FY24 Planning

The State of Delaware – Combined Subcommittee Meeting

October 20, 2022

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Contents

- Actuarial Analysis of Pre-65 Rates and Costs
- Plan design alternatives
  - Plan and contribution benchmarking
  - Premium equivalents and employee contributions
  - PrudentRx
- Site of care steerage
- SurgeryPlus carve-out opportunities beyond bariatric surgery
- Other emerging treatments

Actuarial Analysis of Pre-65 Rates and Costs

Active and Pre-65 Retiree Rates

- GHIP active and pre-65 retirees are currently rated together as one risk pool, with consistent budget rates and contributions for each population
- Based on WTW's FY21 Q4 financial report, pre-65 retirees cost significantly more than active employees on a per member per year (PMPY) basis
  - FY21 PMPY Active Cost = $6,924
  - FY21 PMPY Pre-65 Retiree Cost = $10,752
- Rating actives and pre-65 retirees on their own experience ***does not*** require legislative change
- Rating each population individually would create separate budget rates that match experience for each population, while maintaining existing cost share by plan set by House Bill 81
- Based on current rating methodology, a 14.3% rate increase is needed 7/1/2023 for all statuses, plans and coverage tiers, to solve for the projected FY24 deficit of $113.5m (based on long-term projections presented to SEBC 8/22)
- Rating active and pre-65 retirees on their own experience would create the following rate actions for each population (effective 7/1/2023) to solve for the FY24 deficit (see following slides for impact by population):
  - Actives: +10.5%
  - Pre-65 Retirees: +40.4%
- Reduction in active contributions relative to current rating methodology (+14.3%) could be used to offset increases in cost attributable to potential plan design changes (e.g., deductibles)
- While pre-65 retirees would see a significant increase in their contributions if rated separately from actives, there are options available to the State to mitigate this impact for retirees, while creating savings opportunities for the State, including the pre-65 retiree marketplace

FY24 Illustrative Rates – Status Quo Rating Methodology (+14.3%)

FY24 reflects employee contribution increases of $4.32 - $42.34 per employee per month ($51.84 - $508.08 per year) and State subsidy increases of $103.56 - $279.44 per employee per month ($1,242.72 - $3,353.28 per year) effective 7/1/2023

	FY23 Rates			FY 2024 with 14.3% Increase (effective 7/1/2023)			$ 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	$755.64	$30.22	$725.42	$863.52	$34.54	$828.98	$4.32	$51.84	$103.56	$1,242.72
Employee + Spouse	$1,563.42	$62.54	$1,500.88	$1,786.64	$71.46	$1,715.18	$8.92	$107.04	$214.30	$2,571.60
Employee + Child	$1,148.66	$45.94	$1,102.72	$1,312.66	$52.50	$1,260.16	$6.56	$78.72	$157.44	$1,889.28
Family	$1,954.34	$78.18	$1,876.16	$2,233.38	$89.34	$2,144.04	$11.16	$133.92	$267.88	$3,214.56
CDH Gold										
Employee	$782.08	$39.10	$742.98	$893.74	$44.68	$849.06	$5.58	$66.96	$106.08	$1,272.96
Employee + Spouse	$1,621.60	$81.08	$1,540.52	$1,853.12	$92.66	$1,760.46	$11.58	$138.96	$219.94	$2,639.28
Employee + Child	$1,194.90	$59.74	$1,135.16	$1,365.50	$68.26	$1,297.24	$8.52	$102.24	$162.08	$1,944.96
Family	$2,060.10	$103.00	$1,957.10	$2,354.24	$117.70	$2,236.54	$14.70	$176.40	$279.44	$3,353.28
Aetna HMO										
Employee	$788.88	$51.28	$737.60	$901.52	$58.60	$842.92	$7.32	$87.84	$105.32	$1,263.84
Employee + Spouse	$1,663.28	$108.12	$1,555.16	$1,900.76	$123.56	$1,777.20	$15.44	$185.28	$222.04	$2,664.48
Employee + Child	$1,206.80	$78.44	$1,128.36	$1,379.10	$89.64	$1,289.46	$11.20	$134.40	$161.10	$1,933.20
Family	$2,075.40	$134.90	$1,940.50	$2,371.72	$154.16	$2,217.56	$19.26	$231.12	$277.06	$3,324.72
Comprehensive PPO										
Employee	$862.68	$114.30	$748.38	$985.86	$130.62	$855.24	$16.32	$195.84	$106.86	$1,282.32
Employee + Spouse	$1,790.16	$237.20	$1,552.96	$2,045.76	$271.06	$1,774.70	$33.86	$406.32	$221.74	$2,660.88
Employee + Child	$1,329.54	$176.16	$1,153.38	$1,519.36	$201.32	$1,318.04	$25.16	$301.92	$164.66	$1,975.92
Family	$2,237.94	$296.52	$1,941.42	$2,557.46	$338.86	$2,218.60	$42.34	$508.08	$277.18	$3,326.16

FY24 Illustrative Rates – Actives Rated Separately (+10.5%)

Rating active and pre-65 retiree populations separately reduces active contributions for all plans and coverage tiers; relative to the status quo rate increase of 14.3% (based on combined rating methodology), active employees would see annual reduction in contributions ranging from $13.68 to $133.44)

	FY 2024 with 14.3% Increase (no change to rating methodology)			FY 2024 (10.5% increase for actives only)			$ 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	$863.52	$34.54	$828.98	$835.20	$33.40	$801.80	($1.14)	($13.68)	($27.18)	($326.16)
Employee + Spouse	$1,786.64	$71.46	$1,715.18	$1,728.02	$69.12	$1,658.90	($2.34)	($28.08)	($56.28)	($675.36)
Employee + Child	$1,312.66	$52.50	$1,260.16	$1,269.58	$50.78	$1,218.80	($1.72)	($20.64)	($41.36)	($496.32)
Family	$2,233.38	$89.34	$2,144.04	$2,160.08	$86.42	$2,073.66	($2.92)	($35.04)	($70.38)	($844.56)
CDH Gold										
Employee	$893.74	$44.68	$849.06	$864.42	$43.22	$821.20	($1.46)	($17.52)	($27.86)	($334.32)
Employee + Spouse	$1,853.12	$92.66	$1,760.46	$1,792.32	$89.62	$1,702.70	($3.04)	($36.48)	($57.76)	($693.12)
Employee + Child	$1,365.50	$68.26	$1,297.24	$1,320.70	$66.02	$1,254.68	($2.24)	($26.88)	($42.56)	($510.72)
Family	$2,354.24	$117.70	$2,236.54	$2,276.98	$113.84	$2,163.14	($3.86)	($46.32)	($73.40)	($880.80)
Aetna HMO										
Employee	$901.52	$58.60	$842.92	$871.94	$56.68	$815.26	($1.92)	($23.04)	($27.66)	($331.92)
Employee + Spouse	$1,900.76	$123.56	$1,777.20	$1,838.38	$119.50	$1,718.88	($4.06)	($48.72)	($58.32)	($699.84)
Employee + Child	$1,379.10	$89.64	$1,289.46	$1,333.84	$86.70	$1,247.14	($2.94)	($35.28)	($42.32)	($507.84)
Family	$2,371.72	$154.16	$2,217.56	$2,293.88	$149.10	$2,144.78	($5.06)	($60.72)	($72.78)	($873.36)
Comprehensive PPO										
Employee	$985.86	$130.62	$855.24	$953.50	$126.34	$827.16	($4.28)	($51.36)	($28.08)	($336.96)
Employee + Spouse	$2,045.76	$271.06	$1,774.70	$1,978.62	$262.18	$1,716.44	($8.88)	($106.56)	($58.26)	($699.12)
Employee + Child	$1,519.36	$201.32	$1,318.04	$1,469.50	$194.70	$1,274.80	($6.62)	($79.44)	($43.24)	($518.88)
Family	$2,557.46	$338.86	$2,218.60	$2,473.54	$327.74	$2,145.80	($11.12)	($133.44)	($72.80)	($873.60)

FY24 Illustrative Rates – Pre-65 Retirees Rated Separately (+40.4%)

Rating active and pre-65 retiree populations separately increases pre-65 retiree contributions for all plans and coverage tiers; relative to the status quo rate increase of 14.3% (based on combined rating methodology), pre-65 retirees would see annual increases in contributions ranging from $94.56 to $928.08)

