The State of Delaware

FY24 Planning

SEBC Combined Subcommittee Meeting

December 15, 2022

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Updates provided to the SEBC in November 2022

Benefits Modernization Initiative /
Employee Preferences Survey

Modernizing benefits initiative

Overview

- At the June 2022 SEBC meeting, an overview of this project was provided to the Committee
  - U.S. employee preferences are changing, and employers are re-evaluating and adjusting benefit offerings to meet employee needs
  - Like other employers, the State of Delaware is experiencing employee attraction and retention challenges, and evolving workforce demographics
  - SEBC is tasked with solving for the needs of both employees and retirees, ideally within the existing State funding
  - Opportunity exists to refine the benefits offered to employees and future retirees to ensure they continue to meet the needs of the State's diverse and changing workforce while allowing the State to continue attracting/retaining key talent
  - Would include a survey that would solicit input from State employees, higher education and school district personnel on benefits preferences and gaps for underserved populations
- Next steps
  - SEBC, SBO and WTW would work with the Subcommittees to evaluate options for GHIP benefits modernization for active employees and non-Medicare (pre-65) retirees
  - Recommendations would be brought before the SEBC in early 2023 which would include timing for phased-in approach starting with FY24

Modernizing benefits initiative

Updates since June 2022

- Work on the employee survey began in August 2022
  - Work group includes representation from SBO, Finance, Office of Pensions, Office of the State Treasurer, and DHR; group was selected to provide input on various topics that could be included in the benefits survey (health care, leave, deferred compensation, professional development, etc.)
  - Would solicit feedback from employees on current benefits and gauge interest in future benefits
  - Would also include questions about potential changes to their benefits upon retirement, such as eligibility for retiree medical benefits and vesting, in alignment with areas for further study that were captured in the March 2022 recommendations of the Retirement Benefits Study Committee
- To prepare the Subcommittees for this work, an overview of the project was provided during the August 2022 combined Subcommittee meeting
- Also in August, Subcommittee members were also provided with pre-read materials outlining the components and pros and cons of flexible spending accounts, health savings and reimbursement accounts and lifestyle spending accounts, which was on the agenda for discussion at a future meeting
- Subcommittees met in September to explore further plan design updates; however, further work on the project and survey had been postponed, which was reported to the SEBC in September

Next steps

- Survey work has restarted; targeting release of survey to employees in Q1 CY2023
  - Preliminary results may inform some of the SEBC's decisions for the FY24 plan year, which are needed by March 2023 in order to implement in time for the start of FY24 (7/1/2023)
  - Results of detailed survey analysis will likely be available by Q3 CY2023 for consideration towards changes effective 7/1/2024 or later

- Further details on survey components and more specific timing will be provided to the SEBC in December
- SEBC to provide direction on prioritization of Subcommittee areas of focus related to modernizing benefits and other initiatives

Updates provided to the SEBC in November 2022

SEBC Update around Subcommittee Areas of Focus

Planning considerations for FY24 and beyond

Overview

- SEBC annual budget process and decisions on plan design/rate setting for the 2024 fiscal year (starts on July 1, 2023) must be completed no later than mid-March 2023
- Current long-term financial projections for the GHIP are reflecting a multi-year deficit; with no changes to current benefits, there is an inability to solve this deficit fully without additional funding
- The work of the Subcommittees is directed by the SEBC, which includes a thorough vetting of potential policy and plan changes culminating with recommendations on next steps to the SEBC
- Input from Subcommittee members during recent meetings has included topics that are not short-term in nature; included for discussion in today's material

Planning considerations for FY24 and beyond

- Following slides outline considerations for various initiatives that have been discussed in recent Subcommittee meetings, broken out by those initiatives with a shorter planning timeframe (i.e., effective 7/1/2023) and a longer planning timeframe (i.e., effective 7/1/2024 or later)
- Unless the SEBC provides direction otherwise, recommend that the Subcommittees continue focus on short-term items listed below to prepare recommendations for the SEBC no later than February 2023
- Suggest that further pursuit of longer-term items is paused pending resolution of items for FY24

