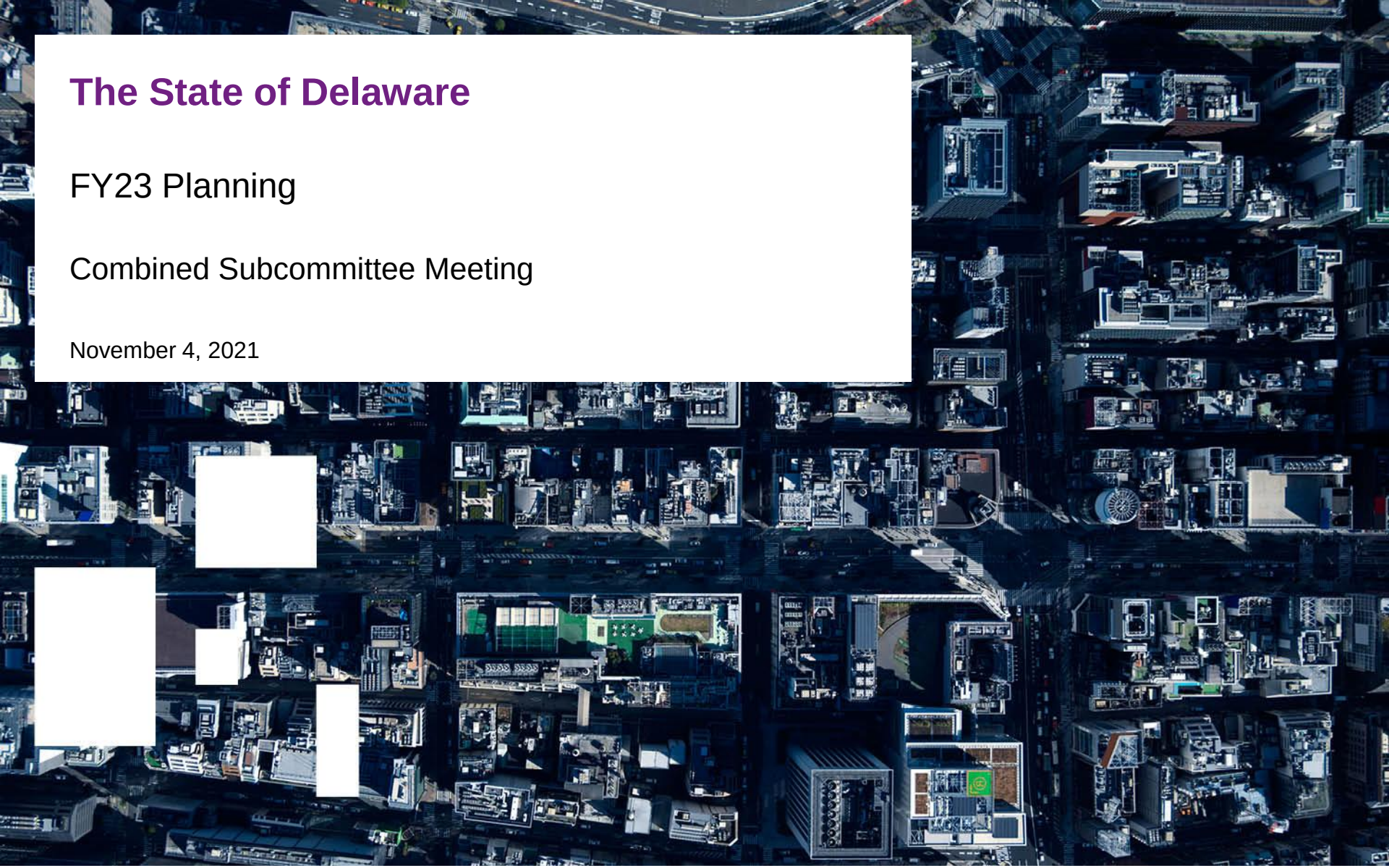

The State of Delaware

FY23 Planning

Combined Subcommittee Meeting

November 4, 2021

Willis Towers Watson

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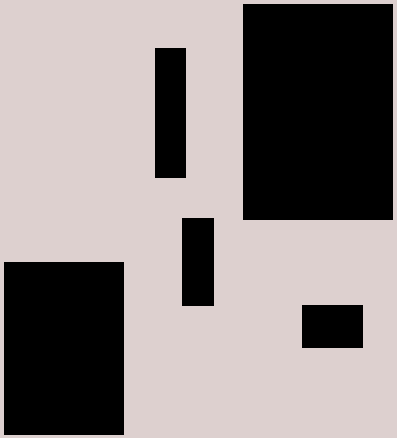
GHIP long term health care cost projections – recap



GHIP long term health care cost projections (FY22 Q1 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	130,179	131,481	132,796	134,124	135,465
GHIP Revenue							
Premium Contributions (Increasing with Enrollment)[2]	$830.8	$839.4	$840.1	$848.5	$857.1	$865.6	$874.3
Hold premium rates flat FY21 and beyond	-	-	$0.0	$0.0	$0.0	$0.0	$0.0
Other Revenues[3]	$122.8	$128.9	$191.0	$182.0	$202.0	$219.3	$237.3
Total Operating Revenues	**$953.7**	**$968.3**	**$1,031.1**	**$1,030.5**	**$1,059.1**	**$1,084.9**	**$1,111.6**
GHIP Expenses (Claims/Fees)							
Operating Expenses[4]	$927.7	$1,005.7	$1,080.5	$1,160.9	$1,239.3	$1,323.0	$1,412.4
% Change Per Member	*0.9%*	*7.4%*	*7.1%*	*6.4%*	*5.7%*	*5.7%*	*5.7%*
Adjusted Net Income (Revenue less Expense)	**$26.0**	**($37.4)**	**($49.4)**	**($130.4)**	**($180.2)**	**($238.1)**	**($300.8)**
Balance Forward	$163.8	$189.8	$152.3	$102.9	($27.5)	($207.7)	($445.8)
Ending Balance	$189.8	$152.3	$102.9	($27.5)	($207.7)	($445.8)	($746.6)
