The State of Delaware

GHIP Long-term Projections & FY23 Opportunities

December 9, 2021

Willis Towers Watson

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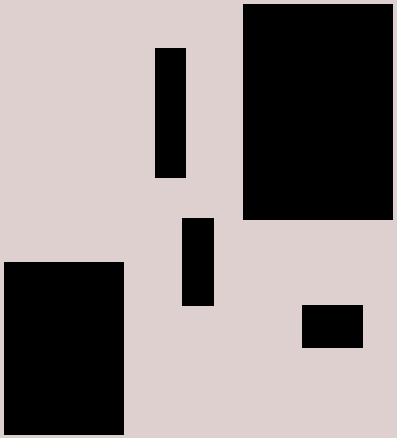
Today's discussion

- GHIP long term health care cost projections
- GHIP long term health care cost projections (with additional COVID-19 expense reimbursement)
- FY23 planning opportunities
- Next steps

GHIP long term health care cost projections



GHIP long term health care cost projections (updated through Oct '21)

Revised projections

- Projected FY23 budget of $963.7m is down 1.6% ($15.2M) from November SEBC update of $978.9m; reflects experience through October 2021; assumes no additional COVID-19 expense reimbursement
- Claims Experience reduction due to inclusion of savings from the following initiatives expected to be voted on by the SEBC at the December meeting and implemented in FY23:
  - PRC award recommendations from medical TPA RFP[1]
  - Reinstatement of member cost sharing for telehealth visits with community providers
  - Implementation of CVS Drug Savings Review program
  - Implementation of CVS Transform Diabetes Care program
- Other Revenues reduction due to increase in monthly per retiree prospective reinsurance payment (from $48.52 in 2021 to $65.68 in 2022); increase impacts timing of federal reinsurance revenues, with no change to amount expected to be earned in 2022
- Final projections and FY23 rate impact to be presented to SEBC in February

Component ($M)	Description	FY23
November SEBC Update (*includes* impact of COVID-19)		**$978.9**
Claims Experience	Claims experience updated based on experience through October 2021	($8.8)
Enrollment	Expected claims and premium increase due to growth in covered population	$0.0
Updated Other Revenues	Includes revised EGWP payments, pharmacy rebates and participating group fees	($6.4)
December SEBC Update (*includes* impact of COVID-19)		**$963.7**

[1]Reflects savings attributable to PRC award recommendations only; cost/savings from outstanding decisions to be made pursuant to PRC award recommendation (e.g., care management programs, Medicare plan options and other value-added services) will be reflected in future projections if/when approved by SEBC

GHIP long term health care cost projections (updated through Oct '21)

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	$188.4	$216.0	$234.3	$253.3
Total Operating Revenues	**$953.7**	**$968.3**	**$1,031.1**	**$1,036.9**	**$1,073.1**	**$1,099.9**	**$1,127.6**
GHIP Expenses (Claims/Fees)							
Operating Expenses[4]	$927.7	$1,005.7	$1,080.5	$1,152.1	$1,229.1	$1,241.4	$1,253.9
% Change Per Member	*0.9%*	*7.4%*	*7.1%*	*5.6%*	*5.6%*	*0.0%*	*0.0%*
Adjusted Net Income (Revenue less Expense)	**$26.0**	**($37.4)**	**($49.4)**	**($115.2)**	**($156.0)**	**($141.5)**	**($126.3)**
Balance Forward	$163.8	$189.8	$152.3	$102.9	($12.3)	($168.3)	($309.9)
Ending Balance	$189.8	$152.3	$102.9	($12.3)	($168.3)	($309.9)	($436.1)
- Less Claims Liability[5]	*$57.5*	*$57.5*	*$61.0*	*$65.0*	*$69.3*	*$70.0*	*$70.7*
- Less Minimum Reserve[5]	*$24.3*	*$24.3*	*$24.3*	*$25.9*	*$27.6*	*$27.9*	*$28.2*
- Less COVID-19 Reserve[6]	-	-	-	-	-	-	-
GHIP Surplus (After Reserves/Deposits)	**$108.0**	**$70.5**	**$17.6**	**($103.2)**	**($265.2)**	**($407.8)**	**($535.0)**

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 18) and detailed projection footnotes (slide 19)

GHIP long term health care cost projections (updated through Oct '21)