	FY 2024 with 14.3% Increase (no change to rating methodology)			FY 2024 (40.4% increase for pre-65 retirees only)			$ 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	$863.52	$34.54	$828.98	$1,060.66	$42.42	$1,018.24	$7.88	$94.56	$189.26	$2,271.12
Employee + Spouse	$1,786.64	$71.46	$1,715.18	$2,194.50	$87.78	$2,106.72	$16.32	$195.84	$391.54	$4,698.48
Employee + Child	$1,312.66	$52.50	$1,260.16	$1,612.32	$64.48	$1,547.84	$11.98	$143.76	$287.68	$3,452.16
Family	$2,233.38	$89.34	$2,144.04	$2,743.20	$109.74	$2,633.46	$20.40	$244.80	$489.42	$5,873.04
CDH Gold										
Employee	$893.74	$44.68	$849.06	$1,097.76	$54.88	$1,042.88	$10.20	$122.40	$193.82	$2,325.84
Employee + Spouse	$1,853.12	$92.66	$1,760.46	$2,276.16	$113.80	$2,162.36	$21.14	$253.68	$401.90	$4,822.80
Employee + Child	$1,365.50	$68.26	$1,297.24	$1,677.22	$83.86	$1,593.36	$15.60	$187.20	$296.12	$3,553.44
Family	$2,354.24	$117.70	$2,236.54	$2,891.66	$144.58	$2,747.08	$26.88	$322.56	$510.54	$6,126.48
Aetna HMO										
Employee	$901.52	$58.60	$842.92	$1,107.30	$71.98	$1,035.32	$13.38	$160.56	$192.40	$2,308.80
Employee + Spouse	$1,900.76	$123.56	$1,777.20	$2,334.66	$151.76	$2,182.90	$28.20	$338.40	$405.70	$4,868.40
Employee + Child	$1,379.10	$89.64	$1,289.46	$1,693.92	$110.10	$1,583.82	$20.46	$245.52	$294.36	$3,532.32
Family	$2,371.72	$154.16	$2,217.56	$2,913.14	$189.36	$2,723.78	$35.20	$422.40	$506.22	$6,074.64
Comprehensive PPO										
Employee	$985.86	$130.62	$855.24	$1,210.90	$160.44	$1,050.46	$29.82	$357.84	$195.22	$2,342.64
Employee + Spouse	$2,045.76	$271.06	$1,774.70	$2,512.76	$332.94	$2,179.82	$61.88	$742.56	$405.12	$4,861.44
Employee + Child	$1,519.36	$201.32	$1,318.04	$1,866.20	$247.26	$1,618.94	$45.94	$551.28	$300.90	$3,610.80
Family	$2,557.46	$338.86	$2,218.60	$3,141.28	$416.20	$2,725.08	$77.34	$928.08	$506.48	$6,077.76

Plan design alternatives

Plan & Contribution Benchmarking

WTW 2022 Healthcare Financial Benchmarks Survey

Survey overview

965	Participating companies*	$77.0B	Medical — total annual budget dollars	$4.6B	Dental — total annual budget dollars
61	Government/Public Sector/Education companies	5.4M	Medical — covered employees	5.3M	Dental — covered employees

** Database Participation as of April 20, 2022*

Major focus areas

Cost efficiency

Medical and dental plans are evaluated on how efficiently they perform by adjusting cost data for plan design, demographics, family size and geographic cost differences. This helps employers understand how their plan costs compare on an apples-to-apples basis.

Employee cost sharing

Explore how employee costs compare, from a dollar and percentage of premium standpoint — including not only premium costs, but out-of-pocket (OOP) expenses as well.

Account funding and incentives

Compare HSA and HRA funding amounts, and wellness incentives and delivery methods amongst employers.

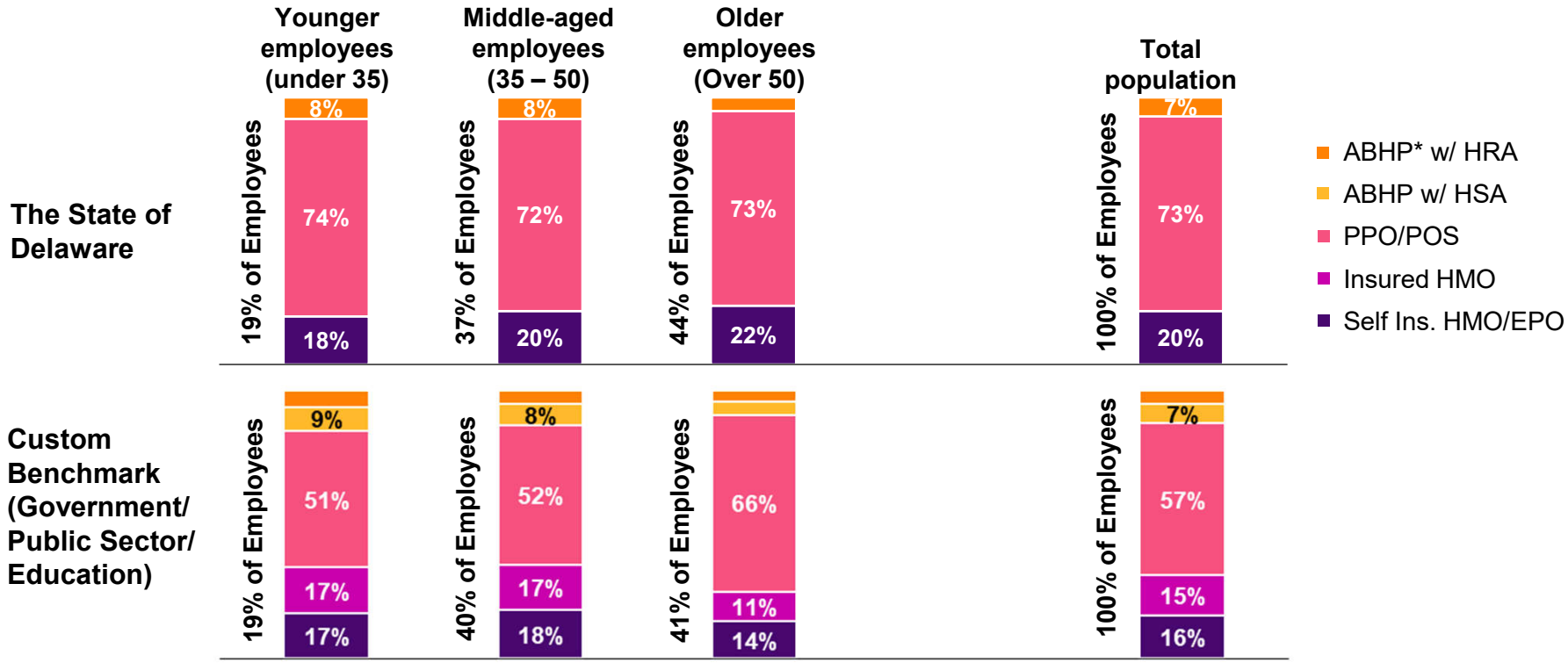
Plan design

Examine a side-by-side comparison of medical, pharmacy and dental plan benefits against both industry and database norms.

Medical cost benchmarks

Enrollment by plan type and age breakdown

? How does enrollment by plan type compare to the database?
Does the enrollment by age have implications for plan pricing?
Is the plan enrollment by age influenced by employer funding of employees/dependents?