- Less Claims Liability[5]	*$57.5*	*$57.5*	*$61.0*	*$65.5*	*$69.9*	*$74.6*	*$79.6*
- Less Minimum Reserve[5]	*$24.3*	*$24.3*	*$24.3*	*$26.1*	*$27.9*	*$29.8*	*$31.8*
- Less COVID-19 Reserve[6]	-	-	-	-	-	-	-
GHIP Surplus (After Reserves/Deposits)	**$108.0**	**$70.5**	**$17.6**	**($119.1)**	**($305.5)**	**($550.2)**	**($858.0)**

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 29) and detailed projection footnotes (slide 30)

GHIP long term health care cost projections (FY22 Q1 update)

- 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 **$119.1m 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 14.0% premium increase will be needed on July 1, 2022 to solve for the projected FY23 deficit of $119.1m
  - A 14.0% premium increase yields $86m in State share revenue and $10m in employee/pensioner revenue for the active/pre-65 retiree population

FY23 monthly rates and employee/retiree contributions

Illustrative: 14.0% increase effective 7/1/2022

FY22 reflects employee contribution increases of $3.90 - $38.20 per employee per month ($46.80 - $458.40 per year) and State subsidy increases of $93.45 - $252.13 per employee per month ($1,121.40 - $3,025.56 per year) effective 7/1/2022

