrudentRx to enroll in this program
  - Enrollment would allow members to pay $0 out-of-pocket for all specialty medications on the State of Delaware's exclusive specialty drug list dispensed by CVS Specialty®, regardless of whether a copay card is available
  - If copay card is available, then copay assistance provided by the drug manufacturer will be used to offset the plan sponsor's share of the specialty drug cost
  - According to PrudentRx, 96% of specialty brand drug scripts have copay assistance

Proposed CVS Health pharmacy programs

PrudentRx specialty copay card program (continued)

- Program would require significant engagement from members and would increase member out-of-pocket costs for individuals who do not enroll in the program
  - Members must take action to enroll in PrudentRx once contacted by the program
  - Any member who does not take action to enroll in PrudentRx would be subject to a 30% coinsurance on specialty medications dispensed by the CVS specialty pharmacy
  - Currently, members with new specialty medications are allowed one “grace fill” of their specialty medication outside of the CVS Specialty pharmacy; this would be removed if PrudentRx is implemented, requiring members to utilize the CVS Specialty pharmacy exclusively for these Rx
- All specialty medications on the CVS exclusive specialty list would be included; a list of the most common conditions for GHIP members who use specialty drugs that would be affected by PrudentRx are noted to the right
  - Can be expanded to also include specialty drugs for other conditions noted below that are not currently included on the CVS exclusive specialty list
- Program is also dependent upon the continuation of drug manufacturer copay assistance programs
- CVS-estimated annual net savings to the GHIP: $6.9M
  - Savings increases to $7.7M with specialty drugs for expanded list of conditions
  - Highly dependent upon members’ enrollment in PrudentRx
  - May vary based on actual specialty drug utilization and spend
- No upfront administrative fees but savings is shared with PrudentRx

Most common conditions for GHIP members using specialty drugs that would be affected by PrudentRx

- Atopic Dermatitis
- Autoimmune
- Multiple Sclerosis
- Oncology

Other conditions that could be included in PrudentRx

- Hepatitis B
- HIV
- Transplants

Proposed CVS Health pharmacy programs

Next Generation Transform Diabetes Care (ngTDC)

- Potential replacement for the Livongo diabetes care management program for Medicfill plan participants, who will lose access to Livongo on 12/31/2021 when the State's contract with Express Scripts terminates
- Several key differences between the Livongo and ngTDC programs, including the glucose meters used by both programs
  - Livongo provides all enrolled participants with a "connected meter" that uses wireless technology to transmit blood glucose test results to Livongo coaches, who will contact members with abnormally high or low glucose levels
  - ngTDC uses a different connected meter for members at high risk of abnormal glucose values; all other enrolled participants will be offered another meter available from the CVS formulary
  - While lower-risk members will still be required to change their glucose meter, there are additional benefits for those members under the ngTDC
    - Formulary meter uses testing supplies that are covered at no cost under the Rx plan, and can connect to the CVS mobile app to synch readings, provide additional wellness support and send results to external providers
    - These participants are also eligible for diabetes coaching from nurses, nutrition counseling and in-person support at CVS pharmacies, which are all enhancements from the Livongo program
- While the estimated annual cost of ngTDC is about $115,000 more than Livongo, there is a guaranteed ROI of at least 2:1

Proposed CVS Health pharmacy programs

Next Generation Transform Diabetes Care (ngTDC) (continued)

- In order to have ngTDC in place by 1/1/2022 to avoid a gap in diabetes care management for Medicfill plan participants, CVS required notification of intent to implement by October 1, 2021
- SBO obtained conditional approval from the SEBC co-chairs to begin implementation of this program with CVS but will be seeking final approval from the SEBC at the October 11, 2021 meeting
  - If the SEBC does not provide final approval to implement this program at the October 11 meeting, CVS has agreed to terminate the implementation process at no cost to the State and with no impact to members
- Subcommittee members will still need to determine whether this program should be adopted for active employees and non-Medicare pensioners and assess the value of this program against other diabetes offerings available through the medical TPAs
  - Estimated annual net savings to the GHIP: $1.9M on medical and pharmacy costs for active employees and non-Medicare pensioners
- Further discussion of outcomes from the current diabetes management programs is included later in this document, following which the Subcommittee will be asked for feedback on these programs

Proposed CVS Health pharmacy programs

For discussion with Subcommittee members

- Are there any questions about either the Drug Savings Review program or the PrudentRx specialty copay card program?