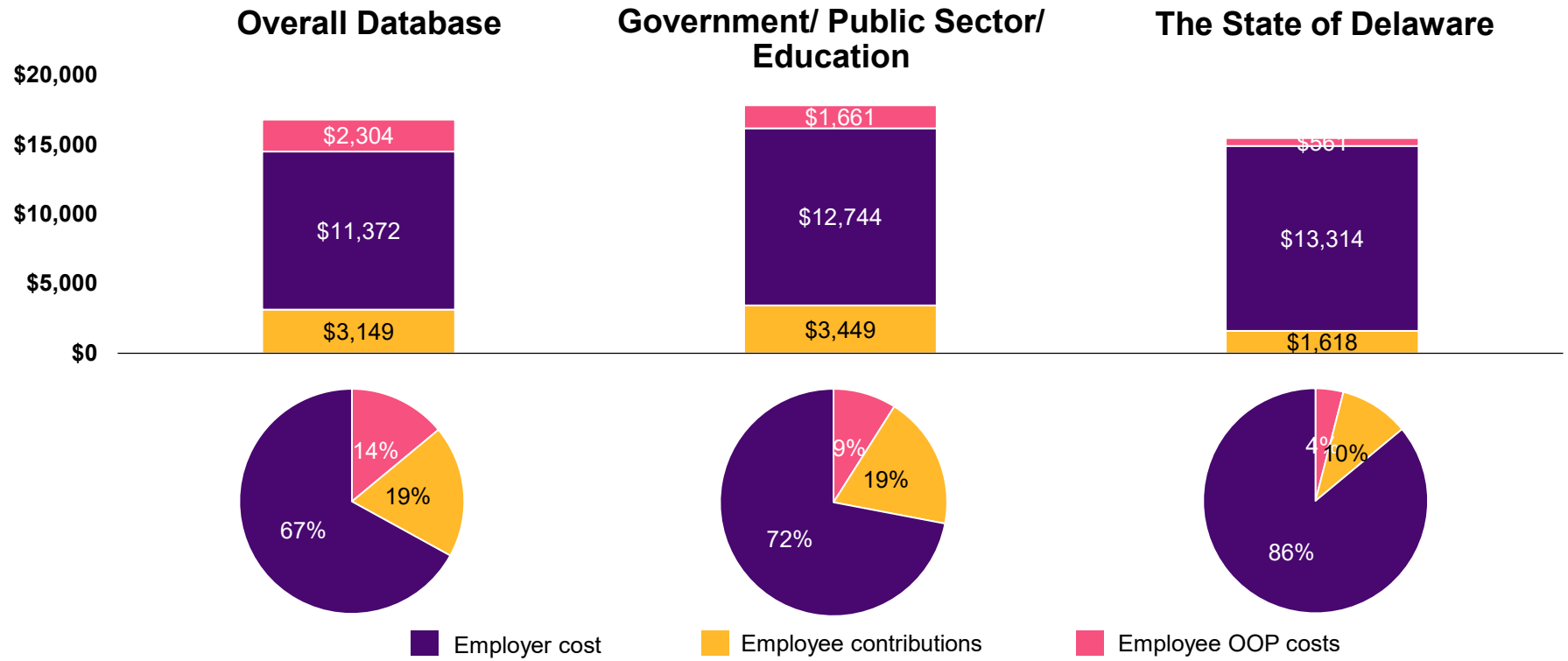
✓ 15% of younger employees with Other Governmental plan sponsors enrolled in an Account Based Health Plan (9% with HSA)

*ABHP = Account Based Health Plan

Medical cost benchmarks

Total cost and contributions

? How does your employees' share of total cost, including contributions and out-of-pocket expenses, compare to benchmarks?

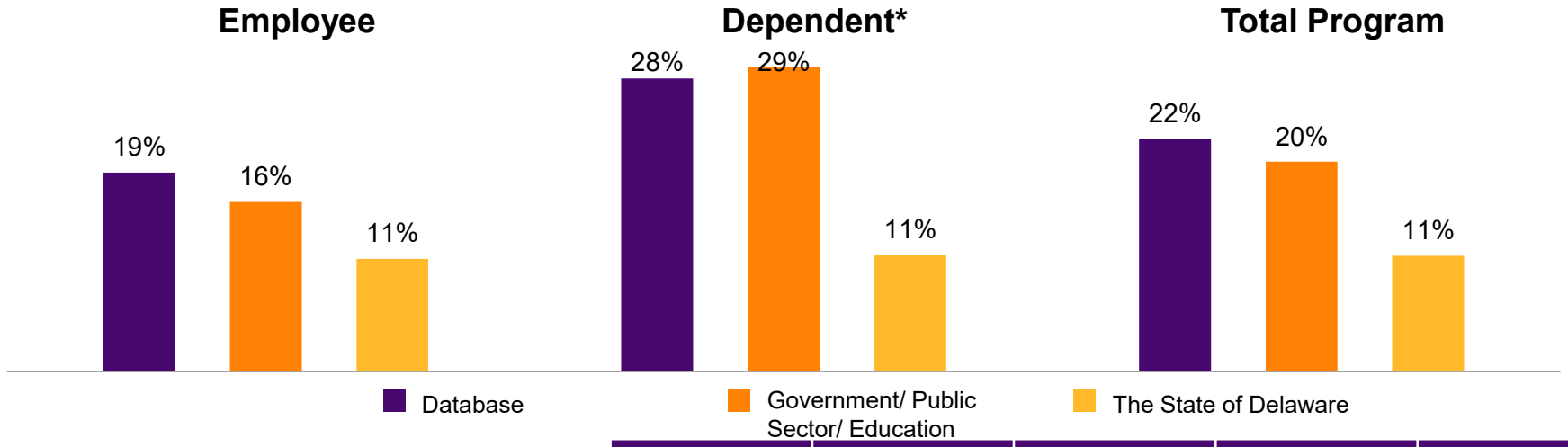


✓
- The State has richer plans than both the database and industry benchmarks (employees pay less in out-of-pocket expenses at the point of care)
- The State also subsidizes those plans at a higher rate than the benchmark averages

Medical cost benchmarks

Employee contributions as a share of plan cost

? How does your cost sharing, for employees and dependents, compare to benchmarks?



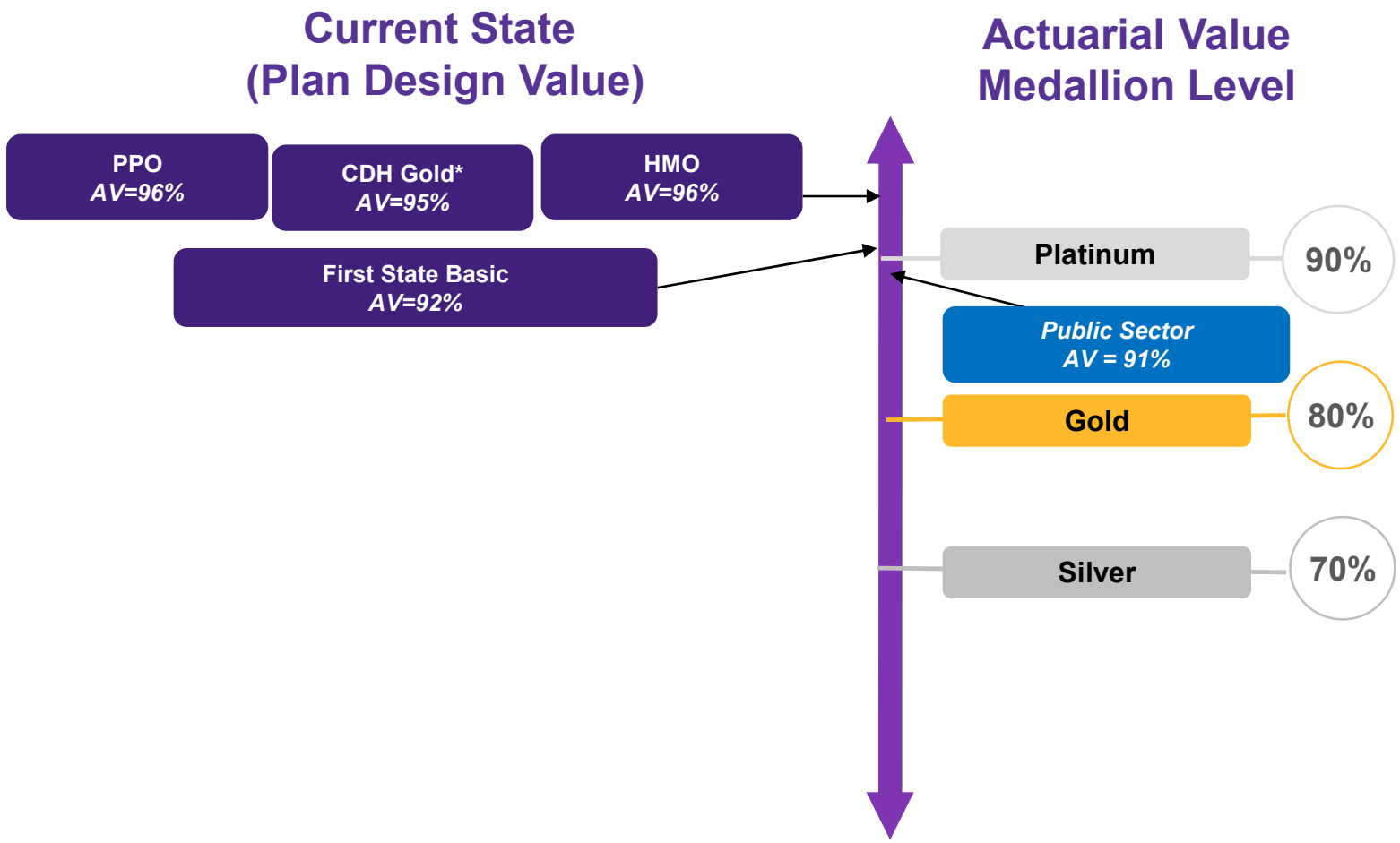
	ABHP w/ HRA	ABHP w/ HSA	PPO/POS	Insured HMO	Self Ins. HMO/EPO
The State of Delaware	5%	N/A	12%	N/A	7%
Overall Database	23%	18%	26%	24%	23%

✓ State employee contributions significantly lower than the benchmark averages, especially dependents

*Dependent includes spouse, children, family, etc.