	Current Rates			FY 2023 with 14.0% 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	$792.71	$31.74	$760.97	$3.90	$46.80	$93.45	$1,121.40
Employee + Spouse	$1,438.68	$57.52	$1,381.16	$1,640.10	$65.57	$1,574.53	$8.05	$96.60	$193.37	$2,320.44
Employee + Child	$1,057.02	$42.26	$1,014.76	$1,205.00	$48.18	$1,156.82	$5.92	$71.04	$142.06	$1,704.72
Family	$1,798.42	$71.92	$1,726.50	$2,050.20	$81.99	$1,968.21	$10.07	$120.84	$241.71	$2,900.52
CDH Gold										
Employee	$719.68	$35.98	$683.70	$820.44	$41.02	$779.42	$5.04	$60.48	$95.72	$1,148.64
Employee + Spouse	$1,492.22	$74.58	$1,417.64	$1,701.13	$85.02	$1,616.11	$10.44	$125.28	$198.47	$2,381.64
Employee + Child	$1,099.56	$54.96	$1,044.60	$1,253.50	$62.65	$1,190.85	$7.69	$92.28	$146.25	$1,755.00
Family	$1,895.74	$94.78	$1,800.96	$2,161.14	$108.05	$2,053.09	$13.27	$159.24	$252.13	$3,025.56
Aetna HMO										
Employee	$725.94	$47.16	$678.78	$827.57	$53.76	$773.81	$6.60	$79.20	$95.03	$1,140.36
Employee + Spouse	$1,530.58	$99.50	$1,431.08	$1,744.86	$113.43	$1,631.43	$13.93	$167.16	$200.35	$2,404.20
Employee + Child	$1,110.52	$72.18	$1,038.34	$1,265.99	$82.29	$1,183.70	$10.11	$121.32	$145.36	$1,744.32
Family	$1,909.82	$124.12	$1,785.70	$2,177.19	$141.50	$2,035.69	$17.38	$208.56	$249.99	$2,999.88
Comprehensive PPO										
Employee	$793.86	$105.18	$688.68	$905.00	$119.91	$785.09	$14.73	$176.76	$96.41	$1,156.92
Employee + Spouse	$1,647.34	$218.26	$1,429.08	$1,877.97	$248.82	$1,629.15	$30.56	$366.72	$200.07	$2,400.84
Employee + Child	$1,223.46	$162.08	$1,061.38	$1,394.74	$184.77	$1,209.97	$22.69	$272.28	$148.59	$1,783.08
Family	$2,059.40	$272.86	$1,786.54	$2,347.72	$311.06	$2,036.66	$38.20	$458.40	$250.12	$3,001.44

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 slides detail 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 $119.1m

FY23 opportunities for consideration

Presented to the Subcommittees in September and October

FY23 Opportunity	Description	Est. # Members Impacted*	Est. FY23 Net Savings / Cost Avoided	Impact to required FY23 premium increase of 14.0%
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 *(PPO & HMO only)*	**$1.5M** – **$11.7M**, depending on deductible level	**0.2%** – **1.4%** reduction in required increase
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 *(Medicfill only)*	Each change ranges from **$0.8M** to **$3.9M** (max: **$10.3M**)	**0.1%** – **0.5%** (max: **1.2%**) reduction in required increase
Rx copay changes	WTW modeled impact of increasing Rx copays for Commercial (non-Medicare) and EGWP populations	Commercial: 102,100 EGWP: 28,000	Commercial: **$3.9M** EGWP: **$2.3M** Total: **$6.2M**	Commercial: **0.5%** EGWP: **0.3%** Total: **0.7%** reduction in required increase
Telemedicine copay changes	WTW modeled reinstatement of member cost sharing for telehealth visits with community providers	102,100 *(Commercial plans only)*	**$4.0M**, assuming future utilization mirrors pre-pandemic utilization	**0.5%** reduction in required increase
CVS Drug Savings Review	Program reviews Rx utilization to ensure that prescriptions follow evidence-based medical guidelines	102,100 *(Commercial plans only)*	**$1.0M** – **$2.8M,** assuming 7/1/22 effective date	**0.1%** – **0.3%** reduction in required increase
CVS PrudentRx	Program leverages manufacturer assistance with specialty medications and requires significant engagement from members	102,100 *(Commercial plans only)*	**$6.9M**, current Exclusive Specialty formulary **$7.7M**, with enhanced Excl. Specialty formulary	**0.8%** reduction in required increase, current formulary **0.9%** with enhanced formulary

*Based on enrollment as of August 2021.

