The State of Delaware

FY24 Planning

SEBC Health Policy & Planning Subcommittee Meeting

January 17, 2023

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Contents

- PrudentRx
- Other emerging treatments
  - Stem cell therapy for orthopedic conditions and degenerative diseases including multiple sclerosis
  - Cell and gene therapy (CGT)
- Plan design and drug formulary changes
  - Weight loss medications
  - Site of care steerage copays
  - Plan design alternatives

- Appendix
  - References: stem cell therapy
  - Illustrative modeling: site of care copay changes

Overview of today's discussion

- Today's presentation will focus on follow-up items from the December 2022 Subcommittee Meeting regarding:
  - PrudentRx
  - Selected emerging medical treatments:
    - Stem cell therapy for orthopedic conditions and degenerative diseases including multiple sclerosis
    - Cell and gene therapy (CGT)

- Material related to plan design and drug formulary changes that was originally prepared for the December 2022 Subcommittee meeting will also be reviewed today

- Regarding the two other planning topics for FY24 that had previously been discussed with the combined Subcommittees during the Fall 2022:
  - Actuarial analysis of pre-65 rates and costs and discussion of the pre-65 marketplace – noting this item as closed with no further consideration for FY24 (limited/no interest from Subcommittees in moving forward with splitting the active/pre-65 rates at this time)
  - SurgeryPlus carve-out opportunities beyond bariatric surgery – further evaluation of these opportunities will be conducted following completion of FY24 planning for a future effective date in FY25 or later

PrudentRx

Follow-up from last month's Subcommittee meeting

- As requested by the Subcommittees during December's meeting, CVS has provided a list of specialty drugs that would be subject to the PrudentRx program
  - This list was included in the meeting materials provided to Subcommittee members
- Details on GHIP member utilization of these drugs were discussed at prior Subcommittee meetings in the Fall 2022; as a refresher:
  - Approximately 1,600 Commercial plan members (1.6% of total active employee/non-Medicare retiree population) utilizing specialty drugs that would be subject to this program, based on latest analysis from CVS (November 2022)
    - Excludes HIV and fertility drugs – HIV drugs would continue to be filled at any pharmacy via CVS's Open Network, and fertility drugs would continue to be subject to a 25% coinsurance with $15K lifetime maximum
    - PrudentRx would not apply to the State's EGWP (Medicare retiree) population
  - The most common conditions for GHIP members using specialty drugs that would be affected by PrudentRx are:
    - Autoimmune
    - Multiple Sclerosis
    - Oncology
- Specialty drugs are usually high-cost prescription medications used to treat complex, chronic conditions like cancer, rheumatoid arthritis, and multiple sclerosis. They typically require special handling or safety protocols. Some specialty medications are appropriate only for limited conditions or certain patient characteristics

State benchmarks and PrudentRx

- Additional discussion occurred during last month's Subcommittee meeting about the PrudentRx program's use of the Utah state benchmark for essential health benefits, and how that would apply to the GHIP

- The framework for the PrudentRx program's plan design utilizes the Affordable Care Act (ACA) standards for essential health benefits and maximum out-of-pocket limits

What this means:

- The ACA introduced the concept of Essential Health Benefits (EHBs), which were later defined by the U.S. Department of Health and Human Services
- By definition, EHBs are items and services in 10 general categories of health benefits; "prescription drugs" is one category
- Under the ACA, self-insured group health plans like Delaware's GHIP are not required to cover EHBs; this requirement is limited to health insurance carriers offering coverage in the individual or small group market
- However, to the extent that a self-insured group health plan like the GHIP does cover an EHB, the ACA prohibits the imposition of any annual and lifetime dollar limits on the plan's coverage of that EHB; further, the plan must comply with maximum out-of-pocket limits that apply to member cost sharing

State benchmarks and PrudentRx (continued)

- The framework for the PrudentRx program's plan design utilizes the Affordable Care Act (ACA) standards for essential health benefits and maximum out-of-pocket limits

What this means – continued:

- These requirements for plan and member limits (annual, lifetime, maximum out-of-pocket) apply only to benefits designated as EHB
- Self-insured group health plans must determine which of the benefits covered by the plan are designated as EHB for purposes of complying with these limits; to do this:
  - The Department of Health and Human Services allows self-insured group health plans to define EHBs using "any available benchmark option, supplemented as needed to ensure coverage of all ten statutory categories [of EHBs]"
  - HHS has approved and authorized state benchmark plans in all 50 states
  - A self-insured group health plan is **not required** to:
    - use the benchmark plan of the state in which the plan or employer is headquartered,
    - use the benchmark plan of the state(s) in which members or employees reside,
    - adopt the design features (such as deductibles and copays) of the benchmark plan, or
    - cover all benefits included in the benchmark plan.