Strategic Opportunities – Program Observations

Actuarial Value
Measures the percentage of medical claims cost that insurance is expected to cover after employees pay cost sharing (e.g. deductible and coinsurance)



Observations

- The State's plans are both very high in value but also very bunched, with little difference in value between the PPO, CDH Gold and HMO plans
- Should consider both:
  - Lowering overall value of each option to align with benchmarks and drive better engagement in healthcare
  - Spreading option value to drive more meaningful choice

*Actuarial value includes HRA seed

Strategic Opportunities – Program Observations

Current Plan Designs

Plan Name	First State Basic	Comprehensive PPO	HMO	CDH Gold
Enrolled	3,527	29,745	9,256	3,396
Medical				
Deductible (Single/Family)	$500/$1000	$0/$0	$0/$0	$1500/$3000
Accumulation Method (Ded)	Embedded	Embedded	Embedded	Embedded
General Coinsurance	90%	100%	100%	90%
Office Visit - PCP	90%	$20	$15	90%
Office Visit - SPC	90%	$30	$25	90%
Urgent Care	$25	$20	$15	90%
Emergency Room	90%	$200	$200	90%
Out-Of-Pocket Max (Single/Family)	$2000/$4000	$4500/$9000	$4500/$9000	$4500/$9000
Accumulation Method (OOP Max)	Embedded	Embedded	Embedded	Embedded
Pharmacy				
Generic	$8	$8	$8	$8
Formulary	$28	$28	$28	$28
Non-Formulary	$50	$50	$50	$50
Specialty	n/a	n/a	n/a	n/a
Mail Order - Generic	$16	$16	$16	$16
Mail Order - Formulary	$56	$56	$56	$56
Mail Order - Non-Formulary	$100	$100	$100	$100
Seed				
Annual Funding (Single/Family)	N/A	N/A	N/A	$1250/$2500
Actuarial Value				
AV - Without Account Funding	91.8%	96.1%	96.4%	83.1%
AV - With Account Funding	91.8%	96.1%	96.4%	95.1%
HB81 Mandated				
Employee Share of Premium	4%	13.25%	6.5%	5%
Value to Participant (State Share of Total Cost)	88%	83%	90%	90%

Observations

- Minimal spread in actuarial value across GHIP plans
- 85% of GHIP enrollment in $0 deductible plans (zero stewardship of plan)
- All GHIP plans have low pharmacy copays relative to benchmark
- GHIP weighted average actuarial value of 96% exceeds benchmark actuarial value of 91%
- GHIP plan value gets richer each year due to fixed deductible / copay designs
- Employee share of premium also low relative to benchmark (employees pay less for richer plans)
- The State can modify plan design without legislative change
- Can produce significant savings while continuing to offer platinum level plans at lower employee cost than benchmark

Plan Design Alternatives Savings

FY24 Deductible	Current State		$100 / $200		$250 / $500		$500 / $1000	
	Savings	AV	Savings	AV	Savings	AV	Savings	AV
HMO	--	96%	$1.3 M	95.7%	$3.0 M	94.7%	$5.1 M	93.4%
CDH Gold	--	84%/96%	$0.3 M	83.1%/95.1%	$0.9 M	82.3%/94.3%	$1.6 M	81.2%/93.2%
First State Basic	--	92%	$0.2 M	91.7%	$0.5 M	91.2%	$0.9 M	90.5%
Comprehensive PPO	--	96%	$4.2 M	95.4%	$9.4 M	94.4%	$16.2 M	93.1%
Subtotal (Medical)	**--**		**$6.1 M**		**$13.7 M**		**$23.8 M**	
Prescription Drug Copay Change	--		$0.6 M		$0.6 M		$0.6 M	
Total	**--**		**$6.7 M**		**$14.3 M**		**$24.4 M**	

- Deductible modeling reflects adding deductible of listed amount to both the PPO and HMO plans, and increasing the existing deductibles for the First State Basic and CDH Gold plans by the same amount
- Prescription drug copay changes reflect the following design based on Governmental Benchmark from 2022 Financial Benchmark Survey:
  - Generic: $10 / $20 (retail / mail)
  - Formulary: $32 / $64
  - Non-formulary: $60 / $120
  - Specialty: $100 / $100

Plan design alternatives

Premium Equivalents & Employee Contributions

2023 Premium Equivalents & Employee Contributions

	FY2023					FY2023 with Design Changes (target 5% reduction in plan value)					
	FSB	PPO	HMO	CDH Gold	Total	FSB	PPO	HMO	CDH Gold	Total	
Enrollment	**3,527**	**29,745**	**9,256**	**3,396**	**45,924**	**3,527**	**29,745**	**9,256**	**3,396**	**45,924**	
Employee	2,086	11,896	3,532	1,500	19,014	2,086	11,896	3,532	1,500	19,014	
Employee+Spouse	384	4,054	1,175	404	6,017	384	4,054	1,175	404	6,017	
Employee+Child(ren)	599	7,238	2,264	857	10,958	599	7,238	2,264	857	10,958	
Family	458	6,557	2,285	635	9,935	458	6,557	2,285	635	9,935	
Premium Equivalents											
Employee	$755.64	$862.68	$788.88	$782.08	$830.87	$717.86	$819.55	$749.44	$742.98	$789.33	
Employee+Spouse	$1,563.42	$1,790.16	$1,663.28	$1,621.60	$1,739.59	$1,485.25	$1,700.65	$1,580.12	$1,540.52	$1,652.62	
Employee+Child(ren)	$1,148.66	$1,329.54	$1,206.80	$1,194.90	$1,283.76	$1,091.23	$1,263.06	$1,146.46	$1,135.16	$1,219.58	
Family	$1,954.34	$2,237.94	$2,075.40	$2,060.10	$2,176.12	$1,856.62	$2,126.04	$1,971.63	$1,957.10	$2,067.31	
Employee Contributions ($)											
Employee	$30.23	$114.31	$51.28	$39.10	$87.44	$28.71	$108.59	$48.71	$37.15	$83.07	
Employee+Spouse	$62.54	$237.20	$108.11	$81.08	$190.36	$59.41	$225.34	$102.71	$77.03	$180.84	
Employee+Child(ren)	$45.95	$176.16	$78.44	$59.75	$139.75	$43.65	$167.36	$74.52	$56.76	$132.76	
Family	$78.17	$296.53	$134.90	$103.01	$236.92	$74.26	$281.70	$128.16	$97.85	$225.07	
Employee Contributions Annual Impact ($)											
Employee	n/a	n/a	n/a	n/a	n/a	($18.24)	($68.64)	($30.84)	($23.40)	($52.44)	
Employee+Spouse	n/a	n/a	n/a	n/a	n/a	($37.56)	($142.32)	($64.80)	($48.60)	($114.24)	
Employee+Child(ren)	n/a	n/a	n/a	n/a	n/a	($27.60)	($105.60)	($47.04)	($35.88)	($83.88)	
Family	n/a	n/a	n/a	n/a	n/a	($46.92)	($177.96)	($80.88)	($61.92)	($142.20)	
Totals											**Savings**
Gross Costs	**$45,100,000**	**$501,800,000**	**$146,600,000**	**$49,900,000**	**$743,400,000**	**$42,900,000**	**$476,700,000**	**$139,300,000**	**$47,400,000**	**$706,300,000**	**$37,100,000**
Employee Contributions	**($1,800,000)**	**($66,500,000)**	**($9,500,000)**	**($2,500,000)**	**($80,300,000)**	**($1,700,000)**	**($63,200,000)**	**($9,100,000)**	**($2,400,000)**	**($76,400,000)**	**($3,900,000)**
Net Cost	**$43,300,000**	**$435,300,000**	**$137,100,000**	**$47,400,000**	**$663,100,000**	**$41,200,000**	**$413,500,000**	**$130,200,000**	**$45,000,000**	**$629,900,000**	**$33,200,000**

Plan design alternatives

PrudentRx

PrudentRx specialty copay card program

- PrudentRx is an independent third-party organization that CVS Health has partnered with to offer this program
  - Previously discussed with the combined Subcommittees in the Fall 2021
- 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
  - Approximately Commercial plan 1,900 members utilizing specialty drugs (including HIV and fertility, which can be excluded from the program if the State chooses to do so)
- 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

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
    - If the State opts to exclude HIV medications, then the State's current copay-based plan design, not the 30% coinsurance, would apply to this class of drugs, which would also continue to be able to be filled at any pharmacy via CVS's Open Network
    - If the State opts to exclude fertility medications, then that therapeutic class would continue to be subject to a 25% coinsurance with a $15,000 lifetime maximum
  - 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

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.