FY23 opportunities for consideration (continued)

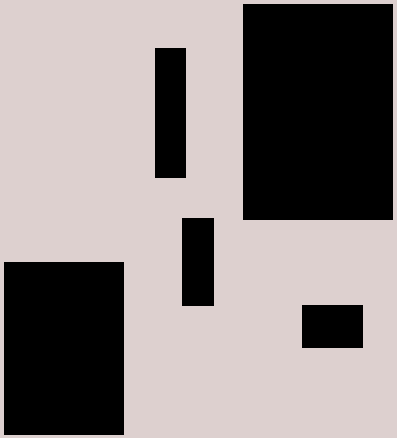
Presented to the Subcommittees in September and October

FY23 Opportunity	Description	Est. # Members Impacted*	Est. FY23 Net Savings / Cost Avoided	Impact to required FY23 premium increase of 14.0%
CVS Transform Diabetes Care	Engages members with diabetes on actionable steps to address gaps in care, evaluate medical needs and facilitate overall wellness	102,100 *(Commercial plans only)*	**$1.9M** *(impact on Medicfill plans addressed separately)*	**0.2%** reduction in required increase
SurgeryPlus bariatric carve-out	Adoption of mandatory bariatric surgery only through SurgeryPlus providers	102,100 *(Commercial plans only)*	**$1.2M** *(assumes 50% of previous 24 months utilization)*	**0.1%** reduction in required increase
SurgeryPlus incentive design changes	Adoption of changes to financial incentives provided to members who choose to use SurgeryPlus program for elective surgeries	102,100 *(Commercial plans only)*	**$0.1M** *(based on FY21 utilization, excluding bariatric surgeries)*	Negligible (<0.1%) reduction in required increase

- Maximum annual savings opportunity if all above program changes adopted for FY23 is **$24M-$45M**
  - Reduces the projected FY23 deficit from $119.1M to **$74M - $95M**
  - 9% - 11% premium increase will be needed on July 1, 2022 to solve for the remaining deficit, if all above program changes adopted

*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 at the September and October Combined Subcommittee meetings:
  - ***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
  - Estimated annual net savings range (after member cost sharing): $1.0M – $2.8M
- Program can only be implemented at the beginning of a quarter
  - For a 1/1/2022 effective date, CVS would have needed to be notified by October 15, 2021
  - Next possible effective date: 4/1/2022

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)

- 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 (based on Medicfill population only), there is a guaranteed ROI of at least 2:1

Proposed CVS Health pharmacy programs

Next Generation Transform Diabetes Care (ngTDC) (continued)

- At the October 2021 SEBC meeting, the Committee approved the implementation of ngTDC for Medicfill plan participants with a 1/1/2022 effective date to avoid a gap in diabetes care management

- 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 took place at the September Combined Subcommittee meeting

Potential program changes for the SurgeryPlus benefit

Overview of opportunities

- Mandating use of SurgeryPlus for selected types of surgery:
  - Updates to the prior analysis of the cost and estimated savings associated with bariatric surgery is included within
  - 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
    - Potential cost avoided by removing the incentive for bariatric surgery was factored into the prior estimates
    - Potential cost avoided through further changes to remaining incentives for optional use of this benefit is highly dependent upon member utilization; based on FY21 experience, the State paid members approximately $407,000 in incentives (reflects the maximum potential cost avoided if incentive changes were made for FY21)
  - Opportunities to modify incentive levels for other surgeries will be explored as well

Delaware-based bariatric COEs

Highmark and Aetna networks

- COE network is developed around facilities; quality is measured at the facility level
- Chart below lists the facilities that are designated COEs in one or both medical carrier networks

				GHIP Utilization (# patients)	
Facility Name	**Location**	**Highmark COE**	**Aetna COE**	**CY2019***	**CY2020***
Christiana Care Health Services	Wilmington, DE	—	✓	28	49
	Newark, DE	✓	—		
St. Francis Hospital	Wilmington, DE	✓	✓	7	13
BayHealth Kent General Hospital	Dover, DE	✓	—	3	5
BayHealth Milford Memorial Hospital	Milford, DE	✓	—	9	16
Nanticoke Memorial Hospital	Seaford, DE	✓	✓	1	2
American Surgery Center	Wilmington, DE	—	✓	51	65

* Source: SurgeryPlus. Based on claims paid during the calendar year specified.