Short-term: FY24

- PrudentRx
- Cell & gene therapies
- Plan design and drug formulary changes
- Plan design adjustments pending outcome of Inclusive Benefits Review
- Underwrite medical premiums separately for active employees and non-Medicare retirees

Long-term: FY25 or later

- Carving-out coverage of additional procedures to SurgeryPlus
- Implement a high deductible health plan with an HSA ("HSA plan")
- Primary care clinics
- Direct contracting with a hospital system
- Pre-65 marketplace
- Reference-based pricing
- Remove medical TPA(s) and administer plans in-house

Outcomes from this discussion with the SEBC in November 2022

- The Committee was in support of the Subcommittees continuing to focus on the short-term areas of opportunity for FY24 while pausing on further review of longer-term initiatives (for FY25 and later)
  - January and February SEBC meetings would include updates with feedback from the Subcommittees as FY24 planning discussions continue
  - Recommendations from the Subcommittees on proposed FY24 rate actions and program changes are required by February 2023, which allows the SEBC time to consider those recommendations prior to the March 2023 deadline for finalizing decisions for FY24

Next steps

- Additional discussion about the short-term initiatives for FY24 will continue throughout the next several Subcommittee meetings through February 2023

Short-term initiatives for FY24	Comments and questions for Subcommittee members
PrudentRx	• Further discussion of PrudentRx will take place today
Cell & gene therapies	• Overview will be provided today, for further study and discussion in January
Plan design and drug formulary changes	• Supports benefits modernization initiative through designing meaningfully different plan options • Recap of prior discussions and additional dialogue on drug formulary changes will be provided today
Plan design adjustments pending outcome of Inclusive Benefits Review	• Inclusive Benefits Review is in progress • Results of this review will be included for discussion at the January 2023 Subcommittee meetings
Underwrite medical premiums separately for active employees and non-Medicare retirees	• Previously discussed during the October 2022 combined Subcommittee meeting • Is there interest in continuing to evaluate as an FY24 solution?

- Longer-term initiatives for FY25 and later will be referenced during upcoming discussions with the SEBC about refreshing the GHIP Strategic Framework, starting in December 2022

PrudentRx

Follow-ups from last month's Subcommittee meeting

- Following last month's combined Subcommittee meeting, several questions were raised by a Subcommittee member regarding the program; responses to those questions follow below

Questions	Response
Why was the Utah State benchmark selected for PrudentRx? Is it more "limited" than other state benchmarks?	The Utah state benchmark plan has the lowest number of drugs that must be considered to be Essential Health Benefits (EHBs) per therapeutic class (relative to the other 49 state and District of Columbia benchmark plans). Under the Affordable Care Act (ACA), there is a maximum out-of-pocket limit for EHBs. A lower number of EHB prescription drugs allows programs like PrudentRx to include a greater number of non-EHB prescription drugs in the program (i.e., by increasing the out-of-pocket amounts for those drugs to 30% coinsurance) and deliver the more savings to plan sponsors.
Recognizing that the Utah state benchmark is not currently customizable, is there an option for plan sponsors to change the state benchmark selection in the future?	Per CVS, no, as this would necessitate maintaining multiple versions of the program design simultaneously.
Is the Utah benchmark aligned with the medical needs of Delaware citizens or does it reflect the medical needs of Utah citizens?	The publicly available details on the Utah state benchmark plan are not specific enough (i.e., doesn't contain drug-by-drug formulary listing) to allow an evaluation of how the EHB drugs within the Utah benchmark align with the GHIP's Rx utilization. Per CVS, the sole method by which the benchmark is utilized is to determine if a medication is EHB vs non-EHB, this will simply drive if accumulator dollars are factored in during adjudication.

