FY24 Planning

The State of Delaware – Combined Subcommittee Meeting

November 17, 2022

Disclaimer

Willis Towers Watson has prepared this information solely in our capacity as consultants under the terms of our engagement with you with knowledge and experience in the industry and not as legal advice. This information is exclusively for the State of Delaware's State Employee Benefits Committee to use in the management, oversight and administration of your state employee group health program. It may not be suitable for use in any other context or for any other purpose and we accept no responsibility for any such use.

Willis Towers Watson is not a law firm and therefore cannot provide legal or tax advice. This document was prepared for information purposes only and it should not be considered a substitute for specific professional advice. As such, we recommend that you discuss this document with your legal counsel and other relevant professional advisers before adopting or implementing its contents. This document is based on information available to Willis Towers Watson as of the date of delivery and does not account for subsequent developments after that date.

Willis Towers Watson shares available medical and pharmacy research and the views of our health management practitioners in our capacity as a benefits consultant. We do not practice medicine or provide medical, drug, or legal advice, and encourage our clients to consult with both their legal counsel and qualified health advisors as they consider implementing various health improvement and wellness initiatives.

This material was not prepared for use by any other party and may not address their needs, concerns or objectives. This document may not be reproduced, disclosed or distributed to any other party, whether in whole or in part, other than as agreed with you in writing, except as may be required by law.

We do not assume any responsibility, or accept any duty of care or liability to any other party who may obtain a copy of this material and any reliance placed by such party on it is entirely at their own risk.

Contents

- Continued discussion from October meeting
- CVS PrudentRx program

Continued discussion from October 2022 meeting

General update and next steps

- The FY24 planning topics from the October combined Subcommittee meeting (see box to the right) will be discussed with the SEBC at the November 21 meeting alongside other planning items that have recently surfaced with the Subcommittees
- The SEBC will provide direction on which topics the Subcommittees should focus on from December 2022 through March 2023 so FY24 decisions can be finalized in time for Open Enrollment and so the GHIP budget for FY24 can be finalized
- Updates will be provided to the Subcommittees in December regarding the SEBC's feedback on the near-term areas of focus for the Subcommittees
- Information on follow-up questions asked at the October Subcommittee meeting follows

FY24 Planning topics from the October 2022 Combined Subcommittee meeting:

- 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
  - Stem cell therapy for orthopedic conditions and degenerative diseases
  - Genetic therapy

Actuarial analysis of pre-65 rates and costs

- Prior discussion at the October Subcommittee meeting included commentary that if the pre-65 population is rated separately from active employees, action would be necessary to mitigate the rate increase for pre-65 retirees
- Additional cost saving options for the pre-65 retirees were discussed, notably, providing a Health Reimbursement Account (HRA) and offering retirees coverage in the pre-65 retiree marketplace, where premium tax credits for lower income members could result in cheaper coverage options of similar quality available in the Affordable Care Act (ACA) Marketplace
- Pending SEBC feedback on how this topic is prioritized, additional analysis of the availability of ACA tax credits to support lower income pre-65 retirees who purchase medical coverage on the ACA marketplace can be provided at a future meeting

Plan design alternatives

- Prior discussion at the October Subcommittee included Subcommittee members asking about other interventions outside of plan design changes that could reduce costs for the GHIP and plan participants; these interventions included:
  - Implementing a high deductible health plan with an HSA (“HSA plan”)
  - Direct contracting with a hospital system
  - Reference-based pricing
  - Removing the medical TPAs and administering the medical plans in-house
- These additional interventions will be discussed with the SEBC at the November 21 meeting where the SEBC will be requested to provide direction on which topics should be prioritized for short- and long-term consideration
- Updates on what other states are doing regarding hospital reference-based pricing and direct contracting follows