- WTW's latest FY23 budget projection reflects a **$103.2m 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 12.2% premium increase will be needed on July 1, 2022 to solve for the projected FY23 deficit of $103.2m
  - A 12.2% premium increase yields approximately $75m in State share revenue and $9m in employee/pensioner revenue for the active/pre-65 retiree population
  - Targeting $0 deficit by the end of FY25 requires an annual premium increase of 7.5% in FY23, FY24 and FY25 (in this scenario, Fund would end FY23 and FY24 in deficit position after reserves)
    - A 7.5% premium increase yields approximately $46m in State share revenue and $6m in employee/pensioner revenue for the active/pre-65 retiree population

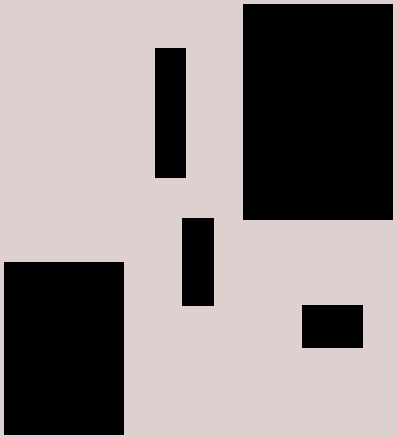
FY23 monthly rates and employee/retiree contributions

Illustrative: 12.2% increase effective 7/1/2022

FY22 reflects employee contribution increases of $3.40 - $33.29 per employee per month ($40.80 - $399.48 per year) and State subsidy increases of $81.43 - $219.72 per employee per month ($977.16 - $2,636.64 per year) effective 7/1/2022

	Current Rates			FY 2023 with 12.2% 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	$780.19	$31.24	$748.95	$3.40	$40.80	$81.43	$977.16
Employee + Spouse	$1,438.68	$57.52	$1,381.16	$1,614.20	$64.54	$1,549.66	$7.02	$84.24	$168.50	$2,022.00
Employee + Child	$1,057.02	$42.26	$1,014.76	$1,185.98	$47.42	$1,138.56	$5.16	$61.92	$123.80	$1,485.60
Family	$1,798.42	$71.92	$1,726.50	$2,017.83	$80.69	$1,937.14	$8.77	$105.24	$210.64	$2,527.68
CDH Gold										
Employee	$719.68	$35.98	$683.70	$807.48	$40.37	$767.11	$4.39	$52.68	$83.41	$1,000.92
Employee + Spouse	$1,492.22	$74.58	$1,417.64	$1,674.27	$83.68	$1,590.59	$9.10	$109.20	$172.95	$2,075.40
Employee + Child	$1,099.56	$54.96	$1,044.60	$1,233.71	$61.67	$1,172.04	$6.71	$80.52	$127.44	$1,529.28
Family	$1,895.74	$94.78	$1,800.96	$2,127.02	$106.34	$2,020.68	$11.56	$138.72	$219.72	$2,636.64
Aetna HMO										
Employee	$725.94	$47.16	$678.78	$814.50	$52.91	$761.59	$5.75	$69.00	$82.81	$993.72
Employee + Spouse	$1,530.58	$99.50	$1,431.08	$1,717.31	$111.64	$1,605.67	$12.14	$145.68	$174.59	$2,095.08
Employee + Child	$1,110.52	$72.18	$1,038.34	$1,246.00	$80.99	$1,165.01	$8.81	$105.72	$126.67	$1,520.04
Family	$1,909.82	$124.12	$1,785.70	$2,142.82	$139.26	$2,003.56	$15.14	$181.68	$217.86	$2,614.32
Comprehensive PPO										
Employee	$793.86	$105.18	$688.68	$890.71	$118.01	$772.70	$12.83	$153.96	$84.02	$1,008.24
Employee + Spouse	$1,647.34	$218.26	$1,429.08	$1,848.32	$244.89	$1,603.43	$26.63	$319.56	$174.35	$2,092.20
Employee + Child	$1,223.46	$162.08	$1,061.38	$1,372.72	$181.85	$1,190.87	$19.77	$237.24	$129.49	$1,553.88
Family	$2,059.40	$272.86	$1,786.54	$2,310.65	$306.15	$2,004.50	$33.29	$399.48	$217.96	$2,615.52

GHIP long term health care cost projections (with additional COVID-19 expense reimbursement)



GHIP long term health care cost projections (updated through Oct '21)