Follow-ups from last month's Subcommittee meeting (continued)

- As requested by the Subcommittees during November's meeting, CVS is gathering data on other state plan sponsors that have adopted PrudentRx and their actual vs. expected savings
- The SBO recently connected with their benefits office counterparts within the State of Kentucky, which has previously implemented PrudentRx, for an update on their ongoing experience with the program
  - Key insights from the discussion included Kentucky's general satisfaction with the program's operations, member experience and the savings achieved by the plan

Recommendation for discussion

- Implement PrudentRx effective 7/1/2023 for non-Medicare medical plans (PPO, HMO, CDH Gold, First State Basic)
  - Reduces member out of pocket cost when members opt into the program
  - Program facilitates member enrollment in copay assistance programs and completes enrollment on member's behalf unless drug manufacturer requires direct involvement by the member
  - According to CVS, very few members opt out of the program and default to 30% coinsurance on specialty drugs
  - CVS-estimated net annual savings to the GHIP is $6.6M*; less than 2% of Commercial plan participants (about 1,600 members) utilize drugs that would be included in this program

- Do Subcommittee members have further questions regarding this program, or is there readiness to discuss making a recommendation to the SEBC?

*Excluding HIV and fertility medications; requires member engagement to enroll in the program, and savings estimate assumes 100% enrollment.

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

- A brief overview of selected emerging medical treatments was originally included in the October 2022 combined Subcommittee meeting materials, but was not presented at that meeting
- This overview included:
  - **Stem cell therapy** for orthopedic conditions and degenerative diseases including multiple sclerosis
  - **Cell and gene therapy (CGT)**

- Today's discussion will review this information

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

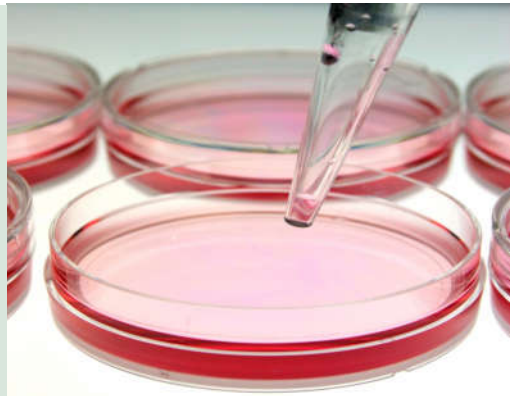
Cell and gene therapy

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
- Eleven CGTs have been approved (as of 12/1/2022), 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

Cell and gene therapy coverage by vendor

Data provided by vendors as of 12/1/2022

Vendor	Lymphomas				Myelomas		Ocular	SMA[1]	Beta-Thal	CALD[2]	Hemo-philia	Additional Management
	Breyanzi	Kymriah	Tecartus	Yescarta	Abecma	Carvykti	Luxturna	Zolgensma	Zynteglo	Skysona	Hemgenix	
Aetna	PA	PA	PA	PA	PA	PA	PA; SOC	PA; SOC	TBD	TBD	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	PA	PA	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.
2 CALD = Cerebral adrenoleukodystrophy.

Next steps: cell and gene therapy

- Modeling has been requested 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 at the January 2023 meeting