PrudentRx specialty copay card program (continued)

- Program is also dependent upon the continuation of drug manufacturer copay assistance programs
- CVS-estimated annual net savings to the GHIP: $9.1M (including HIV and fertility medications)
  - 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
- Proposed next step:
  - If there is interest from Subcommittee members in continuing to evaluate this program, consider inviting CVS Health to present further details on the member experience and address questions from Subcommittee members at the November 2022 meeting

Site of care steerage

Follow-ups from the September 2022 Subcommittee meeting

- At the September 2022 Combined Subcommittee meeting, Subcommittee members expressed interest in continued evaluation of site-of-care plan design changes
- Several follow-up questions and requests were voiced by Subcommittee members at that meeting, which are outlined below:
  - Interest in continuing to evaluate impact of increased copays to incentivize members to use care at lower cost facilities, including additional analysis to tailor copays by site and type of services provided and exploration of utilization management opportunities including post-authorization of certain services such as emergency care
  - Interest in providing enhanced member education regarding preferred sites of care
  - Information pertaining to the number of care facilities in Delaware that are independent vs. owned by a hospital system
- Today's discussion will focus on addressing those follow-up items

Recap: Site of care steerage – current copay differentials and member communications/educational materials

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" or "site of service")
- Chart reflects current site of care copay differentials, which have been in place since July 1, 2019
  - Exception: telemedicine copay was lowered to $0 in March 2022

Copays by type of service	HMO & PPO plans (effective since July 1, 2019)
Basic Imaging (X-rays, ultrasounds)	
▪ In-network non-hospital affiliated freestanding facility (preferred)	▪ $0 copay
▪ Hospital-based facility	▪ $50 copay *(+$15 from FY19)*
High Tech Imaging (MRI, CT, PET scan)	
▪ In-network non-hospital affiliated freestanding facility (preferred)	▪ $0 copay
▪ Hospital-based facility	▪ $75 copay *(+$25 from FY19)*
Outpatient Lab	
▪ In-network non-hospital affiliated preferred lab	▪ $10 copay
▪ Other lab	▪ $50 copay *(+$30 from FY19)*
Emergency / Urgent Care	
▪ Urgent Care	▪ $15 HMO / $20 PPO
▪ Emergency Room	▪ $200 copay *(+$50 from FY19)*
Outpatient Surgeries (through medical carrier network provider)	
▪ Ambulatory Surgery Center	▪ $50 copay
▪ Hospital	▪ $100 copay
In-network telemedicine provider through third-party vendors	▪ $0 copay[1] *(-$15 HMO / -$20 PPO from FY19)*

1 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.

Site of care steerage – member communications and educational materials

- For the past several years, the SBO, Highmark and Aetna have implemented multiple communications (i.e., emails, letters, flyers, postcards, posters, and online training courses) to educate members[1] throughout each fiscal year about selecting the most appropriate site of care for members' individual needs
- Recent communication efforts include:
  - February 2021 – June 2021:
    - Highmark Delaware sent a flyer to over 32,000 members[1] about how and when to use Amwell and Doctor on Demand telemedicine providers
    - Aetna sent three letters/flyers to over 13,000 members[1] including a Teladoc Welcome Letter, guidance on when to use telemedicine instead of going to the ER, and details on how they can receive quality healthcare using telemedicine
  - July 2021: SBO sent emails to employees enrolled in a health plan with specific information about their plan, including information on choosing the right care and selecting the most appropriate site of care
  - Beginning November 2021: Highmark Delaware and Aetna started mailing site of care postcards to members[2] who, based on claims data, could have used:
    - A more affordable, non-hospital affiliated freestanding facility for lab and/or imaging services
    - A less emergent setting (i.e., PCP, telemedicine or urgent care) instead of going to the ER for less severe symptoms like coughs or colds, sore throat, fever, etc.
    - Since inception, Highmark has distributed over 31,400 mailings and Aetna has distributed over 7,300 mailings

1 Includes employees and non-Medicare eligible pensioners.
2 Includes employees and non-Medicare eligible pensioners. Members with cancer or heart disease are excluded from these communications; other members will only receive a postcard once in a given 90-day period even if non-preferred sites are used multiple times (e.g., repeat user of the ER for non-emergency care will only receive one postcard in a 90-day period)

Site of care steerage – member communications and educational materials

- Recent communication efforts (continued):
  - February 9, 2022: SBO sent the Benefits Bulletin[1] to over 38,000 benefit-eligible State of Delaware employees, which included an article titled “Navigating Health Care Options” and promoted SBO’s new “Know Where to Go for Care”[2] flyer
- In addition to these communication efforts, Highmark and Aetna customer service teams and care management nurses are trained on the State’s plan design and know to direct members to preferred sites of care
- SBO website contains a robust section titled Choosing the Right Care[3] containing guidance on selecting the most appropriate site of care for an individual’s care needs, such as:
  - Lists of preferred sites of care in Delaware that participate in Highmark and Aetna’s provider networks
  - Details on preventive care services and medications
  - Tools to compare doctors and hospitals
  - Education on quality and patient safety considerations
  - Resources to help members prepare for visits with their doctors

1 https://dhr.delaware.gov/benefits/news/documents/2022/020922.pdf
2 https://dhr.delaware.gov/benefits/medical/documents/where-to-go-for-care.pdf
3 https://dhr.delaware.gov/benefits/right-care/index.shtml

Site of care copay changes

- The following slides outline recommendations and potential copay changes for categories of services with site of care copay differentials
- Discussions are ongoing with the medical carriers to determine capabilities around providing post-authorization for emergency room use as well as the capability to administer a plan design that varies based on place of service and type of service
    - Further insights and options from those conversations will be shared with the Subcommittee at the November 2022 meeting

Impact of increased copays

Highlights copay change

Copays by type of service	HMO & PPO plans (effective since July 1, 2019)	WTW Comments
Basic Imaging (X-rays, ultrasounds) ▪ In-network non-hospital affiliated freestanding facility (preferred) ▪ Hospital-based facility	▪ $0 copay ▪ $50 copay *(+$15 from FY19)*	▪ Due to favorable recent increases in utilization[1] of preferred sites of care (non-hospital affiliated freestanding facilities) for this type of service, no changes are recommended to the current copay structure ▪ However, WTW modeled several scenarios for increasing the hospital-based facility copay (range: $55 - $75 total per visit) ▪ Potential range of cost avoidance in first year following change: $150,000 to $740,000 assuming future utilization is consistent with CY21 experience; see Appendix for further details
High Tech Imaging (MRI, CT, PET scan) ▪ In-network non-hospital affiliated freestanding facility (preferred) ▪ Hospital-based facility	▪ $0 copay ▪ $75 copay *(+$25 from FY19)*	▪ High-tech imaging services were up overall in 2021, with a decrease in services performed in hospital-based facilities[1]; given the high net cost of these procedures, consider additional copay changes for non-preferred sites of care ▪ WTW modeled several scenarios for increasing the hospital-based facility copay (range: $100 - $150 total per visit) ▪ Potential range of cost avoidance in first year following change: $180,000 - $545,000 assuming future utilization is consistent with CY21 experience; see Appendix for further details

- Without additional communications to remind plan participants of increased copays for hospital-based facilities, the level of cost avoidance may diminish in the subsequent years following a change to these copays, based on similar pattern observed previously among GHIP participants

1 Data presented at the August 18, 2022 combined Subcommittee meeting. https://dhr.delaware.gov/benefits/sebc/documents/sub-comm-2022/0818-site-of-care.pdf

Impact of increased copays

Highlights copay change

Copays by type of service	HMO & PPO plans (effective since July 1, 2019)	WTW Comments
Outpatient Lab ▪ In-network non-hospital affiliated preferred lab ▪ Other lab	▪ $10 copay ▪ $50 copay *(+$30 from FY19)*	▪ Increases in outpatient lab utilization[1] is attributable to increased COVID-19 testing and has been driven entirely use of preferred labs; non-preferred lab use has declined each year between CY19 and CY21 ▪ Despite the downward trend in non-preferred lab use, WTW modeled several scenarios for increasing the non-preferred lab copay (range: $55 - $65 total per visit) ▪ Potential range of cost avoidance in first year following change: $300,000 to $900,000 assuming future utilization is consistent with CY21 experience; see Appendix for further details
Emergency / Urgent Care ▪ Urgent Care ▪ Emergency Room	▪ $15 HMO / $20 PPO ▪ $200 copay *(+$50 from FY19)*	▪ Discussions are ongoing with the medical carriers to determine capabilities around providing post-authorization for emergency room use ▪ WTW modeled several scenarios for increasing the emergency room copay (range: $225 - $275 total per visit) ▪ Potential range of cost avoidance in first year following change: $265,000 to $800,000 (for ER use for non-emergent / primary care treatable conditions) assuming future utilization is consistent with CY21 experience; see Appendix for further details

- Without additional communications to remind plan participants of increased copays for hospital-based facilities, the level of cost avoidance may diminish in the subsequent years following a change to these copays, based on similar pattern observed previously among GHIP participants

1 Data presented at the August 18, 2022 combined Subcommittee meeting. https://dhr.delaware.gov/benefits/sebc/documents/sub-comm-2022/0818-site-of-care.pdf
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.