Bariatric surgery

Carve-out opportunity for FY23

- One opportunity for consideration is mandating the use of the SurgeryPlus network for bariatric surgeries
- Currently, GHIP members who want to obtain these procedures have the choice to use their medical plan's provider network (i.e., through Highmark or Aetna) or obtain the surgery through the SurgeryPlus program
- There is potential for significantly different member experiences when seeking this surgery through the medical plan vs. the SurgeryPlus program in terms of:
  - Concierge support for locating a provider, scheduling an appointment, coordination of follow-up care with the member's PCP, etc.
  - Availability of participating providers
  - Health outcomes associated with the selected surgical provider
  - Claim billing and adjudication process
  - Travel benefits associated with using a provider of excellence
- The medical carriers have had challenges with administering this benefit for the State in the past, such as not applying the 25% coinsurance to members using non-COE facilities

Bariatric surgery

Carve-out opportunity for FY23

- SurgeryPlus has indicated that 12% of plan sponsors within its book of business are mandating use of the SurgeryPlus program for a limited set of procedures
  - Bariatric surgery is the most popular procedure to “carve-out” entirely to SurgeryPlus
- There are several potential benefits to GHIP participants and the plan if the State were to do this:
  - Travel requirements for plan participants would be limited
  - This procedure requires a lengthy coordination process with patients prior to surgery, and the SurgeryPlus program could support patients through this process via the concierge services offered through the program
  - Potential for members to share in the potential savings realized through steering members to SurgeryPlus providers
- The SEBC has discretion in how to offer coverage for this benefit -- bariatric benefits are not an ACA Essential Health Benefit; therefore, not required to be covered at all

Bariatric surgery

Carve-out: potential cost avoidance for FY23

- Potential cost avoidance associated with carving out bariatric surgery is highly dependent upon the number of procedures that will be conducted during FY23
- Several factors can impact number of procedures, including:
  - Continued impact of COVID-19 on deferral of elective procedures, and
  - Length of any grace period offered for members who are scheduled to have bariatric surgery with a non-SurgeryPlus provider within a given period of time following the effective date of the carve-out
- Number of procedures noted below are based the average annual bariatric surgery procedures in the prior 24 months (Calendar Years 2019-2020)
- Estimate below also assumes financial incentive for using SurgeryPlus program is discontinued, given that GHIP coverage of bariatric procedures would only be available through the SurgeryPlus program in this scenario

Estimated FY23 cost avoidance	per procedure
Gross Cost Avoidance	
Estimated medical carrier claims cost	$31,000
SurgeryPlus claim cost	$12,000
Gross Cost Avoidance from SurgeryPlus	**$19,000**
Administrative Fee and Other Expenses	
SurgeryPlus administrative fee	$5,000
Financial incentives	$0
Travel benefits	$249
Net Cost Avoidance to the State	**$13,751**

	1/4 previous 24 month average	1/2 previous 24 month average	Previous 24 month average
Total number of procedures	44	88	176
Total estimated FY23 cost avoidance to the State	**$608,000**	**$1,217,000**	**$2,433,000**

