The State of Delaware

FY24 Planning

SEBC Health Policy & Planning Subcommittee Meeting

February 13, 2023

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FY24 opportunities for consideration

Recap of recent discussions with the Subcommittees

- Due to the FY24 deficit, the SEBC has asked the Subcommittees to review alternatives that will generate GHIP plan savings and reduce the anticipated FY24 premium increase needed to solve for the projected $138.1M FY24 deficit
- Savings opportunities can come from, but are not limited to, the following alternatives:
  - Adoption of the PrudentRx program under CVS
  - Adoption of copay changes to promote site-of-care steerage to preferred sites of care
  - Adoption of Rx copay changes
- The following slides detail the potential savings associated with these alternatives
  - Savings estimates are intended to highlight the magnitude of program changes needed to solve for the projected FY24 deficit of $138.1m
  - Also summarized is the financial impact of other changes that will result in an initial and/or ongoing cost to the GHIP, such as the addition of coverage for weight loss medications and the expiration of the COVID-19 national and public health emergency periods

- ***For further discussion with Subcommittee members today:*** Which FY24 opportunities do Subcommittee members want to recommend to the SEBC for a vote at the March 20th meeting?

FY24 opportunities for consideration

FY24 Opportunity	Description	Estimated # Members or Services Impacted*	Est. FY24 Net $ Impact + Cost / (Savings)	Impact to required FY24 premium increase of 16.6%	Comments
Already brought before the SEBC					
CVS PrudentRx	Program leverages manufacturer assistance with specialty medications and requires significant engagement from members	Approximately 1,600 members utilizing specialty drugs (excluding HIV and fertility) *Non-Medicare plans only*	Savings of: **($6.6M)** to the GHIP **($358K)** to plan participants	**0.7%** reduction to the required increase	Based on prior Subcommittee recommendation, was discussed with SEBC in January 2023 with potential vote in February 2023
For discussion with the HP&P Subcommittee in February 2023					
Aetna's GCIT Network	Narrow network of high quality providers that have agreed to discounted pricing for several expensive, emerging therapies	None currently (no utilizers of these therapies in any non-Medicare plan) *HMO and CDH Gold only*	N/A	N/A	**Recommended by WTW** Opportunity to mitigate future impact of these high cost therapies by implementing now.
Weight loss medications	Consider adding coverage of a relatively new class of drugs that have demonstrated effectiveness in achieving weight loss	N/A (not covered today) *Non-Medicare plans only*	Added cost to the GHIP of: **+$1.8M with UM*** **+$2.9M without UM***	**+0.2-0.4%** addition to the required increase	**Not recommended by WTW** If the Subcommittee wishes to recommend coverage of these drugs to the SEBC, then WTW recommends including UM.
Site-of-care steerage: ER copay changes	Increase ER visit copay to encourage use of alternate sites of care for non-emergency use	Varies by year; in FY22, only 6% of about 33K ER visits were for non-emergency use *Non-Medicare plans only*	Cost avoidance to GHIP of: **($264K)** to **($792K)** based on range of copay options modeled	**0.1% - 0.2%** reduction to the required increase	**Not recommended by WTW** Any increases to ER copay (currently $200) would exceed the max copay per inpatient stay ($200)