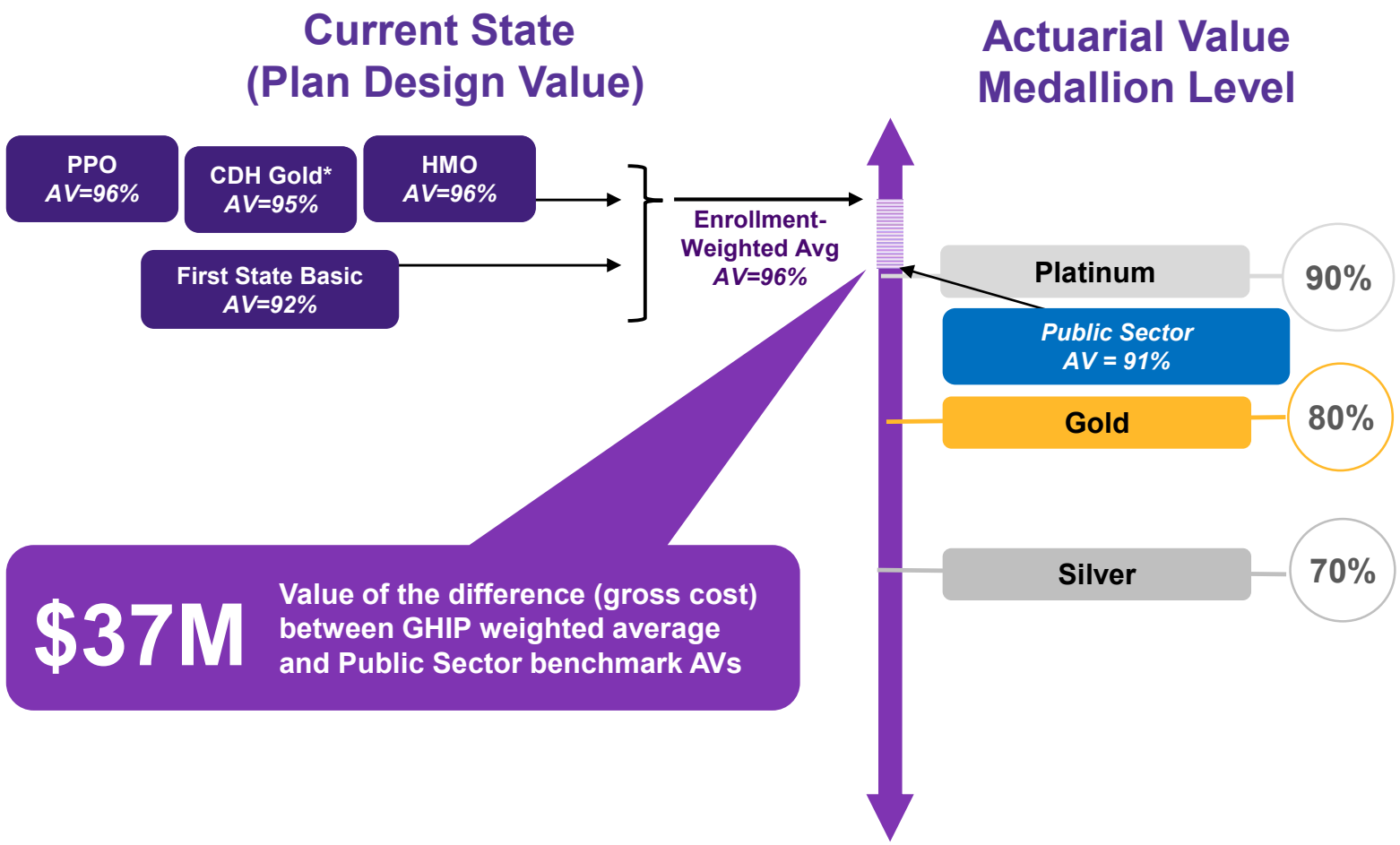
Plan design and drug formulary changes

Overview

- At the October 20, 2022 meeting, the Subcommittees reviewed data that compared the plan designs and actuarial values of the GHIP's non-Medicare health plans with benchmarks from the WTW 2022 Healthcare Financial Benchmarks Survey
  - This survey included over 965 companies and 61 government, public sector, and education companies' healthcare programs and analyzes the cost efficiency, employee cost sharing, account fund and incentives, and design of participating companies' medical plans
- Based on the SEBC's direction for the Subcommittees to continue reviewing plan design alternatives for potential FY24 recommendations, a recap of the plan design alternatives, including site-of-care steerage, discussed in October follows

Strategic Opportunities – Program Observations

Actuarial Value (AV)
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 Medical 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 medical deductible of listed amount to both the PPO and HMO plans, and increasing the existing medical 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