- Would Subcommittee members want to receive any additional information about either program before making a decision about whether to recommend either program to the SEBC for further consideration?

SurgeryPlus mandatory carve-out for bariatric and incentive modifications

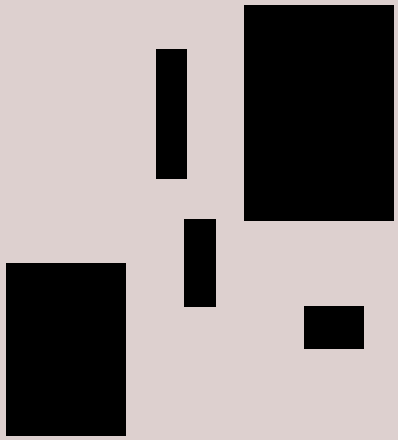
Update on opportunities for Subcommittee consideration

- Bariatric surgery carve-out:
  - Updates to the prior analysis of the cost and estimated savings associated with bariatric surgery is ongoing
  - Results of this analysis will be shared with the Subcommittee in November
  - Recent feedback from members who used the SurgeryPlus benefit will be shared as part of this discussion

- Incentive modifications:
  - Impact of mandating use of the SurgeryPlus benefit on incentives paid to members will also be presented at the November Subcommittee meeting

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

Program design considerations



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)
- Following is an update on the utilization and outcomes associated with these initiatives based on the most recent data available

	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)

Site of care steerage – copay changes

Highlights copay change

- The GHIP PPO and HMO plans include variable copays for the same type of service depending on where the service is provided ("site of care")
- Chart below reflects historical copay changes promoting site-of-care steerage; unless otherwise noted, copays apply to both plans

Copays by type of service	FY16	FY17	FY18	FY19	FY20	FY21 & FY22
Basic Imaging **(X-rays, ultrasounds)**						
In-network non-hospital affiliated freestanding facility (preferred)	$20 copay	$20 copay	$20 copay	$0 copay	$0 copay	$0 copay
Hospital-based facility	$20 copay	$20 copay	$20 copay	$35 copay	$50 copay	$50 copay
High Tech Imaging **(MRI, CT, PET scan)**						
In-network non-hospital affiliated freestanding facility (preferred)	$15 HMO / $20 PPO	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay
Hospital-based facility	$15 copay	$35 copay	$35 copay	$50 copay	$75 copay	$75 copay
Outpatient Lab						
In-network non-hospital affiliated preferred lab	$10 copay	$10 copay	$10 copay	$10 copay	$10 copay	$10 copay
Other lab	$10 copay	$10 copay	$10 copay	$20 copay	$50 copay	$50 copay
Emergency / Urgent Care						
Urgent Care	$25 HMO / $30 PPO	$15 HMO / $20 PPO[1]	$15 HMO / $20 PPO	$15 HMO / $20 PPO	$15 HMO / $20 PPO	$15 HMO / $20 PPO
Emergency Room	$150 copay	$150 copay	$150 copay	$150 copay	$200 copay	$200 copay
In-network telemedicine provider through third-party vendors	N/A	$15 HMO / $20 PPO	$15 HMO / $20 PPO	$15 HMO / $20 PPO	$0 copay[2]	$0 copay

1 Change made to match PCP office visit copay.
2 Effective March 2020, $0 copay temporarily applied to CDH Gold and First State Basic plans and virtual telemedicine services provided by a primary care or other physician.

Update on utilization of services with variable copays by site of care

- IBM Watson Health and Willis Towers Watson compared the most recent 12 months of incurred claims experience (April 2020 – March 2021) to the prior two years to evaluate changes that occurred during the initial year of the pandemic
- Key findings include:
  - Visits to emergency rooms, urgent care and primary care for similar conditions decreased by about 30% compared to the prior 12-month period (i.e., April 2019 – March 2020)
  - The proportion of visits to emergency rooms, urgent care and primary care providers as a percent of total remained relatively consistent across the three years studied
    - Example: Visits to emergency rooms represented about 6% of total visits to these three types of providers in all three years
  - Visits for high-tech radiology services on an outpatient basis decreased by 13.5% overall during the most recent 12-month period (decreases of 15.6% at hospitals and 10.6% at freestanding facilities)
  - The proportion of visits to freestanding facilities for high-tech radiology services increased by 1 percentage point each year (from 42% of total visits to 44% of total visits in the most recent 12-month period)
  - Visits for basic imaging services on an outpatient basis at hospitals decreased by 17.7% whereas visits to freestanding facilities for the same types of service decreased only 8.7% in the most recent 12-month period
    - Exception: Visits for mammograms at freestanding facilities increased by 0.1%
  - Visits for lab services on an outpatient basis increased at hospitals (3.1%) and preferred labs (5.4%)
    - There were notable increases in utilization of microbiology services at both outpatient hospital labs (96.4%) and independent labs (30.4%), which was mainly attributable to COVID-19 testing