Overview of states' hospital reference-based pricing to Medicare initiatives

Bolded State / Covered Programs = State Employee Health Plan

State	Calendar Year Adopted	Mechanism	Covered Programs	Number of Covered Facilities/Entities	Rates Established (as multiple of Medicare rates)
Colorado	2021 (coverage effective 1/1/23)	Legislation	Colorado Standardized Health Benefit Plan	n/a	In cases where the negotiated rate does not allow for the premiums and network adequacy requirements set by the legislation: a minimum of 155% of Medicare for hospitals Certain types of hospitals are eligible for adjustments that increase their baseline rates: ranging from +20% for essential hospitals (rural with 25 or fewer beds) OR independent hospitals to +55% for pediatric hospitals (not eligible for other adjustments)
Montana	2014 (coverage effective 7/1/16)	Contracts	**State of Montana (Employee) Benefit Plan**	11 acute care hospitals	Hospital inpatient range: 220% to 225% of Medicare Hospital outpatient range: 230% to 250% of Medicare
North Carolina	2020 (coverage effective 1/1/21)	Contracts	**State Health Plan for Teachers and State Employees**	26,000 providers including 5 hospitals	196% of Medicare hospital inpatient/outpatient aggregate
Nevada	2021 (coverage effective 1/1/26)	Legislation	Nevada Public Option	n/a	Specific reimbursement rate not established under legislation; in the aggregate, reimbursements under the public option must be comparable to, or "better than," those paid by Medicare
Oregon	2017 (effective 10/1/19 for OEBB and 1/1/20 for PEBB)	Legislation	**Public Employees' Benefit Board (PEBB); Oregon Educators Benefit Board (OEBB)**	24 large, urban hospitals Exempted: Type A or B hospitals, Critical Access Hospitals (CAH), or Sole Community Hospitals (SCH) in county of less than 70,000 people with Medicare comprising over 40% of patient revenue	200% of Medicare in-network cap and 185% of Medicare out-of-network cap on hospital inpatient and outpatient services and supplies
Washington	2019 (coverage effective 1/1/21)	Legislation	Cascade Care public option insurance plans	Plans carried by 5 insurers across 19 counties	160% of Medicare aggregate to providers and facilities 101% of Medicare floor for critical access hospitals and sole community hospitals 135% of Medicare floor for primary care services

Source: Adapted from https://www.nashp.org/overview-of-states-hospital-reference-based-pricing-to-medicare-initiatives/

Overview of states' use of direct contracting in the past three years

- Georgetown University's Center on Health Insurance Reforms published a report in 2021 containing findings from a survey of 47 state employee health plan (SEHP) administrators and in-depth interviews with 11 of them
- Fourteen (14) states reported engaging in direct negotiations or contracting with providers in the last three years
  - The report did not provide further detail on the nature of each direct contract across these 14 states
  - Based on other publicly available information, some of these states' direct contracts were established through negotiations directly between the state and providers (such as in Montana and North Carolina) for a broad set of health care services, whereas others may be for a narrower set of services with high quality provider "centers of excellence"
- Key benefits and challenges noted in the report:
  - One state using direct contracting across all services and providers cited this approach as its "primary source of savings" and reported "minimal friction with providers"
  - Another state reported ability to negotiate a "preferential government rate" for state employees and teachers plans
  - Challenges included difficulty finding TPAs to administer the direct contracts, as well as provider market consolidation and provider shortages that limited SEHPs' negotiating leverage
  - "Many states are dominated by a very small number of 'must have' hospital systems, such that efforts to engage in direct contracting or offer a narrow network plan wouldn't generate much in savings."

Source: https://sehpcostcontainment.chir.georgetown.edu/documents/SEHP-report-final.pdf

Plan design alternatives

PrudentRx (for non-Medicare medical plan options only)

In-Network Pharmacies **(Out-of-Network Pharmacies not covered except in travel emergency situations)**	**Current State** **(PPO, HMO, CDH Gold, First State Basic plans)**	**Under PrudentRx** **(PPO, HMO, CDH Gold, First State Basic plans)**
Annual Rx Deductible	None	None
Member Cost-sharing (Retail / Mail Order) Tier 1 – Generics Tier 2 – Preferred Tier 3 – Non-Preferred	 $8 / $16 $28 / $56 $50 / $100	 $8 / $16 $28 / $56 $50 / $100 Drugs on Exclusive Specialty List (excluding HIV and fertility drugs): • *If opted into PrudentRx (and regardless of whether a drug manufacturer copay card program is available for a member's specialty drug):* $0 • *If opted out of PrudentRx:* 30% coinsurance (*see box to right)
Annual Rx Out-of-Pocket Maximum	$2,100 per employee $4,200 per family	$2,100 per employee $4,200 per family *Excludes member payments toward 30% coinsurance for specialty drugs listed as non-EHB (*see box to right), unless otherwise required by applicable law.*
Infertility Rx Maximum	$15,000 lifetime	$15,000 lifetime

*PrudentRx uses Affordable Care Act standards for essential health benefits (EHB) and maximum out-of-pocket limits; drug classifications and the required number of drugs considered EHB are characterized by state benchmarks, and PrudentRx uses the Utah state benchmark (not customizable).