Bariatric surgery

Other considerations with carve-out opportunity

- Member-facing considerations:
  - Carve-out would require member communications and updates to plan documents and benefits summaries describing this change, along with procedures for claim denials and appeals
    - Members would need to understand any differences between current bariatric surgery clinical policy guidelines through Highmark and Aetna and SurgeryPlus
  - Description of benefits and restrictions would need to be added to plan summaries
  - Grace period may be necessary for members who are scheduled to have bariatric surgery with a non-SurgeryPlus provider within a given period of time following the effective date of the carve-out
- Medical carrier considerations
  - Coverage for specific procedure codes associated with bariatric surgery would need to be "turned off"
  - Scripting required for carrier customer service and care management teams to ensure consistent messaging about this change; also, referral protocols should be established and tracked
  - Discussion of claim denials and appeals process would be necessary
  - Online provider portals and member websites would need to be updated to reflect carve-out arrangement (i.e., non-coverage of bariatric surgery through Highmark and Aetna plans and coverage only through SurgeryPlus)

Bariatric surgery: Incentive modifications

Potential cost avoidance for FY23

- Exhibit below explores the opportunity to avoid costs through further changes to remaining incentives for optional use of the SurgeryPlus program
- Based on FY21 experience, the State paid members approximately $407,000 annually in incentives, though is highly dependent on member utilization and the continued impact of COVID-19 on deferral of elective procedures

FY2023 Estimated Incentive Cost

Incentive Tier	Incentive Per Procedure	Estimated # Procedures (based on FY21 experience, paid & pending procedures)	Total Incentive Cost
Tier A - Joint Replacement / Spine	$4,000	51	$204,000
Tier B - Cardiac / GYN	$2,000	37	$74,000
Tier C - Hernia / Gallbladder / Orthopedics / ENT	$1,000	65	$65,000
Tier D - Gastroenterology, Pain Management, Other	$500	127	$63,500
Total Incentive Cost			**$406,500**

- The exhibit below indicates the potential cost avoidance by decreasing Tiers A-C by $500 per procedure and Tier D by $250 per procedure

FY2023 Estimated Incentive Cost – Modified Incentives

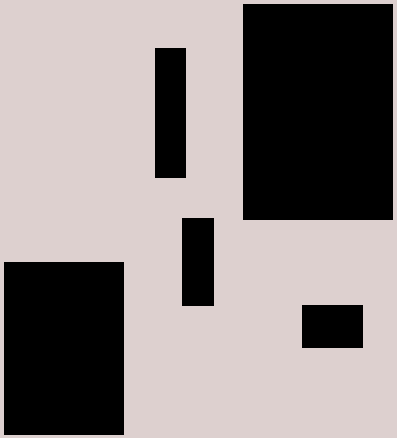
Incentive Tier	Incentive Per Procedure	Estimated # Procedures (based on FY21 experience, paid & pending procedures)	Total Incentive Cost
Tier A - Joint Replacement / Spine	$3,500	51	$178,500
Tier B - Cardiac / GYN	$1,500	37	$55,500
Tier C - Hernia / Gallbladder / Orthopedics / ENT	$500	65	$32,500
Tier D - Gastroenterology, Pain Management, Other	$250	127	$31,750
Total Incentive Cost			**$298,250**
Estimated Cost Avoided			**$108,250**

SurgeryPlus: Member feedback

- SurgeryPlus provides surveys to members to provide feedback via email following the completion of their case. The survey questions and the average score are provided below.

Member Feedback	
Survey Question	**Response**
Overall, how would you rate the quality of your experience? Very Positive, Somewhat Positive, Neutral, Somewhat Negative, Negative	>90% responded “very positive” or “somewhat positive”
How likely is it that you would recommend your Care Advocate to a friend or colleague? 0 – 10; with 0 being Not at all likely and 10 being Extremely likely	>75% responded 8+
How likely is it that you would recommend your provider to a friend or colleague? 0 – 10; with 0 being Not at all likely and 10 being Extremely likely	>90% responded 8+
How likely is it that you would recommend this benefit to a friend or colleague? 0 – 10; with 0 being Not at all likely and 10 being Extremely likely	>85% responded 8+
What was the most important factor in your choice to use the SurgeryPlus benefit? Care Advocate, Quality, Cost, Other	>50% responded “Cost”

Next steps



Next steps

- ***For further discussion with Subcommittee members today:*** Which FY23 opportunities would Subcommittee members want to consider further for recommendation to the SEBC in December 2021? (see recap on next two slides)
- Update on today's discussion will be shared with SEBC at next Monday's meeting
  - No vote will be requested in November
- December Subcommittee meeting will be used to finalize any recommendations to the SEBC, for presentation and a vote in December 2021

For discussion:

Which FY23 opportunities would Subcommittee members want to consider further for recommendation to the SEBC in December 2021?