State benchmarks and PrudentRx (continued)

- The framework for the PrudentRx program's plan design utilizes the Affordable Care Act (ACA) standards for essential health benefits and maximum out-of-pocket limits

What this means – continued:

- State benchmark plans note the categories of drugs and the required minimum number of drugs to be considered EHB; however, they do not designate specific lists of drugs that are EHB
- PrudentRx uses the Utah state benchmark, which includes a limited number of specialty drugs that are defined as EHBs
  - Payments made on a member's behalf for the medications on the PrudentRx drug list, including amounts paid by a manufacturer's copay assistance program, will not count toward the member's maximum out-of-pocket limit, unless otherwise required by law (i.e., except for drugs designated as EHBs on the PrudentRx drug list)
  - Choosing a state benchmark that has fewer drugs characterized as EHBs on the state benchmark plan's formulary provides more opportunity to tap into manufacturer assistance programs for other specialty drugs that are not EHBs
- Plan sponsors who opt into PrudentRx cannot select a different state benchmark
- If the GHIP were to adopt PrudentRx, the plan formulary would not change (i.e., in the event there are any drugs on the PrudentRx drug list that are not on the GHIP's formulary, then the GHIP formulary would govern)

For discussion

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

- *Potential draft recommendation/rationale:*

  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 the net annual savings to plan participants is $358K and 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
  - Programs that utilize manufacturer copay assistance programs including PrudentRx are subject to continued availability of those funds available through drug manufacturers

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

Other emerging treatments

Follow-up from last month's Subcommittee meeting

- At the combined Subcommittee meeting in December 2022, a brief overview of selected emerging medical treatments was discussed

- This overview included:
  - **Stem cell therapy** for orthopedic conditions and degenerative diseases including multiple sclerosis
  - **Cell and gene therapy (CGT)**

- Subcommittee member comments and questions raised in December, for discussion today:
  - One member shared they recently received a joint therapy treatment called Vitti-Pure, which helped them avoid surgery, and inquired about opportunities to expand coverage of this treatment
  - One member asked about whether CRISPR technology has been used to develop any of the CGT

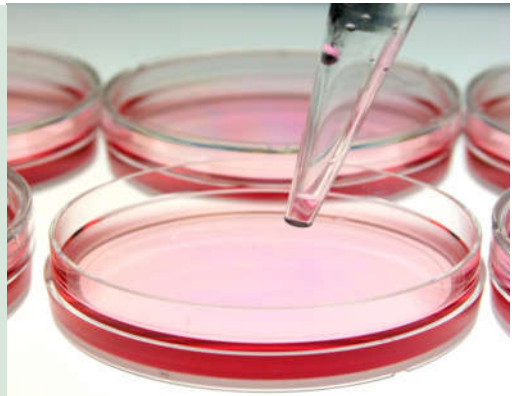
Cell and gene therapy

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 utilization under the GHIP

- The GHIP currently covers all of the cell and gene therapies noted below
- Utilization of these therapies under the GHIP is very low; only two plan participants utilized these services during FY22, and no members used these services during the first quarter of FY23 (July – September)
- Total plan payment of approximately $2,800 for FY22 reflect coordination of benefits with Medicare (primary payer)
  - If the GHIP were primary for these members, total plan cost would have been approximately $300,000
- Of note, Hemgenix was approved by the FDA on 11/22/2022 and is expected to hit the market rapidly
  - Hemgenix is the first gene therapy for hemophilia (with a price tag of $3.5M), which would replace ongoing treatment with a one-time administration
  - Currently, ongoing treatment costs for one patient averages about $282K per year
  - Based on FY2022 plan experience, the GHIP has 1 member with this condition, so it is possible the plan may pay up to $3.5M for Hemgenix treatment over the next year

	Lymphomas				Myelomas		Ocular	SMA[1]	Beta-Thal	CALD[2]	Hemo-philia	Comments
	Breyanzi	Kymriah	Tecartus	Yescarta	Abecma	Carvykti	Luxturna	Zolgensma	Zynteglo	Skysona	Hemgenix	
Unique utilizers, FY2022 (7/1/2021 - 6/30/2022)	0	1	0	1	0	0	0	0	N/A	N/A	N/A	Both members utilizing these treatments were covered under the GHIP as secondary (Medicare paid primary)
Net plan cost, FY2022 (7/1/2021 - 6/30/2022)	$0	$1,416.52	$0	$1,408.93	$0	$0	$0	$0	N/A	N/A	N/A	