With additional COVID-19 expense reimbursement projected in FY23

- Current long-term projections reflect $23.3m COVID-19 expense reimbursement payment received June 2021
- Based on IBM Watson Health reporting of COVID-19 expenses through October 2021, an additional $15.8m in potential COVID-19 expense reimbursements ***could*** hit the Fund in FY22 or FY23
- The long-term projections on the following pages reflect an additional $15.8m in COVID-19 relief, projected to be received in FY23
  - Reduces projected FY23 deficit to $86.3m
  - If no other program changes, a 10.2% premium increase will be needed on July 1, 2022 to solve for the projected FY23 deficit of $86.3m
    - A 10.2% premium increase yields approximately $63m in State share revenue and $8m in employee/pensioner revenue for the active/pre-65 retiree population
  - Targeting $0 deficit by the end of FY25 requires an annual premium increase of 7.2% in FY23, FY24 and FY25 (in this scenario, Fund would end FY23 and FY24 in deficit position after reserves)
    - A 7.2% premium increase yields approximately $44m in State share revenue and $5m in employee/pensioner revenue for the active/pre-65 retiree population

GHIP long term health care cost projections (updated through Oct '21)

No premium increases FY22-FY26 (***includes*** $20m supplemental bill funding in FY22 ***and*** additional $15.8m in COVID-19 expense reimbursement in FY23[1])

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	$188.4	$216.0	$234.3	$253.3
Total Operating Revenues	**$953.7**	**$968.3**	**$1,031.1**	**$1,036.9**	**$1,073.1**	**$1,099.9**	**$1,127.6**
GHIP Expenses (Claims/Fees)							
Operating Expenses[4]	$927.7	$1,005.7	$1,080.5	$1,136.3	$1,229.1	$1,241.4	$1,253.9
% Change Per Member	*0.9%*	*7.4%*	*7.1%*	*4.1%*	*7.1%*	*0.0%*	*0.0%*
Adjusted Net Income (Revenue less Expense)	**$26.0**	**($37.4)**	**($49.4)**	**($99.4)**	**($156.0)**	**($141.5)**	**($126.3)**
Balance Forward	$163.8	$189.8	$152.3	$102.9	$3.5	($152.6)	($294.1)
Ending Balance	$189.8	$152.3	$102.9	$3.5	($152.6)	($294.1)	($420.4)
- Less Claims Liability[5]	*$57.5*	*$57.5*	*$61.0*	*$64.2*	*$69.4*	*$70.1*	*$70.8*
- Less Minimum Reserve[5]	*$24.3*	*$24.3*	*$24.3*	*$25.6*	*$27.7*	*$28.0*	*$28.3*
- Less COVID-19 Reserve[6]	-	-	-	-	-	-	-
GHIP Surplus (After Reserves/Deposits)	**$108.0**	**$70.5**	**$17.6**	**($86.3)**	**($249.7)**	**($392.2)**	**($519.5)**

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 18) and detailed projection footnotes (slide 19)

[1]Based on IBM Watson Health reporting of actual COVID-19 expenses through October 2021; $15.8m payment reflected as offset to FY23 operating expenses

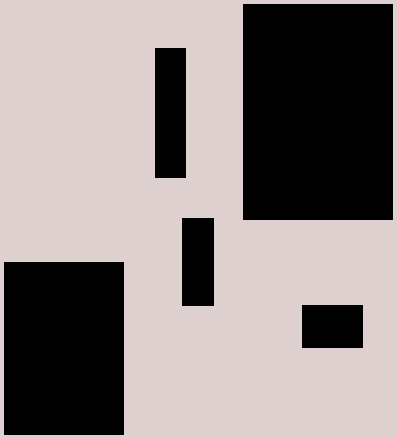
FY23 monthly rates and employee/retiree contributions

Illustrative: 10.2% increase effective 7/1/2022

FY22 reflects employee contribution increases of $2.84 - $27.83 per employee per month ($34.08 - $333.96 per year) and State subsidy increases of $68.09 - $183.70 per employee per month ($817.08 - $2,204.40 per year) effective 7/1/2022