Question for Subcommittee members: **Is there any additional information you would like to review about this topic to support your readiness to consider making a recommendation to the SEBC?**

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 2020
- 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
  - See October 2022 Subcommittee meeting materials for more details

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) ▪ Hospital-based facility	 ▪ $0 copay ▪ $50 copay *(+$15 from FY19)*
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)*
Outpatient Lab ▪ In-network non-hospital affiliated preferred lab ▪ Other lab	 ▪ $10 copay ▪ $50 copay *(+$30 from FY19)*
Emergency / Urgent Care ▪ Urgent Care ▪ Emergency Room	 ▪ $15 HMO / $20 PPO ▪ $200 copay *(+$50 from FY19)*
Outpatient Surgeries (through medical carrier network provider) ▪ Ambulatory Surgery Center ▪ Hospital	 ▪ $50 copay ▪ $100 copay
In-network telemedicine provider through third-party vendors	▪ $0 copay[2] *(-$15 HMO / -$20 PPO from FY19)*

1 Includes employees, non-Medicare eligible pensioners and their covered dependents.
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.

Highlights copay change

Impact of increased site of care copays

Copays by type of service	HMO & PPO plans (effective since July 1, 2019)	WTW-modeled copay changes	Potential range of cost avoidance (annual, first year following change)[2]
Basic Imaging (X-rays, ultrasounds) ▪ In-network non-hospital affiliated freestanding facility (preferred) ▪ Hospital-based facility	▪ $0 copay ▪ $50 copay *(+$15 from FY19)*	▪ $0 copay ▪ $55 - $75 copay	$150,000 to $740,000
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)*	▪ $0 copay ▪ $100 - $150 copay (*)	$180,000 to $545,000
Outpatient Lab ▪ In-network non-hospital affiliated preferred lab ▪ Other lab	▪ $10 copay ▪ $50 copay *(+$30 from FY19)*	▪ $10 copay ▪ $55 - $65 copay	$300,000 to $900,000
Emergency / Urgent Care ▪ Urgent Care ▪ Emergency Room	▪ $15 HMO / $20 PPO ▪ $200 copay *(+$50 from FY19)*	▪ $15 HMO / $20 PPO ▪ $225 - $275 copay	$265,000 to $800,000
Outpatient Surgeries (through medical carrier network provider) ▪ Ambulatory Surgery Center ▪ Hospital	▪ $50 copay ▪ $100 copay	▪ $50 copay ▪ $150 - $250 copay (*)	$76,000 to $228,000[3]
In-network telemedicine provider through third-party vendors	▪ $0 copay[1] *(-$15 HMO / -$20 PPO from FY19)*	▪ No changes	n/a

Total cost avoidance (annual, first year following changes): $0.9M - $3.2M

(*) WTW-recommended changes only: $0.3M - $0.8M

Without additional communications to plan participants, level of cost avoidance may diminish in the subsequent years based on similar pattern observed previously among GHIP participants

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.
2 Assumes future utilization is consistent with CY21 experience
3 Does not reflect any change in utilization to a preferred site of care, but would expect some utilization to shift to ambulatory surgery centers.

Impact of increased site of care copays (continued)

Copays by type of service	WTW Comments
Basic Imaging (X-rays, ultrasounds) ▪ In-network non-hospital affiliated freestanding facility (preferred) ▪ Hospital-based facility	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.
High Tech Imaging (MRI, CT, PET scan) ▪ In-network non-hospital affiliated freestanding facility (preferred) ▪ Hospital-based facility	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.
Outpatient Lab ▪ In-network non-hospital affiliated preferred lab ▪ Other lab	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.
Emergency / Urgent Care ▪ Urgent Care ▪ Emergency Room	Potential range of cost avoidance in first year following change is based on ER use for non-emergent / primary care treatable conditions only.
Outpatient Surgeries (through medical carrier network provider) ▪ Ambulatory Surgery Center ▪ Hospital	These copays have not been increased in multiple years; consider increasing the copay for hospital-based outpatient surgeries. Further analysis would be necessary to evaluate member access to ambulatory surgery centers throughout Delaware.
In-network telemedicine provider through third-party vendors	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, though likely to be extended through April 2023), which was the impetus for lowering telemedicine copays initially.