* UM = utilization management

FY24 opportunities for consideration

FY24 Opportunity	Description	Estimated # Members or Services Impacted*	Est. FY24 Net $ Impact + Cost / (Savings)	Impact to required FY24 premium increase of 16.6%	Comments
For discussion with the HP&P Subcommittee in February 2023					
Site-of-care steerage: Hospital outpatient surgery copay changes	Increase hospital outpatient surgery copay to encourage use of alternate sites of care	Varies by year; in FY22, about 30% of top 10 types of outpatient surgeries (2,300 total) were conducted at an outpatient hospital *Non-Medicare plans only*	Cost avoidance to GHIP of: **($52K)** to **($156K)** based on range of copay options modeled	**0.0% - 0.1%** reduction to the required increase	**Recommended by WTW** These copays have not been increased in multiple years despite increases to other site-of-care copays. Outpatient facility was the most expensive medical service category in both FY21 and FY22.
Site-of-care steerage: High-tech imaging copay changes	Increase high-tech imaging copay to encourage use of alternate sites of care	Varies by year; in FY22, about 54% of 13,500 high-tech imaging services were conducted at non-preferred sites of care *Non-Medicare plans only*	Cost avoidance to GHIP of: **($37K)** to **($183K)** based on range of copay options modeled	**0.0% - 0.1%** reduction to the required increase	**Recommended by WTW** Opportunity to continue managing future use of non-preferred sites of care for these high cost procedures.
Rx copay changes	WTW modeled impact of increasing Rx copays	Approximately 102,000 members enrolled in non-Medicare plans (as of 12/2022) *Non-Medicare plans only*	Cost avoidance to GHIP of: **($565K)** total **($530K)** if PrudentRx is also implemented	**0.2%** reduction to the required increase (same impact if PrudentRx is also implemented)	**Recommended by WTW** Rx copays have not been increased in multiple years and have not kept pace with Rx unit cost trends.
Regulatory changes – no vote required by the SEBC					
Expiration of COVID-19 national and public health emergency (PHE) periods	Expiration of the COVID-19 national and PHE periods will end federal funding of COVID-19 vaccine ingredient costs and oral antivirals. Will also end GHIP benefit enhancements (extended EAP eligibility, waived member cost share for COVID-19 testing/treatment, waived telehealth cost share) *Non-Medicare plans only*	**+$2.4M** to **+$8.3M** for COVID-19 vaccine and oral antiviral costs **($1.4M)** for ending benefit enhancements	Expiration of PHE already included in 16.6% premium increase for FY24 deficit **0.2%** reduction to the required increase for ending benefit enhancements	Biden Administration has announced that the COVID-19 national and PHE periods will end on May 11, 2023.	

Cell and Gene Therapies

Cell and gene therapy (CGT)

Recap from last month's Subcommittee meeting

- Continued discussion of cell and gene therapies (CGT) took place during the January meeting
  - Goal: achieve the normal expression and function of cells to treat an inherited or developed disease
  - Treatment involves introducing new genetic material into the cells of a patient to help the body make cells that can either treat or fully resolve the condition or disease

- Conditions treated include spinal muscular atrophy, certain diseases of the retina, hemophilia, and certain lymphomas and myelomas that are resistant to first line treatment

- CGT is currently covered under the GHIP for Highmark and Aetna non-Medicare plan participants
  - Utilization of these therapies under the GHIP is very low; in the 15 months ending September 2022, only two plan participants utilized a CGT (both in FY22)
  - Future utilization of at least one additional CGT may be possible: Hemgenix for hemophilia (just approved by FDA on 11/22/2022, with price tag of $3.5M for a one-time administration that replaces ongoing treatment)

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
  - Does not address the unit price of CGT treatment (i.e., still possible for providers to apply a mark-up)

- 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

Aetna's GCIT Network could *reduce total cost of care* for the GHIP and its Aetna members, with the following *trade-off*: requires members to *use narrower network* of high-quality providers to access selected CGT at a *lower total cost*

Aetna's GCIT Network

- Available for the following CGT:
  - ***Luxturna***: diseases of the retina can cause night blindness, light sensitivity, progressive vision loss
  - ***Spinraza*** and ***Zolgensma***: spinal muscular atrophy
  - There is no GHIP member use of these therapies for the entire FY22 plan year through the present
  - There are 3 therapies that Aetna is looking to add to the GCIT network in the future: Hemgenix, Skysona & Zynteglo, all which received FDA approval in the latter part of 2022

- GCIT Network consists of 130 centers of excellence across the country delivering high quality care
  - Includes the following providers in Delaware or surrounding states[1]:
    - Nemours Children's Hospital Delaware (Spinraza and Zolgensma)
    - Children's Hospital of Philadelphia (Luxturna, Spinraza and Zolgensma)
    - Penn Presbyterian Medical Center, Scheie Eye Institute (Luxturna only)
    - Hospital of the University of Pennsylvania Health System (Spinraza only)
    - Milton Hershey Medical Center, Pennsylvania State University (Spinraza and Zolgensma)

1 Source: https://www.aetna.com/content/dam/aetna/pdfs/health-care-professionals/GCIT-designated-providers.pdf. Retrieved 2/7/2023.