Impact of increased copays

Highlights copay change

Copays by type of service	HMO & PPO plans (effective since July 1, 2019)	WTW Comments
In-network telemedicine provider through third-party vendors	▪ $0 copay[2] *(-$15 HMO / -$20 PPO from FY19)*	▪ Due to favorable recent increases in utilization[1] of telemedicine services, no changes are recommended to the current copay structure ▪ Plan design may be adjusted upon the expiration of the federal Public Health Emergency period (currently in effect until January 2023), which was the impetus for lowering telemedicine copays initially
Outpatient Surgeries (through medical carrier network provider) ▪ Ambulatory Surgery Center ▪ Hospital	▪ $50 copay ▪ $100 copay	▪ These copays have not been increased in multiple years; consider increasing the copay for hospital-based outpatient surgeries ▪ WTW modeled several scenarios for increasing the copay for outpatient surgery at a hospital (range: $150 - $250 total per visit) ▪ Potential range of cost avoidance in first year following change: $76,000 to $228,000 assuming future utilization is consistent with recent claims experience; see Appendix for further details ▪ Does not reflect any change in utilization to a preferred site of care, but would expect some utilization to shift to ambulatory surgery centers ▪ Further analysis would be necessary to evaluate member access to ambulatory surgery centers throughout Delaware

1 Data presented at the August 18, 2022 combined Subcommittee meeting. https://dhr.delaware.gov/benefits/sebc/documents/sub-comm-2022/0818-site-of-care.pdf
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.

Care facilities in Delaware that are independent vs. hospital-owned

Based on publicly available information available to GHIP participants

	Aetna	Highmark
Basic Imaging **(X-rays, ultrasounds)** ▪ In-network non-hospital affiliated freestanding facility (preferred) ▪ Hospital-based facility	▪ Preferred imaging facilities: 22 facilities in DE ▪ Hospital-based facilities: 12 facilities in DE	▪ Preferred imaging facilities: 22 facilities in DE ▪ Hospital-based facilities: 12 facilities in DE
High Tech Imaging **(MRI, CT, PET scan)** ▪ In-network non-hospital affiliated freestanding facility (preferred) ▪ Hospital-based facility	▪ Preferred imaging facilities: 23 facilities in DE ▪ Hospital-based facilities: 12 facilities in DE	▪ Preferred imaging facilities: 24 facilities in DE ▪ Hospital-based facilities: 12 facilities in DE
Outpatient Lab ▪ In-network non-hospital affiliated preferred lab ▪ Other lab	▪ Preferred labs: LabCorp and Quest Diagnostics (total of 36 locations in DE) ▪ Non-preferred labs: total of 22 locations in DE	▪ Preferred labs: LabCorp and Quest Diagnostics (total of 36 locations in DE) ▪ Non-preferred labs: total of 5 locations in DE
Urgent Care ▪ Independent ▪ Hospital-affiliated	▪ Total of 49 urgent care locations in DE ▪ 8 walk-in clinics, 26 independent, 15 hospital-affiliated locations	▪ Total of 34 urgent care locations in DE ▪ 20 independent, 14 hospital-affiliated locations

- Consolidation of providers within Delaware, particularly of independent facilities such as radiology centers, labs and physician offices, has slowed in the most recent 2-3 years

See Appendix for links to source information available online and “data as of” dates.

Next steps: site of care steerage

- Continued discussion with the medical carriers to determine capabilities around providing post-authorization for emergency room use as well as the capability to administer a plan design that varies based on place of service and type of service
  - Further insights and options from those conversations will be shared with the Subcommittee at the November 2022 meeting
- Additional analysis of ambulatory surgery centers throughout Delaware if copay changes for outpatient surgeries remain under consideration

SurgeryPlus carve-out opportunities beyond bariatric surgery

Overview

Topic Refresher:

A Center of Excellence (COE) is a medical facility or professional (sometimes called a "Surgeon of Excellence") that has been identified as delivering high quality services and superior outcomes for specific procedures or conditions. COEs may incorporate separate contracting arrangements for a predetermined set of services (e.g., bundled payments), which often results in lower cost. Some plan sponsors use plan design steerage or other incentives to encourage use of COEs.

- On July 25, 2022, the SEBC voted to carve out coverage of bariatric surgery to SurgeryPlus for an effective date no earlier than 1/1/2023
  - "Carve out" refers to mandating use of a SurgeryPlus participating provider in order to receive coverage for bariatric surgery under the GHIP
  - SurgeryPlus participating providers are required to meet strict credentialing guidelines for high quality care delivery
  - Transition of care planning is currently underway for members who are in the process of preparing for bariatric surgery at the time that this change takes effect

- SurgeryPlus has also recommended carving out coverage of the following **planned (non-emergency) procedures**: **total joint** (hip/knee replacements, revisions, etc.) and **spine** (fusion, laminectomy, discectomy, etc.)

Current GHIP coverage for elective joint and spine procedures

- Today, member out-of-pocket cost for elective (non-emergency) joint and spine procedures varies depending on the type of provider utilized for those procedures
  - Members who use a SurgeryPlus provider have no out-of-pocket cost for these procedures
  - Members who use a COE facility within their medical carrier's provider network will pay a lower out-of-pocket cost than those who use a participating (in-network) provider that is not a COE

Coverage through Medical carrier

Type of provider / network status	PPO / HMO	CDH Gold / First State Basic
COE Facility SurgeryPlus provider	$0 (no member out-of-pocket cost)	$0 (no member out-of-pocket cost)
COE Facility In-network provider	$100 copay per day $200 copay max/admission	10% coinsurance after deductible
Non-COE Facility In-network provider	$500 copay per admission	10% coinsurance after deductible
Non-COE Facility Out-of-network provider	PPO: 20% coinsurance, no deductible HMO: not covered	30% coinsurance after deductible

Current GHIP coverage for elective joint and spine procedures (continued)

- In the PPO and HMO plans, this variable cost sharing applies to the following elective joint and spine procedures available from medical carrier COEs:
  - PPO: total knee and hip replacements, cervical and lumbar fusion, cervical laminectomy, lumbar laminectomy/discectomy
  - HMO: total knee and hip replacements, primary fusion, fusion revision, laminectomy, discectomy (w/out decompression), decompression (w/out fusion)

Type of provider / network status	PPO / HMO
COE Facility **SurgeryPlus provider**	$0 (no member out-of-pocket cost)
COE Facility **In-network provider**	$100 copay per day $200 copay max/admission
Non-COE Facility **In-network provider**	$500 copay per admission
Non-COE Facility **Out-of-network provider**	PPO: 20% coinsurance, no deductible HMO: not covered

Note: The above list of COE-eligible procedures is narrower than the list of joint and spine procedures recommended by SurgeryPlus

Subcommittee has two avenues to explore around promoting additional use of COEs for elective joint and spine procedures

Carve out coverage through SurgeryPlus program

- Future decision point for the SEBC: scope of joint and spine procedures that would be carved out
  - SurgeryPlus recommendation includes other joint procedures (e.g., shoulder, ankle) that are not subject to variable cost sharing if obtained through the medical carrier networks today
  - Additional dialogue with the medical carriers is necessary to determine ability to “turn off” coverage for non-COE procedures such as shoulder or ankle surgery
- SurgeryPlus estimated annual savings of approximately $7M+ includes a broader scope of joint procedures including shoulder and ankle surgeries; WTW to validate this estimate and confirm financial impact if only some joint procedures (e.g., hip, knee) were carved out
- SurgeryPlus book of business: Few customers (<10) with 2+ procedure categories carved out; limited experience coordinating beyond bariatrics with Aetna and Highmark DE

Additional steerage to Aetna/Highmark COEs

- Modify plan design differential that is already in place to further encourage use of Aetna/Highmark COEs
- Preserves broader choice of providers with stronger financial disincentive to select non-COE provider
- Additional analysis needed to further explore:
  - Impact of current plan design on utilization of medical carrier COEs for elective joint and spine procedures since implementation (effective 7/1/2018)
  - Estimated impact of future plan design changes on increased use of COEs in terms of utilization, health outcomes and cost