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

Weight loss medications

Overview

- Over the past 12-18 months, the SBO has received numerous requests from plan participants and other stakeholders to add coverage of weight loss medications to the State Group Health Plan
  - An overview of weight loss medications and coverage cost estimates for the GHIP follows
- Trends in obesity prevalence among U.S. adults and youth continue to rise
  - 42% of U.S. adults reported undesired weight gain since the start of the pandemic, with an average of 29 pounds[1]
  - Over 30% of adults in the U.S. have obesity[2]
- Until recently, medical therapy for obesity has been far less successful than surgery
- A relatively new class of drugs, initially marketed for diabetes, is associated with weight loss that rivals bariatric surgery, although this weight is regained if the drugs are stopped; includes:
  - Liraglutide (approved in 2010 as Victoza for diabetes and in 2015 as Saxenda for weight loss)
  - Semaglutide (approved in 2017 as Ozempic and in 2019 Rybelsus for diabetes, and approved in 2021 as Wegovy for weight loss)
  - Tirzepatide (Mounjaro) was approved earlier this year and is on the market for type-2 diabetes and is likely expected to be approved for obesity by April 2023
- This class of drugs are very expensive, with some drugs carrying an average wholesale price of $15,000 annually (after rebates, range is $8,000 - $9,000 per year)

Sources: [1]https://www.apa.org/monitor/2021/07/extra-weight-covid, [2]https://www.cdc.gov/obesity/data/obesity-and-covid-19.html,

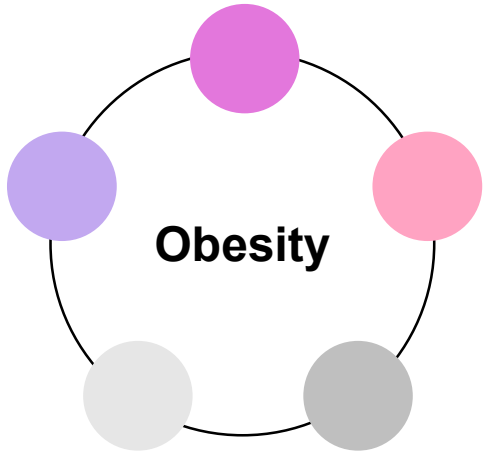
Weight loss medications are one aspect of a broader suite of weight loss options to support members with a diagnosis of obesity

Direct to consumer

- OTC and nutritional supplements
- Weight management and food vendors
- Medical tourism for medications and bariatric surgery
- Alternative interventions (e.g., hypnosis, acupuncture)

Behavioral health

- Complex interrelationship between obesity and mental health
- Adults who carry excess weight struggle with depression and other mental health disorders
- Effective treatment must take both obesity and mental health into account
- Intensive behavioral therapy is an important component of care for patients with obesity



Weight management vendors

- Behavior and lifestyle changes
- Nutrition and wellness coaching
- Financial incentives
- Combining techniques for holistic approach

Bariatric surgery

- Procedures range in complexity and require high quality facilities and trained staff to limit the risk of postoperative complications
- Requires lifestyle changes after surgery
- Has the highest degree of weight loss

Anti-obesity medications (AOM)

- FDA approved medications
- Medically supervised weight loss
- Intensive lifestyle therapy

Sources: https://www.fda.gov/media/130422/download, https://www.ncoa.org/article/how-excess-weight-impacts-our-mental-and-emotional-health.