1 SMA = spinal muscular atrophy.
2 CALD = Cerebral adrenoleukodystrophy.

Clinical and financial management opportunities for CGT

- Both medical carriers have utilization management protocols in place to ensure the clinical appropriateness of these services
  - Includes site-of-care steerage to most clinically appropriate place of service, with prior authorization required
- Aetna has an additional offering that is not in place today: a designated network, with case-specific pricing negotiations and travel/lodging support for members, called the Gene-Based, Cellular and other Innovative Therapies (GCIT) Network
  - National network of 130 centers of excellence delivering high quality care
  - Discounted pricing negotiated with CGT manufacturers, which limits provider mark-ups
  - Clinical care coordination team supports members through entire process, including assistance with travel plans and cost
  - No additional cost or administrative fees associated with adopting the GCIT network (shared savings associated with site-of-care steerage)

Question for Subcommittee members: **Is there interest in further exploring Aetna's GCIT Network?**

Plan design and drug formulary changes

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,

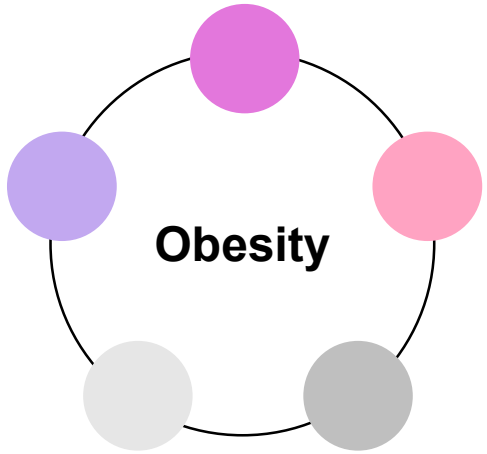
Weight loss medications are one aspect of a broader suite of weight loss options to support members with a diagnosis of obesity

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?**

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.

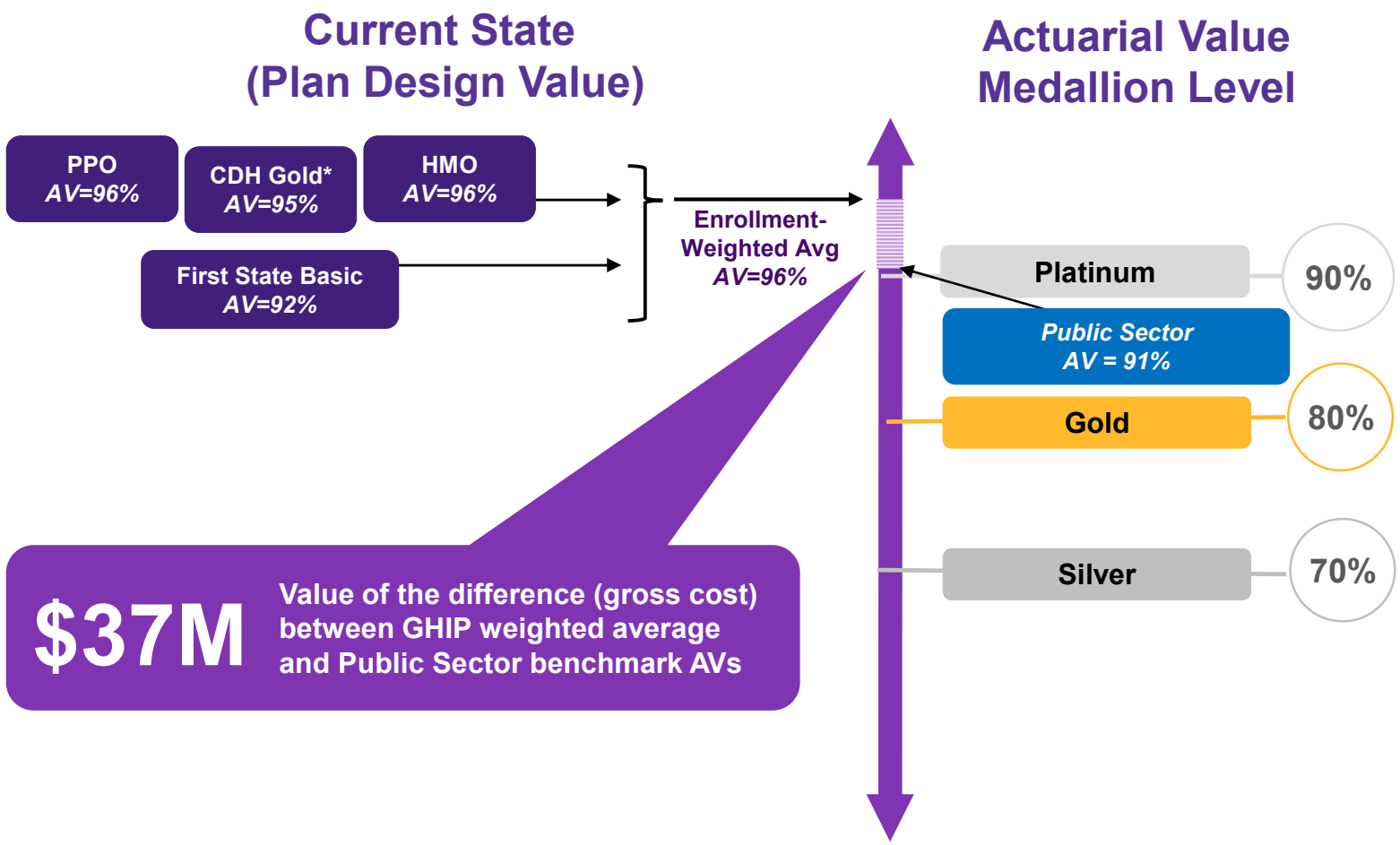
1 Data presented at the August 18, 2022 combined Subcommittee meeting. https://dhr.delaware.gov/benefits/sebc/documents/sub-comm-2022/0818-site-of-care.pdf