	Current Rates			FY 2023 with 10.2% 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	$766.29	$30.68	$735.61	$2.84	$34.08	$68.09	$817.08
Employee + Spouse	$1,438.68	$57.52	$1,381.16	$1,585.43	$63.39	$1,522.04	$5.87	$70.44	$140.88	$1,690.56
Employee + Child	$1,057.02	$42.26	$1,014.76	$1,164.84	$46.57	$1,118.27	$4.31	$51.72	$103.51	$1,242.12
Family	$1,798.42	$71.92	$1,726.50	$1,981.86	$79.26	$1,902.60	$7.34	$88.08	$176.10	$2,113.20
CDH Gold										
Employee	$719.68	$35.98	$683.70	$793.09	$39.65	$753.44	$3.67	$44.04	$69.74	$836.88
Employee + Spouse	$1,492.22	$74.58	$1,417.64	$1,644.43	$82.19	$1,562.24	$7.61	$91.32	$144.60	$1,735.20
Employee + Child	$1,099.56	$54.96	$1,044.60	$1,211.72	$60.57	$1,151.15	$5.61	$67.32	$106.55	$1,278.60
Family	$1,895.74	$94.78	$1,800.96	$2,089.11	$104.45	$1,984.66	$9.67	$116.04	$183.70	$2,204.40
Aetna HMO										
Employee	$725.94	$47.16	$678.78	$799.99	$51.97	$748.02	$4.81	$57.72	$69.24	$830.88
Employee + Spouse	$1,530.58	$99.50	$1,431.08	$1,686.70	$109.65	$1,577.05	$10.15	$121.80	$145.97	$1,751.64
Employee + Child	$1,110.52	$72.18	$1,038.34	$1,223.79	$79.54	$1,144.25	$7.36	$88.32	$105.91	$1,270.92
Family	$1,909.82	$124.12	$1,785.70	$2,104.62	$136.78	$1,967.84	$12.66	$151.92	$182.14	$2,185.68
Comprehensive PPO										
Employee	$793.86	$105.18	$688.68	$874.83	$115.91	$758.92	$10.73	$128.76	$70.24	$842.88
Employee + Spouse	$1,647.34	$218.26	$1,429.08	$1,815.37	$240.52	$1,574.85	$22.26	$267.12	$145.77	$1,749.24
Employee + Child	$1,223.46	$162.08	$1,061.38	$1,348.25	$178.61	$1,169.64	$16.53	$198.36	$108.26	$1,299.12
Family	$2,059.40	$272.86	$1,786.54	$2,269.46	$300.69	$1,968.77	$27.83	$333.96	$182.23	$2,186.76

FY23 planning opportunities



FY23 opportunities for consideration

Recap of recent discussions with the Subcommittees

- 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 $103.2m

- ***For further discussion with Subcommittee members today:*** Which FY23 opportunities do Subcommittee members want to recommend to the SEBC for a vote at next Monday's meeting?

FY23 opportunities for consideration

Previously presented to the Subcommittees

Based on prior feedback from Subcommittee members

FY23 Opportunity	Description	Est. # Members Impacted*	Est. FY23 Net Savings / Cost Avoided	Impact to required FY23 premium increase of 12.2%	Likelihood of advancement to the SEBC for vote on 12/13
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	Unlikely
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	Unlikely
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	Unlikely
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	Likely**
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	Likely**
CVS PrudentRx *(see slides 27-28 for November meeting follow-ups)*	Program leverages manufacturer assistance with specialty medications and requires significant engagement from members	Approximately 1,000 members utilizing specialty drugs (excluding HIV and fertility)	**$6.9M** – **$7.7M**, excluding specialty medications for HIV and fertility	**0.8%** – **0.9%** reduction in required increase	Unlikely

*Based on enrollment as of August 2021.

**Savings included in long-term projections on slides 5 and 10. CVS provided reference from another state customer that can speak to experience with and savings from the program.

FY23 opportunities for consideration

Previously presented to the Subcommittees

Based on prior feedback from Subcommittee members

FY23 Opportunity	Description	Est. # Members Impacted*	Est. FY23 Net Savings / Cost Avoided	Impact to required FY23 premium increase of 12.2%	Likelihood of advancement to the SEBC for vote on 12/13
CVS Transform Diabetes Care	Engages members with diabetes on actionable steps to address gaps in care, evaluate medical needs and facilitate overall wellness	Approximately 6,400 Commercial plan members who are currently participating in the Livongo diabetes management program	**$1.9M** *(impact on Medicfill plans addressed separately)*	**0.2%** reduction in required increase	Likely**
SurgeryPlus bariatric carve-out *(see slide 32 for November meeting follow-ups)*	Adoption of mandatory bariatric surgery only through SurgeryPlus providers	Varies according to utilization, but likely 100-200 members annually	**$1.2M** *(assumes 50% of previous 24 months utilization)*	**0.1%** reduction in required increase	Somewhat likely
SurgeryPlus incentive design changes	Adoption of changes to financial incentives provided to members who choose to use SurgeryPlus program for elective surgeries	Varies according to utilization, but likely up to 500 members annually	**$0.1M** *(based on FY21 utilization, excluding bariatric surgeries)*	Negligible (**<0.1%**) reduction in required increase	Unlikely