Coverage considerations for weight loss medications

- According to CVS, 59% of their employer client book of business covers weight loss medications
  - State employer coverage of this drug class varies
  - Some do not cover, whereas most of those who do, implement utilization management controls (i.e., prior authorization) to ensure ongoing utilization is monitored for clinical appropriateness
- CVS also provided references to several clinical studies that support the benefits of weight loss medications:

Clinical Study Findings	Reference
Expected weight loss with lifestyle is 5–10%, and the addition of medications increases the likelihood of attaining clinically significant weight loss. While lifestyle-based interventions are at the foundation of any obesity treatment plan, we often see less success when used alone, in part due to the pathophysiology of obesity. Once obesity develops, metabolic adaptations and alterations in hunger and satiety signals often lead to weight regain. The purpose of medications is to help patients adhere to the reduced calorie diets by combating the body's mechanisms to resist weight loss. Typically, anti-obesity medications do this by controlling appetite and regulating hunger and satiety signals.	https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8300078/pdf/13679_2021_Article_444.pdf
In a 75-year simulation model for assessment of the impact anti-obesity medications for Medicare and Medicaid , it is estimated that the net fiscal benefits of broad anti-obesity medications use could be close to $750 billion over 75 years.	https://journals.sagepub.com/doi/full/10.1177/0046958021990516
One study modeling a 10-year period of widespread use of anti-obesity medications similarly found significant savings potential. In this study, for each beneficiary receiving anti-obesity medications, Medicare had the potential to save $6,842 to $7,155 over 10 years. Another study which modeled the impact of a 10% to 15% weight loss on Medicare spending over 10 years found gross savings per capita of $8,287 to $9,826, even when accounting for a weight rebound among most patients.	https://journals.sagepub.com/doi/full/10.1177/0046958021990516

Coverage considerations for weight loss medications (continued)

- CVS-estimated annual gross cost (before member cost sharing) to the GHIP for adding coverage of weight loss medications:
  - With no utilization management: $2,873,600
  - With utilization management: $1,778,800

- Cost estimates are based on CVS employer book of business utilization experience from April – June 2022
- Estimates do not account for any additional rebate value that may be earned on these medications

Question for Subcommittee members: **Is there any additional information you would like to review about this topic to support your readiness to consider making a recommendation to the SEBC?**

Next steps

- Subcommittee members to weigh in with feedback on:
  - Readiness to consider recommendation regarding PrudentRx
  - Additional plan design changes – including site-of-care copay changes – to be modeled for January
  - Interest in further exploring adding coverage of weight loss medications
  - Interest in continuing to evaluate underwriting medical premiums separately for active employees and non-Medicare retirees as a FY24 solution

- Additional analysis to be presented in January on:
  - Cost management strategies regarding emerging cell and gene therapies will be presented in January
  - GHIP member access to ambulatory surgery centers across Delaware
  - Findings of Inclusive Benefits Review

Appendix

SEBC Subcommittee Areas of Focus

Short-term initiatives: FY24

Initiative	Potential Scope of Impact		Pros	Cons
PrudentRx	**Medical plans**	PPO, HMO, CDH Gold, FSB	• Members who opt into the PrudentRx program can enjoy $0 copays (no member cost share) for specialty drugs, regardless of whether drug manufacturer copay assistance is available. (The cost of drugs with no copay assistance programs will be subsidized by the plan's net savings from drugs with copay assistance. According to PrudentRx, about 94% of specialty brand drug scripts have copay assistance.) • CVS-estimated net annual savings for PrudentRx is $6.6m (excluding HIV and fertility medications; requires member engagement to enroll in the program, and savings estimate assumes 100% enrollment)	• Requires the SEBC to create a new specialty drug coverage tier at 30% coinsurance (which reduces to $0 if a member enrolls in PrudentRx) • Requires members to take action to enroll in PrudentRx program when prompted by PrudentRx outreach, otherwise members will pay 30% coinsurance for the specialty drug • About 1,600 members in FY22 filled prescriptions that would be subject to the program (Rx count excludes fertility and HIV medications) • Members would lose the benefit of one "grace fill" at retail for all specialty drugs except HIV medication (which is available at any retail pharmacy through CVS's Open Network)
	GHIP participants	Active employees, non-Medicare pensioners (and covered dependents)		
	Potential effective date	7/1/2023 (FY24)		
Cell and Gene Therapies *Details from Aetna and Highmark on the number of members potentially impacted and the potential savings to the GHIP are being requested.*	**Medical plans**	PPO, HMO, CDH Gold, FSB	• Most of the major national and regional medical carriers have cost management strategies available to plan sponsors today, including utilization management such as prior authorization or site-of-care steerage; both Aetna and Highmark require prior authorization for these therapies today • As an optional program, Aetna offers a narrow network of providers with negotiated pricing and navigation and travel assistance to members for a subset of gene therapies	• If any of these drugs are being utilized by GHIP participants today, there would be the potential for member disruption as a result of these utilization management programs
	GHIP participants	Active employees, non-Medicare pensioners (and covered dependents)		
	Potential effective date	7/1/2023 (FY24)		