Aetna's GCIT network (continued)

- Discounted pricing negotiated with CGT manufacturers
  - Savings achieved by Aetna negotiation with providers to maintain reimbursement for these therapies at cost with no mark-up and improved quality of care
- Aetna clinical care coordination team supports members through entire process
  - Integrated with Aetna One Advisor care management program (in place today)
  - Including member assistance with travel plans and cost
    - Travel and lodging reimbursement is available for patients and a companion who must travel over 100 miles from the member's residence
    - This benefit is the same as the travel and lodging allowance that is available to GHIP members when using Aetna's Institutes of Excellence/Quality networks
- 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 support to consider making a recommendation to the SEBC to implement this program for FY24?**

Weight Loss Medications

Weight loss medications

Recap from last month's Subcommittee meeting

- Initial discussion of weight loss medications: recent GHIP member requests for coverage, rise in prevalence of these drugs coming to market, high level coverage cost estimates for the GHIP

- Follow-ups prompted by Subcommittee members' questions centered on two areas:
  - Other state/government entity experience with coverage of this class of medications:
    - Prevalence that cover with utilization management controls in place
    - Savings from covering these medications
  - Impact of weight loss medication coverage on Delaware's Health Care Spending Benchmark

Other state/government entity experience with covering weight loss medications

- According to CVS, 59% of their employer client book of business covers weight loss medications
  - State and other government entities only: about 70% cover this drug class
  - Majority of those with coverage also have utilization management (i.e., prior authorization) in place

- Long term experience with this class of drugs is very limited
  - Savings specific to states and other government employers with this coverage is not available
  - FDA approval for weight loss indication is too new (initially for Saxenda in 2015) to produce results
  - See next slide for longer-term study findings supporting the benefits of weight loss medications

Other state/government entity experience with covering weight loss medications (continued)

- Several longer-term studies support the benefits of weight loss medications in concept; however, these are studies that modeled the impact of weight loss on the health care cost of a population and do not reflect actual experience with savings from weight loss that is directly attributed to these medications
  - *J Med Econ*: Modeled expanded Medicare coverage of anti-obesity interventions; estimated savings of $6,842 to $7,155 per Medicare beneficiary over 10-year period[1]
  - *Health Econ Rev*: Modeled estimated impact of 10% to 15% weight loss in Medicare participants on Medicare spending; estimated gross savings per capita of $8,287 to $9,826, even when accounting for a weight rebound among most patients[2]

1 Chen F, Su W, Ramasamy A, et al. Ten-year Medicare budget impact of increased coverage for anti-obesity intervention. J Med Econ. 2019;22(10):1096-1104. https://pubmed.ncbi.nlm.nih.gov/31378108/
2 Thorpe KE, Yang Z, Long KM, Garvey WT. The impact of weight loss among seniors on Medicare spending. Health Econ Rev. 2013;3(1):7. https://pubmed.ncbi.nlm.nih.gov/23514437/

Impact on Delaware's Health Care Spending Benchmark

- A question was raised regarding whether there is any information captured in the data reported for Delaware's Health Care Spending Benchmark that could support the rationale for the SEBC to consider adding coverage for weight loss medications
- As part of the Delaware Health Care Commission's benchmark initiative, data is collected on 6 quality measures, one of which is adult obesity (source: CDC Behavioral Risk Factor Surveillance System)
- Recent results[1] indicate that the adult obesity rate for Delaware's statewide population is not meeting the benchmark and is actually getting worse

	CY 2019	CY 2020
Delaware Health Care Spending Benchmark	30.0%	29.4%
Delaware Actual Results[1]	34.4%	36.5%

- Next Health Care Spending Benchmark report (for CY 2021) will be released in early April 2023

1 Data provided by the Delaware Health Care Commission.

Impact on Delaware's Health Care Spending Benchmark (continued)

- Another question was raised regarding whether the SEBC adding weight loss medications to the GHIP on a voluntary basis would result in the State having to defray the cost of this coverage to other plans

- To answer this question, this would not result in the State having to defray the cost of this coverage to other plans offered on Delaware's public exchange/marketplace