Update on utilization of services with variable copays by site of care (continued)

- Consistent with earlier utilization analyses[1] presented to the Financial Subcommittee, there continues to be a reduction in utilization of most services with variable copays by site of care, except for outpatient labs, which have increased at both hospitals and preferred labs (driven by COVID-19 testing)
- Likely stems from the combined impact of the COVID-19 pandemic and changes in behavior driven by copay differentials
- Prior to COVID-19, GHIP experience would show reduction in utilization of non-preferred sites of care in the plan years coinciding with copay changes, but in years with no changes, utilization of non-preferred sites of care would revert back to higher levels
- With the pandemic playing a significant role in changing utilization patterns across virtually all types of care, it is necessary to establish a new baseline for GHIP experience with site of care utilization and continue to monitor to determine whether these behavior changes are sustainable
- At this time, no changes to these copay differentials are recommended for FY23

1 See materials from the January 2021 Subcommittee meeting for further details: https://dhr.delaware.gov/benefits/sebc/documents/sub-comm-2021/0121-covid-cost-reporting.pdf

Clinical management programs

- Willis Towers Watson conducted a “current state analysis” of the following clinical management programs that have been previously implemented for the GHIP:
  - Diabetes prevention (“DPP”) and management programs (Livongo, YMCA DPP, Solera)
  - SurgeryPlus surgical centers of excellence (COE)
  - Care management programs (CareVio, Aetna case/disease management, Highmark CCMU)
- Key considerations regarding this analysis:
  - Care and utilization trends based on the most recent data available coincide with peak periods of the COVID-19 pandemic, therefore observed data trends may not be indicative of true program performance
  - Program variations and associated reporting among similar programs such as the diabetes prevention programs do not support an “apples-to-apples comparison” of program outcomes
    - SBO and WTW continue to work with vendor partners to define and standardize metrics across programs where possible
  - Available data reflects varied and disparate reporting periods among similar programs, and in some cases had limited detailed reporting to support further analysis, which impacted the ability to conclusively evaluate the effectiveness of some programs (such as the diabetes prevention programs)
  - For consistent and detailed evaluation between similar programs, recommend continued efforts to define and standardize plan year metrics across programs and an analysis based on defined metrics and outcomes from the vendor partners for purposes of comparison
  - A key challenge with these programs is the administrative effort of the SBO and the GHIP vendor partners in administering, reporting, assessing and determining which vendor takes credit for health improvements/risk reduction/savings
    - Examples: coordination of care management between SurgeryPlus and other care management programs; impact of care management programs vs. Livongo in improving diabetic member health outcomes

Outcomes from current state analysis

Diabetes prevention and management programs

Livongo – Diabetes Management & Prevention Program

- Launch date: July 1, 2019
- Program Objectives
  - Provide diabetes management at no cost to Highmark and Aetna plan participants
  - Participants work with Certified Diabetes Education Specialists and Expert Coaches (available 24/7 for real-time interventions)
  - Free tools provided including meter, mobile app, test strips
  - Also provides online DPP to Highmark members (currently) and Aetna members (prior to 1/1/2021)

Observations – Pre-diabetes Prevention (DPP)

- Available reporting for DPP is limited
- Enrollment numbers are lower than expected for the eligible population

Observations – Diabetes Management

- Enrollment numbers are lower than expected (15%), but once enrolled, Activation at 95% is very high, resulting in a decrease in A1c of >1% at the 6-month milestone; and is above a target of 0.9% decrease
- The program is effective for those who engage and activate

Recommendation

- Effectiveness of Diabetes program is demonstrated; DPP performance inconclusive based on small numbers
- Explore methods and targeted strategies to increase enrollment for DPP and Diabetes programs
- Reassess referral protocols from care management to the Livongo programs to ensure program integration

Outcomes from current state analysis

Diabetes prevention and management programs (continued)

Solera DPP

- Launch date: **January 1, 2021**
- Program Objectives
  - Solera is an Aetna partner administering their National Diabetes Prevention Program (NDPP) to Aetna plan participants via online or virtual modalities (in-person & telephonic also available)
  - Participants are matched with program of best fit and complete weekly/monthly sessions to help them adopt healthier lifestyles over the course of the one-year program
  - Receive free tracking tools like FitBits and scales