Next steps: elective joint and spine procedures

- WTW to validate SurgeryPlus estimated savings and member impact for carve-out approach under several scenarios such as:
  - All joint procedures carved out
  - Selected joint procedures carved out (e.g., hip, knee only)
- Additional discussions with Aetna and Highmark to determine capabilities to support carve-out approach
- Review historical shift in member utilization of medical carrier COEs when current plan design changes went into effect (7/1/2018)
- Further analysis of future plan design changes on increased use of medical carrier COEs in terms of utilization, health outcomes and cost
- Review impact of modifying incentives for members to utilize SurgeryPlus as a choice (not mandated/carved-out) for elective joint and spine procedures

Other emerging treatments

Overview

- At the combined Subcommittee meeting on September 15, 2022, a Subcommittee member asked about any opportunities to consider expanding coverage for emerging medical treatments
  - Example provided by Subcommittee member was related to joint therapy treatments that could avoid surgery

- Following slides are a brief overview of selected emerging medical treatments including:
  - **Stem cell therapy** for orthopedic conditions and degenerative diseases including multiple sclerosis
  - **Genetic therapy**

Stem cell therapy for orthopedic conditions and degenerative diseases including multiple sclerosis

- Multiple clinics offer stem cell therapy for knee pain, shoulder pain, back pain, and other orthopedic maladies, and position care as an alternative to orthopedic surgery procedures
- The treatment involves harvesting bone marrow (which contains stem cells) from the patient, and injecting it into the affected joint
  - The injection is done the same day so that it qualifies under FDA standards
  - In some instances, platelets and other bone marrow products are also injected
- The FDA regulates the use of stem cells for medical treatment and has not approved this procedure
  - However, the FDA provides an exemption for stem cell procedures that are minimally invasive where the stem cells are harvested and reinjected the same day to the same patient
  - Some companies claim that their procedures are “FDA compliant” because the FDA does not regulate “minimally manipulated” bone marrow
  - In 2019, the FDA warned[1] against the use of stem cells that are not either FDA approved or under a current FDA Investigational New Drug Application (IND)

1 https://www.fda.gov/ForConsumers/ConsumerUpdates/ucm286155.htm

Stem cell therapy has not been proven to be clinically effective, and employers should be wary of covering this treatment

- Claims that stem cell injections will obviate the need for orthopedic surgery are not well supported
  - There have been multiple trials, although most have been small and few have been well designed. Many trials excluded those with moderate to severe osteoarthritis
  - Non-blinded trials, even if randomized, were likely to show a positive placebo response
    - A Mayo Clinic study with saline injections in opposite knee showed similar improvements in both knees
  - There are no long-term studies that show decreased future orthopedic surgery in those who have had stem cell therapy
- Stem cell treatment is not proven to lead to regrowth of articular cartilage
- Stem cell injection does carry some clinical risks, including infection of the joint or the bone marrow harvesting site
- Covering this therapy outside of controlled clinical trials could lead to fewer people participating in such trials, lowering the likelihood of determining whether this therapy is genuinely effective in the near future

See Appendix for references to the above studies.

Currently, stem cell therapy is not covered by any major health insurance payers

- Stem cell therapy for orthopedic treatment is currently NOT covered by:
  - Medicare
  - Medicaid
  - Any of the national health plans
- Most stem cell therapy for orthopedic treatment is paid for out of pocket by patients
  - Costs of this treatment can be high, with many procedures costing around $5,000 to $7,000

WTW point-of-view: stem cell therapy

- Stem cell therapy for orthopedic complaints is widely regarded as investigational and experimental
- Claims that providing coverage for this procedure will decrease costs of orthopedic surgery are not proven and clients should be very skeptical of these claims
- Clients should strongly consider waiting until their health plan's technology assessment process recommends coverage for this and other experimental procedures
- Clients should consult with their legal counsel before adding coverage for this set of procedures to their plan coverage
    - Any change should be consistent with a new plan year and not implemented off cycle

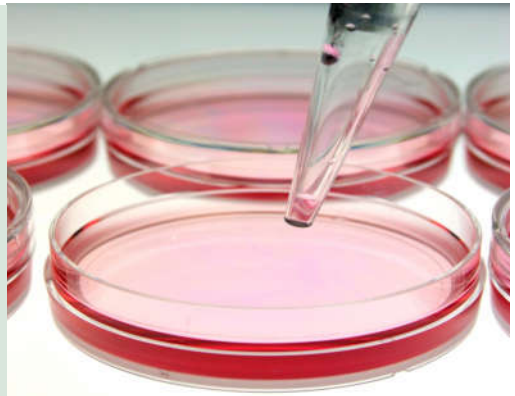
Cell and Gene Therapy (CGT)

Achieving normal expression and function of cells makes a big impact on our overall health

Gene Therapy

- Introduction, removal or change in genetic material in the cells of a patient to treat an inherited or developed disease
- Genetic material, such as a working copy of a gene, is transferred into the target cell using a vector
  - A vector is often a virus, but the genes that could cause disease are removed
- Once in the cell, a working copy of the gene will help make functioning proteins despite the presence of a faulty gene

Examples include Zolgensma and Luxturna®



Cell Therapy

- Cells are removed from the patient, then a new gene is introduced, or a faulty gene can be corrected
- A vector is used to deliver the new, properly functioning genes into the cells
- These genetically modified cells are put back into the body with the goal of improving a disease
- Over time, these cells multiply, so the new genetic material cures or treats the condition

Examples include Tecartus™, Kymriah® and Yescarta®

Source: American Society of Gene + Cell Therapy: https://www.asgct.org/education/different-approaches

Cell and Gene Therapy (CGT)

Background

- CGTs can represent significant advances in medicine, potentially curing a condition or disease with one-time administration
- These drugs often require costly inpatient or other care
- Distribution of CGTs has been historically limited to a few specialty pharmacies, some of which are owned by PBMs and health plans
- Costs of drugs or services under the medical benefit vary based on differing reimbursement rates among health plan vendors and billing practices of authorized treatment centers
- Nine CGTs have been approved, and Zynteglo® costs $2.8M for a one-time treatment. Future CGTs will likely have high prices with similar distribution, administration and management considerations

WTW solicited feedback on the coverage of gene therapies from a variety of PBMs and health plans

- Most PBMs do not have access to the current gene therapy drugs and are directing coverage to health plans
- If a PBM has access to a drug in this category, medical vs. pharmacy coverage options can be explored to determine where cost-versus-benefits for members and the plan intersect
- PBMs and health plans are incorporating prior authorization and exploring value-based contracts where payments are tied to positive health outcomes
- Unique payment models are being developed

CGT coverage by vendor

Data provided by vendors as of 8/1/2022

Vendor	Lymphomas				Myelomas		Ocular	SMA[1]	Beta-Thal	Additional Management
	Breyanzi	Kymriah	Tecartus	Yescarta	Abecma	Carvykti	Luxturna	Zolgensma	Zynteglo	
Aetna	PA	PA	PA	PA	PA	PA	PA; SOC	PA; SOC	TBD	• SOC redirection for administration at a facility within Aetna's designated network, with case-specific pricing negotiations and travel/lodging support for members
CVS	Client can choose to cover or exclude (opt into CVS 'Medical Benefit Only Strategy'); standard PA available									• Stop loss offering leveraging Aetna provider network • Installment payment plan for drugs dispensed through CVS Specialty
Highmark	PA; SOC	PA; SOC	PA; SOC	PA; SOC	PA; SOC	PA; SOC	PA; SOC	PA; SOC	TBD	• Use data to identify potential gene therapy utilizers to prepare for costs

PA = prior authorization; SL = stop loss; SMA = spinal muscular atrophy; SOC = site of care redirection; TBD = to be determined pending follow-up responses from vendors.

- Data provided by vendors in response to a national WTW request-for-information (RFI) and **does not necessarily** reflect coverage details specific to the State of Delaware's GHIP

1 SMA = spinal muscular atrophy.

Next steps: gene therapy

- Request modeling from the GHIP medical carriers and PBM to obtain projections of gene and cell therapies in the pipeline
  - Modeling is good at capturing those with existing diagnoses who might be candidates for future gene therapy but will not capture genetic diseases not yet diagnosed or future newborns who might be candidates for future genetic therapy
  - Modeling may capture all members with a diagnosis, but only a subset would be appropriate for the gene or cell therapy in question

- Further discussion with the Subcommittees on strategies for continued clinical and financial management associated with gene and cell therapies in the pipeline

Appendix

Illustrative modeling: copay changes for basic imaging

- Copay changes for non-preferred sites of care for basic imaging services are modeled below
- Cost avoidance to the GHIP was modeled based on CY21 utilization[1] and reflects the impact of increasing the non-preferred copay
  - Does not reflect any change in utilization to a preferred site of care, but would expect some utilization to shift to freestanding facilities
  - Potential cost avoidance ranges from about $150,000 to $740,000 annually with an increase to the non-preferred copay

Hospital outpatient (non-preferred site of care)	Current	Option 1	Option 2	Option 3	Benchmark[2]
Copay	$50	$55	$65	$75	$300
Potential cost avoidance (n = 29,667 basic imaging services)	$0	($148,335)	($445,005)	($741,675)	($7,416,750)

Matches current high-tech imaging copay for the same site of care (hospital outpatient)

The average cost/visit paid by the plan was $258 during CY21.