FY23 Opportunity	Description	Est. # Members Impacted*	Est. FY23 Net Savings / Cost Avoided	Impact to required FY23 premium increase of 14.0%
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 *(PPO & HMO only)*	**$1.5M** – **$11.7M**, depending on deductible level	**0.2%** – **1.4%** reduction in required increase
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 *(Medicfill only)*	Each change ranges from **$0.8M** to **$3.9M** (max: **$10.3M**)	**0.1%** – **0.5%** (max: **1.2%**) reduction in required increase
Rx copay changes	WTW modeled impact of increasing Rx copays for Commercial (non-Medicare) and EGWP populations	Commercial: 102,100 EGWP: 28,000	Commercial: **$3.9M** EGWP: **$2.3M** Total: **$6.2M**	Commercial: **0.5%** EGWP: **0.3%** Total: **0.7%** reduction in required increase
Telemedicine copay changes	WTW modeled reinstatement of member cost sharing for telehealth visits with community providers	102,100 *(Commercial plans only)*	**$4.0M**, assuming future utilization mirrors pre-pandemic utilization	**0.5%** reduction in required increase
CVS Drug Savings Review	Program reviews Rx utilization to ensure that prescriptions follow evidence-based medical guidelines	102,100 *(Commercial plans only)*	**$1.0M** – **$2.8M,** assuming 7/1/22 effective date	**0.1%** – **0.3%** reduction in required increase
CVS PrudentRx	Program leverages manufacturer assistance with specialty medications and requires significant engagement from members	102,100 *(Commercial plans only)*	**$6.9M**, current Exclusive Specialty formulary **$7.7M**, with enhanced Excl. Specialty formulary	**0.8%** reduction in required increase, current formulary **0.9%** with enhanced formulary

*Based on enrollment as of August 2021.

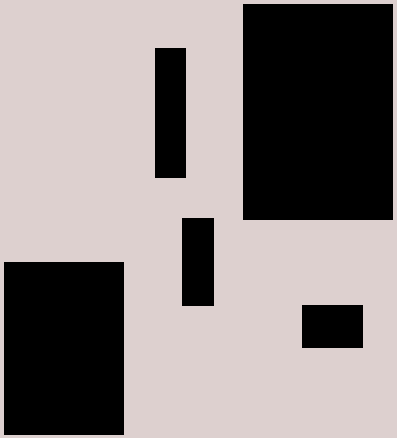
For discussion:

Which FY23 opportunities would Subcommittee members want to consider further for recommendation to the SEBC in December 2021? (continued)

FY23 Opportunity	Description	Est. # Members Impacted*	Est. FY23 Net Savings / Cost Avoided	Impact to required FY23 premium increase of 14.0%
CVS Transform Diabetes Care	Engages members with diabetes on actionable steps to address gaps in care, evaluate medical needs and facilitate overall wellness	102,100 *(Commercial plans only)*	**$1.9M** *(impact on Medicfill plans addressed separately)*	**0.2%** reduction in required increase
SurgeryPlus bariatric carve-out	Adoption of mandatory bariatric surgery only through SurgeryPlus providers	102,100 *(Commercial plans only)*	**$1.2M** *(assumes 50% of previous 24 months utilization)*	**0.1%** reduction in required increase
SurgeryPlus incentive design changes	Adoption of changes to financial incentives provided to members who choose to use SurgeryPlus program for elective surgeries	102,100 *(Commercial plans only)*	**$0.1M** *(based on FY21 utilization, excluding bariatric surgeries)*	Negligible (<0.1%) reduction in required increase

*Based on enrollment as of August 2021.

Appendix



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 FY22 Q1 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.