Other medical plan design changes

- 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 discussed in October follows
- Additional benchmarks were added that reflect a custom benchmark consisting of public and private sector employers (n=31) that have a portion of their medical-enrolled population residing in Delaware, to present another view into the benefit offerings of other employers with whom the State may be competing for talent

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)



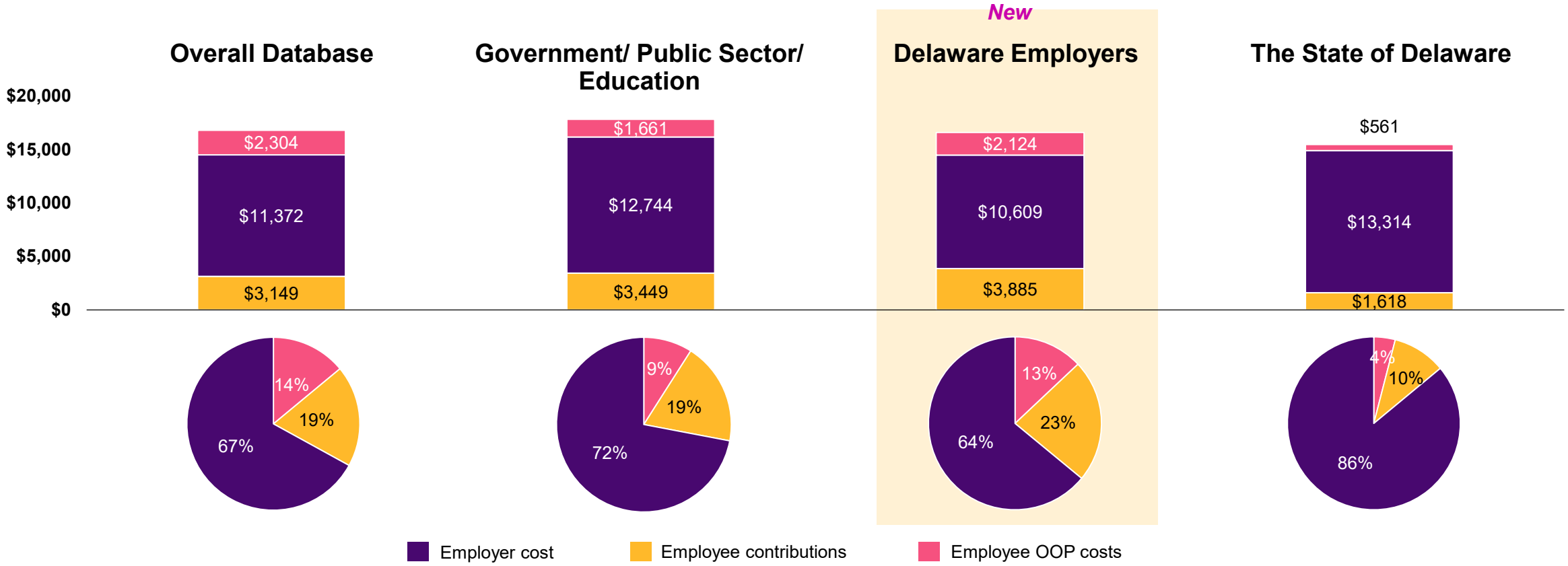
Observations

- 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

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 the overall database, industry and custom Delaware employer benchmarks (employees pay less in out-of-pocket expenses at the point of care)
- The State also subsidizes its plans at a higher rate than the benchmark averages

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?**

Next steps

- Subcommittee members to weigh in with feedback on:
  - Readiness to consider recommendation regarding PrudentRx
  - Interest in further exploring Aetna's GCIT Network
  - Interest in further exploring adding coverage of weight loss medications
  - Additional plan design changes – including site-of-care copay changes – to be modeled for February

- Additional analysis to be presented in February on:
  - GHIP member access to ambulatory surgery centers across Delaware
  - Findings of Inclusive Benefits Review

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.