Observations

- Program newly launched in 2021 and considered to be in the ramp-up period, therefore the data is too immature for evaluation beyond early engagement numbers
- Six-month reporting indicates positive program uptake at 22% for enrollment, but seeing over 50% drop-out between enrollment and completion of 2 sessions

Recommendation

- Continue partnership with Solera on program promotion and monitoring of enrollment, engagement and engagement persistency
- Track engagement at key milestones and monitor for drop-out trends; consider pulse survey of drop-outs if trend continues
- Consider incentive to encourage participation through program completion to maximize program impact and outcomes as needed

YMCA DPP

- Launch date: January 2018
- Program Objectives
  - YMCA is a partner of Aetna and Highmark administering their National Diabetes Prevention Program (NDPP) to plan participants via in-person or on-site modalities
  - Program consists of 25 one-hour sessions where trained Lifestyle coaches teach healthy lifestyle skills
  - Participants receive up to 4 free months of family membership use and future discounts at YMCAs

Observations

- Reporting is extremely limited making it difficult to evaluate program effectiveness and impact year over year
- Program reporting on outcomes results is also limited with small numbers leading to volatility and inconclusive results
- Enrollment is low compared to those eligible for the program
- Session attendance persistency at 70% for 9 sessions is good and indicates participants are committed to the program
- Per national norms, participants achieving 5% weight loss exceeds program expectations

Recommendation

- The YMCA program provides a modality for members who prefer face to face engagement and support, and therefore expands access for the population and is a reason to continue the program
- Because current program reporting is limited, negotiate specific reporting capabilities going forward to support evaluation of program impact and effectiveness

Outcomes from current state analysis

SurgeryPlus surgical centers of excellence (COE)

SurgeryPlus Surgical Centers of Excellence (COE)

- Program Launch: July 1, 2019
- SEBC voted to adopt SurgeryPlus as a third-party COE in October 2018
- In June 2019, SEBC approved a “carve-out” COE program design, communication and engagement strategy, incentive plan, and scope of covered services
- FY21 Design: GHIP participants have the option of using a medical plan COE provider or a SurgeryPlus COE provider
- Use of SurgeryPlus COEs includes concierge member services, travel benefits, and a financial incentive (e.g., $2,000 for bariatric surgery)

Observations

- Despite a decline in elective procedures following the pandemic, utilization is strong resulting in a net plan savings of approximately $2.2M in FY21
- Orthopedic Surgeries (Joint, Spine, etc.) provide the greatest opportunity for program savings and member engagement based on frequency of occurrence and potential for cost variation

Recommendation

- Consider reviewing the State’s tiered benefit for voluntary use of SurgeryPlus, or mandating use of SurgeryPlus. Mandate and/or tiering can be targeted by procedure, e.g., bariatric, joint replacement
- Consider adding Hinge Health to address chronic and acute non-surgical needs in addition to providing virtual physical therapy
  - Most people don’t complete their full physical therapy course of care, which often results in reinjury, absence from work and lower productivity. Virtual physical therapy helps optimize recovery time and can positively impact employee productivity and return to work
- SurgeryPlus customers receive preferred pricing from Hinge Health, a ROI performance guarantee, and substantial fees at risk, which support continuation and expansion of the program

Outcomes from current state analysis

Care management programs

CareVio – Care Management Program

- Launch date: July 2017
- Program Objectives:
  - The CareVio model is a combined Comprehensive CM (CCM) and Disease Management (DM) model powered by ChristianaCare and designed to provide CM and DM services to Aetna HMO plan participants
  - Maximizes partnership between plan participants and local health care providers
  - Proactive outreach based on clinical data in EHRs; member self-initiation also available
  - CareVio team addresses medical condition-related questions and creates personalized care plans
  - Program goal is to reduce negative lifestyle behaviors (including for those at high risk of diabetes), improve care coordination / clinical linkages, and improve health-related outcomes

Observations

- Program reporting has some limitations; greater consistency across metrics included in ongoing quarterly/annual reviews (including consistency in the DM programs captured by each reporting period) would support a more detailed evaluation of program effectiveness and impact
- CCM engagement consistently high across program years, especially for transition of care and outreach to high-cost claimants
- DM engagement across programs varies by reporting period, with most recent annual report for FY21 showing lower engagement and limited program impact over FY20 results
- Low engagement rates limit ability to determine savings estimates or program impact; however, the program is also supported by local PCPs affiliated with ChristianaCare, whose efforts to coordinate care and support members' self-management of their conditions are not fully captured in the CareVio engagement data but are observable in the favorable preventive screening rates which have incrementally improved for the entire HMO population