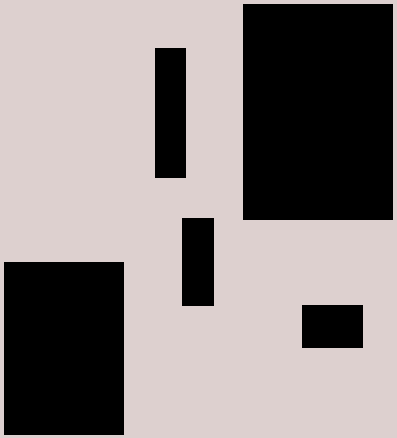
- Maximum annual savings opportunity if all above program changes adopted for FY23 is **$24M-$45M**
  - Reduces the projected FY23 deficit from $103.2M to **$58M - $79M**
  - 7% - 9% premium increase will be needed on July 1, 2022 to solve for the remaining deficit, if all above program changes adopted

*Based on enrollment as of August 2021.
**Savings included in long-term projections on slides 5 and 10.

Next steps

- Recommendations from today's discussion will be shared with SEBC at next Monday's meeting
  - A vote will be requested on any FY23 opportunities recommended by the Subcommittees
- FY23 opportunities that require further study by the Subcommittees will continue to be evaluated during upcoming meetings in January and February 2022
- Any additional recommendations from the Subcommittees will be presented to the SEBC for a vote during either the February 2022 or March 2022 meeting

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 October 2021 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.

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 – telemedicine copay changes

- 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

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
  - See sidebar for CVS clarification of hepatitis B and transplant therapeutic classes
- Program is also dependent upon the continuation of drug manufacturer copay assistance programs
- CVS-estimated annual net savings to the GHIP: $6.9M - $7.7M
  - 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

CVS has clarified that the State currently utilizes the CVS Enhanced Exclusive Specialty list with an open network for HIV drugs, which can be filled at any pharmacy. **Specialty drugs for hepatitis B and transplants are included on the Exclusive Specialty and PrudentRx lists.** If the State implements PrudentRx, the program will include all covered specialty drugs except those for HIV and fertility.

Proposed CVS Health pharmacy programs

PrudentRx specialty copay card program (continued)

- As a follow-up from the November 2021 meeting of the combined Subcommittees, responses to the following questions raised during that meeting are provided below

Question	Answer
For specialty medications not included on the CVS Caremark specialty drug list, would the 30% coinsurance still apply, and would PrudentRx waive the requirement for members to use mail order for first fill at retail pharmacies?	The 30% coinsurance would only apply to the therapeutic classes covered by PrudentRx; per CVS clarification on the prior slide, this includes all covered specialty drug classes except for HIV and fertility. The State's current copay-based plan design, not the 30% coinsurance, would apply to HIV medications, which would also continue to be able to be filled at any pharmacy via CVS's Open Network. Fertility medications would continue to be subject to a 25% coinsurance with a $15,000 with the option to first fill a new script at a retail pharmacy.
Does CVS have any public sector customers that have adopted PrudentRx?	Over 30 public sector customers of CVS have currently adopted PrudentRx.
Can CVS provide references for other plan sponsors that have implemented PrudentRx?	CVS has provided references, and results of outreach/reference checks will be reported to the Subcommittees in January 2022.
Why can't CVS administer this program without PrudentRx?	The intention of CVS choosing PrudentRx to collaborate with exclusively on this program was to provide a high-touch, seamless experience for the member. According to CVS, PrudentRx has deep expertise in member engagement and customer service specific to coaching members through the process for enrolling in copay assistance programs offered by drug manufacturers and is integrated with CVS Specialty pharmacy operations to help ensure a seamless member experience. PrudentRx is not a PBM; it neither adjudicates claims nor dispenses drugs. The responsibility for those operations would remain with CVS Caremark and CVS Specialty. Through a high-touch, proactive multi-channel member engagement process, PrudentRx optimizes program enrollment and helps members obtain non-needs based manufacturer copay card assistance where applicable. Members can choose to opt out of the program by not taking action when contacted by PrudentRx. With a <1% member opt-out rate, CVS believes this model exceeds expectations. CVS has also reported that the PrudentRx has been adopted by 592 customers totaling 3.4M eligible lives, and on a YTD basis through September 2021, aggregate savings for customers is $204M and for plan participants is $28M.