Site of care steerage

- Prior discussion at the October Subcommittee included commentary that ongoing discussions with the medical carriers were in progress 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
- Additional details provided by the medical carriers are follows:
  - Emergency room post-authorization process: neither recommended nor able to operationalize. Conflicts with the “prudent layperson” standard around use of the emergency room that both carriers follow.
  - Plan design that varies based on place and type of service:
    - *Example: A high-tech radiology procedure performed at a freestanding facility would have a copay, but the same procedure at an outpatient hospital would be subject to coinsurance*
    - May be a possibility for the carriers to administer, though further refinement of the specific design provisions (including the impact of a deductible on copays and coinsurance) and system testing would be required to confirm whether a specific benefit design can be administered successfully

SurgeryPlus carve-out opportunities beyond bariatric surgery

- This topic was included but not discussed at the October combined Subcommittee meeting
  - Appendix includes the slides on this topic from the October meeting
- Will be discussed with the SEBC at the November 21 meeting alongside other planning items that have recently surfaced with the Subcommittees
- The SEBC will provide direction on which topics the Subcommittees should focus on from December 2022 through March 2023 so FY24 decisions can be finalized in time for Open Enrollment and so the GHIP budget for FY24 can be finalized
- Updates will be provided to the Subcommittees in December regarding the SEBC's feedback on the near-term areas of focus for the Subcommittees

Other emerging treatments

- This topic was included but not discussed at the October combined Subcommittee meeting
  - Appendix includes the slides on this topic from the October meeting
  - Included two areas of discussion: stem cell therapy for orthopedic conditions and degenerative diseases and cell and gene therapy
- Will be discussed with the SEBC at the November 21 meeting alongside other planning items that have recently surfaced with the Subcommittees
- The SEBC will provide direction on which topics the Subcommittees should focus on from December 2022 through March 2023 so FY24 decisions can be finalized in time for Open Enrollment and so the GHIP budget for FY24 can be finalized
- Updates will be provided to the Subcommittees in December regarding the SEBC's feedback on the near-term areas of focus for the Subcommittees

CVS PrudentRx Program

Appendix

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

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

Coverage through Medical carrier

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

Appendix

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 following page for references to the above studies.

References: stem cell therapy

- US Food and Drug Administration, "FDA Warns About Stem Cell Therapies" FDA, 2017 LINK
- Marks, PW, Witten, CM, Califf, RM "Clarifying Stem Cell Therapy's Benefits and Risks, New Engl J Med 2017, 376:1007 LINK
- Rubin, R, “Unproven but Profitable: the Boom in US Stem Cell Clinics” Journal of the American Medical Association 2018; 320: 1421 LINK
- Shapiro, SA, Kazmerchak, SE, Heckman, MG "A Prospective, Single-Blind, Placebo-Controlled Trial of Bone Marrow Aspirate Concentrate for Knee Osteoarthritis" AJ Sports Med 2017, 45: 82 LINK
- Akpancar, S, Tatar, O, Turgut, H et al "The Current Perspectives of Stem Cell Therapy in Orthopedic Surgery" Arch Trauma Res 2016, 5:e37976 LINK
- Im, GI "Clinical Use of Stem Cells in Orthopaedics" European Cells and Materials 2017; 33:183 LINK
- McFarling, UL "FDA moves to crack down on unproven stem cell therapies" StatNews 2016 LINK

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

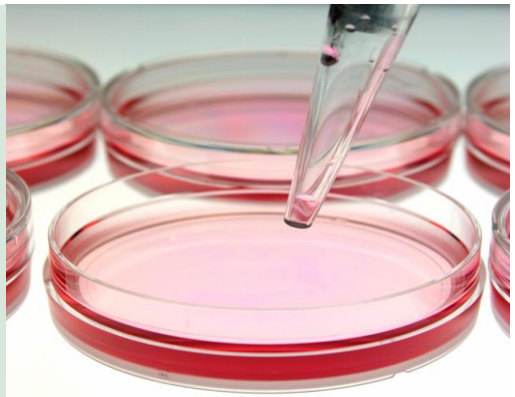
Cell and Gene Therapy (CGT)

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