From CY19 to CY21, there was a modest reduction in use of non-preferred site of care relative to overall use of outpatient basic imaging services.

1 Data presented at the August 18, 2022 combined Subcommittee meeting. https://dhr.delaware.gov/benefits/sebc/documents/sub-comm-2022/0818-site-of-care.pdf
2 Calculated from 2022 WTW Financial Benchmarks Survey, Government/Public Sector/Education industry cut, PPO/POS plans. Benchmark reflects average cost/visit for all types of imaging services (basic and high-tech combined) and all sites of care.

Illustrative modeling: copay changes for high-tech imaging

- Copay changes for non-preferred sites of care for high-tech imaging services are modeled below
- Cost avoidance to the GHIP was modeled based on CY21 utilization[1] and reflects the impact of increasing the non-preferred copay
  - Does not reflect any change in utilization to a preferred site of care, but would expect some utilization to shift to freestanding facilities
  - Potential cost avoidance ranges from about $180,000 to $545,000 annually with an increase to the non-preferred copay

Hospital outpatient (non-preferred site of care)	Current	Option 1	Option 2	Option 3	Benchmark[2]
Copay	$75	$100	$125	$150	$300
Potential cost avoidance (n = 7,278 high-tech imaging services)	$0	($181,950)	($363,900)	($545,850)	($1,637,550)

The average cost/visit paid by the plan was $1,979 during CY21.

From CY19 to CY21, there was a modest reduction in use of non-preferred site of care relative to overall use of outpatient high-tech imaging services.

1 Data presented at the August 18, 2022 combined Subcommittee meeting. https://dhr.delaware.gov/benefits/sebc/documents/sub-comm-2022/0818-site-of-care.pdf
2 Calculated from 2022 WTW Financial Benchmarks Survey, Government/Public Sector/Education industry cut, PPO/POS plans. Benchmark reflects average cost/visit for all types of imaging services (basic and high-tech combined) and all sites of care.

Illustrative modeling: copay changes for lab services

- Copay changes for non-preferred sites of care for lab services are modeled below
- Cost avoidance to the GHIP was modeled based on CY21 utilization[1] and reflects the impact of increasing the non-preferred copay
  - Does not reflect any change in utilization to a preferred site of care, but would expect some utilization to shift to independent labs
  - Potential cost avoidance ranges from about $300,000 to $900,000 annually with an increase to the non-preferred copay

Hospital outpatient lab (non-preferred site of care)	Current	Option 1	Option 2	Option 3	Benchmark[2]
Copay	$50	$55	$60	$65	Not available
Potential cost avoidance (n = 60,510 lab services)	$0	($302,550)	($605,100)	($907,650)	n/a

The average cost/visit paid by the plan was $106 during CY21.

From CY19 to CY21, there was a modest reduction in use of non-preferred site of care relative to overall use of outpatient lab services.

1 Data presented at the August 18, 2022 combined Subcommittee meeting. https://dhr.delaware.gov/benefits/sebc/documents/sub-comm-2022/0818-site-of-care.pdf
2 Benchmark data for lab services is not available.

Illustrative modeling: copay changes for emergency room

- Copay changes for the emergency room are modeled below
- Cost avoidance to the GHIP was modeled based on CY21 utilization[1] and reflects the impact of increasing the emergency room (ER) visit cost
  - Does not reflect any change in utilization to a preferred site of care, but would expect some utilization to shift to urgent care centers and PCPs for non-emergent / primary care treatable conditions
  - Potential cost avoidance ranges from about $265,000 to $800,000 annually with an increase to the ER copay

Emergency room	Current	Option 1	Option 2	Option 3	Benchmark[2]
Copay	$200	$225	$250	$275	$150
Potential cost avoidance (n = 10,677 ER visits for non-emergent/primary care treatable conditions)	$0	($266,925)	($533,850)	($800,775)	+$533,850 (would add cost to the plan – not recommended)

The average cost/visit paid by the plan was $1,377 during CY21.

ER utilization for non-emergent/primary care treatable conditions was consistently 6% of total visits during CY19-CY21

1 Data presented at the August 18, 2022 combined Subcommittee meeting. https://dhr.delaware.gov/benefits/sebc/documents/sub-comm-2022/0818-site-of-care.pdf
2 Calculated from 2022 WTW Financial Benchmarks Survey, Government/Public Sector/Education industry cut, PPO/POS plans.

Illustrative modeling: copay changes for outpatient surgery at a hospital

- Copay changes for outpatient surgery at a hospital are modeled below
- Cost avoidance to the GHIP was modeled based on utilization data for the 12 months ending in April 2022 provided by Merative and reflects the impact of increasing the visit cost only
  - Does not reflect any change in utilization to a preferred site of care, but would expect some utilization to shift to ambulatory surgery centers
  - Merative data reflects non-preventive procedures, filtered by those procedures that have been conducted in both outpatient hospital and ambulatory surgery center (ASC) settings and that have a higher number of procedures conducted in the outpatient hospital place of service; total number of procedures was adjusted to reflect estimated number performed on an in-network basis under PPO and HMO plans only
  - Potential cost avoidance ranges from about $76,000 to $228,000 annually with an increase to the hospital outpatient surgery copay

Hospital outpatient surgery (non-preferred site of care)	Current	Option 1	Option 2	Option 3	Benchmark[1]
Copay	$100	$150	$200	$250	$150
Potential cost avoidance (n = 1,520 outpatient surgeries conducted at hospitals that could have been conducted at ASCs)	$0	($76,000)	($152,000)	($228,000)	($76,000)

1 Calculated from 2022 WTW Financial Benchmarks Survey, Government/Public Sector/Education industry cut, PPO/POS plans. Benchmark reflects average cost/visit for all sites of care (hospital and ambulatory surgery center.

Care facilities in Delaware that are independent vs. hospital-owned

Sources

	Aetna	Highmark
Basic Imaging **(X-rays, ultrasounds)** ▪ In-network non-hospital affiliated freestanding facility (preferred) ▪ Hospital-based facility	▪ Preferred imaging centers (data as of 8/31/2022): https://dhr.delaware.gov/benefits/medical/documents/aetna/aetna-imaging.pdf?ver=0912 ▪ Hospital-based facilities: https://www.aetna.com/dsepublic/#/contentPage?page=providerSearchLanding&site_id=statede	▪ Preferred imaging centers (data as of 10/1/2020): https://dhr.delaware.gov/benefits/medical/documents/highmark/imaging-locations.pdf?ver=0803 ▪ Hospital-based facilities: https://www.highmarkbcbsde.com/login/#/find-a-doctor
High Tech Imaging **(MRI, CT, PET scan)** ▪ In-network non-hospital affiliated freestanding facility (preferred) ▪ Hospital-based facility	▪ Preferred imaging centers (data as of 8/31/2022): https://dhr.delaware.gov/benefits/medical/documents/aetna/aetna-imaging.pdf?ver=0912 ▪ Hospital-based facilities: https://www.aetna.com/dsepublic/#/contentPage?page=providerSearchLanding&site_id=statede	▪ Preferred imaging centers (data as of 10/1/2020): https://dhr.delaware.gov/benefits/medical/documents/highmark/imaging-locations.pdf?ver=0803 ▪ Hospital-based facilities: https://www.highmarkbcbsde.com/login/#/find-a-doctor
Outpatient Lab ▪ In-network non-hospital affiliated preferred lab ▪ Other lab	▪ Preferred labs (data as of 8/31/2022): https://dhr.delaware.gov/benefits/medical/documents/aetna/aetna-labs.pdf?ver=0912 ▪ Non-preferred labs: https://www.aetna.com/dsepublic/#/contentPage?page=providerSearchLanding&site_id=statede	▪ Preferred labs (data as of 7/1/2021): https://dhr.delaware.gov/benefits/medical/documents/highmark/lab-locations.pdf?ver=0803 ▪ Non-preferred labs: https://www.highmarkbcbsde.com/login/#/find-a-doctor
Emergency / Urgent Care ▪ Urgent Care ▪ Emergency Room	▪ Urgent care (data as of 8/31/2022): https://dhr.delaware.gov/benefits/medical/documents/aetna/urgent-care-centers.pdf?ver=0912	▪ Urgent care (data as of 7/2021): https://dhr.delaware.gov/benefits/medical/documents/highmark/urgent-care-centers.pdf?ver=0803

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