Recommendation

- Evaluate current engagement protocols and program promotion for improvement opportunities
- Standardize metrics and programs reported on an ongoing basis to increase consistency across reporting periods, and where possible, consider other reporting enhancements that capture local provider efforts to support population health to a greater degree

Outcomes from current state analysis

Care management programs (continued)

Aetna Case & Disease Management Program

- Launch date: July 2015
- Case Management Model – Regional Care Management
- Disease Management Model – Aetna Health Connections
- Program Objectives
  - The Aetna model is a combined Case Management (CM) and Disease Management (DM) program to provide care management support to Aetna CDH Gold plan participants
  - Goal is to increase self-management of diabetes and increase access to care, improving health outcomes and reducing health care costs
  - Identifies and monitors members with chronic conditions (including diabetes) and encourages gaps in care closure through change management, individualized action plans and member self-empowerment
  - Nurses provide primary support for participants by addressing health questions, monitoring conditions and providing education

Observations

- Detailed CM reporting, including outcomes, not available for this evaluation; DM reporting also limited
- Number of members identified and engaged for CM is low, therefore limited ability to impact savings
- Members identified for DM engagement are reasonable, but the number actively engaged is notably low; hence limited ability to impact results

Recommendation

- Evaluate current engagement protocols and program promotion for improvement opportunities
- Explore other Aetna care management models that may increase opportunities for engagement and integration between clinical and non-clinical interactions

Outcomes from current state analysis

Care management programs (continued)

Highmark Custom Care Management Unit (CCMU)

- Launch date: July 2017
- Program Objectives
  - The Highmark CCMU model is designed to identify potential high-cost members and intervene to mitigate cost before incurred
  - Serve as members' one-call resource for matters related to health care services and health plan coverage
  - Care Advocates are integrated with clinical care and deliver customized support and connect members with RNs/health coaches as appropriate to improve health management

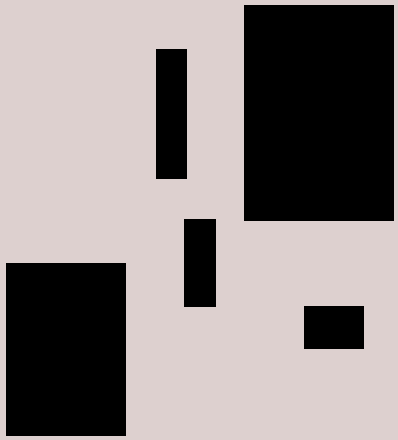
Observations

- Full FY21 plan year data not yet available; results reported reflect FY20 data
- Member engagement for Advocacy needs (non-clinical) are as expected across outreach modalities
- Interactions with a Health Coach is high at 67% with over 83% of members actively engaged with a coach
- Clinical engagement with a nurse exceeds projected targets for intervention at 10%; nearly 70% of members are outreached and over 80% are engaged resulting in 6% decrease in PMPM cost and over 3% decrease in HCC claim spend
- Highmark program results demonstrate positive impact through meeting program objectives and performance targets

Recommendation

- Evaluate current engagement protocols and program promotion for improvement opportunities
- Evaluate opportunities to further impact utilization of hospitals and the emergency room and clinical adherence to evidence-based guidelines for chronic conditions

Next steps

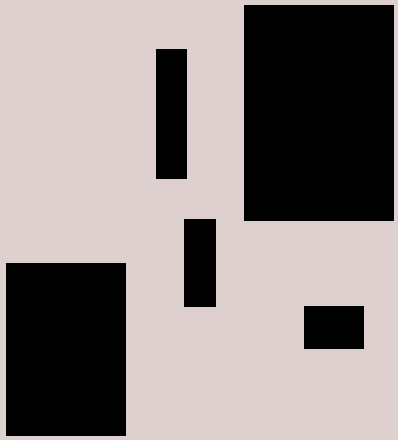


Next steps

- Discuss which savings opportunities should be explored further by Subcommittee
  - Includes CVS Health pharmacy programs and SurgeryPlus program considerations for discussion at the November Subcommittee meeting
- 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

Plan design changes for active/pre-65 and Medicfill programs



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