Proposed CVS Health pharmacy programs

PrudentRx specialty copay card program (continued)

- As a follow-up from the November 2021 meeting of the combined Subcommittees, responses to the following questions raised during that meeting are provided below

Question	Answer
How does PrudentRx impact the average time to fill a specialty drug and deliver it to a member through the CVS Specialty Pharmacy?	PrudentRx does not impact the specialty drug delivery process. Specialty drugs may take longer for a member to receive due to the Specialty Guideline Management process, which is similar to a prior authorization review process. In addition, most specialty medications are not stocked by retail pharmacies and require the member to return after the product is ordered. Most CVS customers do not have a grace fill for specialty medications because most of these drugs are not available at retail and need special counseling in order to ensure proper usage. Even with PrudentRx in place, members may still use the CVS Specialty Connect process to drop off and pick up their specialty medications at their local CVS retail should they choose to do so.
How are urgent fill/refill requests for specialty drug scripts handled, such as a script for an oncology patient with a terminal diagnosis?	Specialty drug prescriptions would be handled by CVS the same as they are today. Overrides are provided regularly for special circumstances regardless of whether PrudentRx is in place or not.
Is there any opportunity to negotiate the percent that PrudentRx would keep as it is paid by monies set aside by drug manufacturers for copay assistance?	CVS confirmed that it is willing to make a one-time exception for the State of Delaware based upon its new relationship with the State and provide a reduction in the shared savings fee.
What can CVS offer as to how copay assistance programs are funded? Do drug manufacturers repurpose funds intended to support patients for use in funding copay assistance programs?	The funding for drug manufacturer coupon cards are part of their marketing budgets similar to advertising. They are not repurposing funds intended to support patients. As to foundational assistance, those funds are specifically for patients who are indigent, uninsured or under-insured. CVS's program with PrudentRx has been designed to neither hinder nor impact the integrity of programs used for these types of patients.
Can further clarification and details on the member experience related to enrollment and utilization of PrudentRx be provided?	This information has been provided and will be reviewed with the Subcommittees at a future meeting in early 2022.

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

Bariatric surgery

Carve-out opportunity: 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

Long term health outcomes associated with bariatric surgery

- As a follow-up from the November 2021 meeting of the combined Subcommittees, additional information was requested on the potential downstream impact of bariatric surgery on outcomes and cost
- The health issues and associated costs for individuals with obesity can be significant
  - Obesity leads to increased risk of heart disease, stroke, diabetes, and certain types of cancer
  - The per member per year medical costs for people who are obese is over $1400 higher than those of normal weight[1]
- Bariatric surgery has been shown to be safe and effective in patients where diet, exercise, and medications have not helped the morbidly obese achieve and sustain normal or near-normal weight
- Over the past few years, medical experts have begun to recommend against LapBand procedures given their high risk of complication and low efficacy
- Bariatric surgery has been demonstrated to reduce diabetes, hypertension, and hyperlipidemia
  - Bariatric surgery has also been shown to decrease diabetes rate by as much as 75% for the morbidly obese with new-onset diabetes[2]
  - Hyperlipidemia improved in 70% of patients and hypertension was resolved in 61.7% of patients after bariatric surgery[3]
- Bariatric surgery has been shown to increase life expectancy[4]

1 Finkelstein EA et al “Annual Medical Spending Attributable To Obesity: Payer-And Service-Specific Estimates” Health Affairs 28, no. 5 (2009): w822–w831 published online 27 July 2009; https://www.healthaffairs.org/doi/10.1377/hlthaff.28.5.w822 (accessed 12/7/2021).

2 Kashyap SR et al “Bariatric surgery for type 2 diabetes: Weighing the impact for obese patients” Cleve Clin J Med. 2010 Jul; 77(7): 468–476. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3102524/ (accessed 12/7/2021).

3 Buchwald H et al “Bariatric surgery: a systematic review and meta-analysis” JAMA. 2004 Oct 13;292(14):1724-37. https://jamanetwork.com/journals/jama/article-abstract/199587 (accessed 12/7/2021).

4 Carlsson L et al “Life Expectancy after Bariatric Surgery — the Swedish Obese Subjects Study” N Engl J Med. 2020 Oct 15; 384:1, 88-89. https://www.nejm.org/doi/full/10.1056/NEJMoa2002449 (accessed 12/7/2021).

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**