Short-term initiatives: FY24

Initiative	Potential Scope of Impact		Pros	Cons
Plan design and drug formulary changes *Includes but not limited to potential changes to the following elements of the medical/Rx plans: deductibles, coinsurance, copays, site-of-care steerage changes (copay changes, adding new services to steerage options such as ASCs[1]), weight management strategy (such as adding coverage for weight loss drugs to the drug formulary).*	**Medical plans**	PPO, HMO, CDH Gold, FSB	• Helps reduce magnitude of FY24 rate action (i.e., lowers required premium increase) • Only affects utilizers of medical/Rx benefit • Encourages health care consumerism by increasing member financial accountability for services incurred	• Produces plan savings through shifting a portion of cost to plan participants • May be more difficult for plan participants who are lower paid and/or on a fixed income to pay for necessary medical care • May cause some members to avoid seeking medical care out of concern for incurring additional out-of-pocket cost • Specifically for prescription drug formulary changes, may add cost to the plan for expanding coverage for weight loss medications
	GHIP participants	Active employees, non-Medicare pensioners (and covered dependents)		
	Potential effective date	7/1/2023 (FY24)		
Plan design adjustments pending outcome of Inclusive Benefits Review	**Medical plans**	PPO, HMO, CDH Gold, FSB	• Low/minimal cost impact changes given low utilization of plan design features that could potentially change (such as gender reassignment surgery), but high value for targeted underserved members of the GHIP • Supports the State's Inclusion and Diversity efforts • Increased wellbeing, engagement, and productivity for impacted members	• Not necessarily a cost savings item, and some recommendations may require a small cost investment
	GHIP participants	Active employees, non-Medicare pensioners (and covered dependents)		
	Potential effective date	7/1/2023 (FY24)		

1 ASCs = Ambulatory Surgery Centers.

Short-term initiatives: FY24

Initiative	Potential Scope of Impact		Pros	Cons
Underwrite medical premiums separately for active employees and non-Medicare retirees *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 FY22 Q4 financial report, pre-65 retirees cost significantly more than active employees on a per member per year (PMPY) basis ($10,752 vs. $6,924 PMPY, respectively). Based on current rating methodology, a 17.2% rate increase is needed 7/1/2023 for all statuses, plans and coverage tiers, to solve for the projected FY24 deficit of $143.5m (based on long-term projections presented to SEBC 11/21/22).*	**Medical plans**	PPO, HMO, CDH Gold, FSB	• 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 • Rating active and pre-65 retirees separately based on their own experience would lower the rate increase necessary for active employees to +10.5% (as of October 2022) • Reduction in active contributions relative to current rating methodology 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	• Rating active and pre-65 retirees separately based on their own experience would increase the rate increase necessary for non-Medicare retirees to +40.4% (as of October 2022)
	GHIP participants	Active employees, non-Medicare pensioners (and covered dependents)		
	Potential effective date	7/1/2023 (FY24)		

Appendix

References: stem cell therapy

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

Appendix

Illustrative modeling:
site of care steerage copay changes

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.