- The scenario in question would only apply in situations where a state legislative mandate results in coverage that is not included in the state benchmark plan for that state's public exchange/marketplace plans
  - Each state's benchmark plan is used to define Essential Health Benefits (EHB), a set of 10 categories of services health insurance plans must cover under the Affordable Care Act (ACA)
  - All plans offered on that state's public exchange/marketplace must cover the EHBs defined in the state's benchmark plan
  - CMS allows states to select an EHB benchmark plan from among the options available across the state's individual and small group markets both inside and outside of the public exchange/marketplace
  - In Delaware, the GHIP would not be an option since it is a self-funded group plan sponsored by the State of Delaware, which meets the ACA definition of a large employer (i.e., ≥51 full-time equivalent employees)

Next steps on weight loss medications

- 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 (recommended if coverage is added)

- 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 support to consider making a recommendation to the SEBC to implement this coverage for FY24?**

Site-of-Care Steerage Copays

Site-of-care steerage copays

Recap from last month's Subcommittee meeting

- Continued discussion of opportunities to further vary copays for certain services based on location where service is rendered
  - WTW modeled impact of increased copays on cost avoided for the use of non-preferred places of service in the Comprehensive PPO and HMO plans
  - This tactic represents a cost shift to plan participants who utilize non-preferred sites of care
    - Members who utilize preferred sites of care will not pay the higher copay
    - An overview of the resources and member education/communications available to help plan participants identify and locate preferred sites of care was previously provided at the October 2022 combined Subcommittee meeting
- Subcommittee members expressed interest in continuing to evaluate copays for emergency room visits and outpatient surgeries
  - WTW updated prior modeling to reflect most recent utilization data available

Current plan designs vs. benchmarks

Comprehensive PPO and HMO

	Comprehensive PPO	Benchmark[1]
Medical		
Deductible (Single/Family)	$0/$0	$625/$1,500
Office Visit - PCP	$20	$25
Office Visit - SPC	$30	$40
Emergency Room	$200	$150
Inpatient Admission	$100/day, max $200	$275
Out-Of-Pocket Max (Single/Family)	$4500/$9000	$3250/$6500

Plan Name	HMO	Benchmark[1]
Medical		
Deductible (Single/Family)	$0/$0	$750/$1,600
Office Visit - PCP	$15	$25
Office Visit - SPC	$25	$35
Emergency Room	$200	$125
Inpatient Admission	$100/day, max $200	$275
Out-Of-Pocket Max (Single/Family)	$4500/$9000	$3500/$7500

Observations

- No medical deductibles in Comp PPO and HMO plans (less than benchmark)
- Office visit copays for GHIP plans slightly less than benchmark
- GHIP emergency room copays are greater than benchmark
- GHIP inpatient admission copays are less than benchmark
- GHIP out-of-pocket maximums are greater than benchmark

1 Calculated from 2022 WTW Financial Benchmarks Survey, Government/Public Sector/Education industry cut.

Illustrative modeling: copay changes for emergency room

- Cost avoidance to the GHIP was modeled based on FY22 utilization and reflects the impact of increasing the emergency room (ER) visit cost
  - Range of potential cost avoidance: $264,000 to $792,000 in the first year following increase to ER copay
  - 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
  - While the potential range of cost avoidance is based on ER use for non-emergent / primary care treatable conditions only, the increased ER copay would apply to all ER visits
- Current ER copay is above benchmark and matches the maximum copay per inpatient admission (not shown below); instead of considering additional increases to ER copays, consider recommending to the SEBC that the medical carriers be required to assist in supporting a focused ER utilization and education campaign that includes a target reduction over FY22 by the end of FY24

Emergency room	Current	Option 1	Option 2	Option 3	Benchmark[1]
Copay	$200	$225	$250	$275	$150
Potential cost avoidance (n = 10,558 ER visits for non-emergent/primary care treatable conditions)	$0	($263,950)	($527,900)	($791,850)	+$527,900 (would add cost to the plan – not recommended)

1 Calculated from 2022 WTW Financial Benchmarks Survey, Government/Public Sector/Education industry cut, PPO/POS plans.

The average cost/visit paid by the plan was $1,411 during FY22.

ER utilization for non-emergent/primary care treatable conditions was consistently about 6% of total visits during FY20-FY22

Illustrative modeling: copay changes for outpatient surgery at a hospital

- Cost avoidance to the GHIP was modeled based on utilization data for FY22 provided by Merative and reflects the impact of increasing the visit cost only
  - Range of potential cost avoidance: about $52,000 to $156,000 in the first year following increase to hospital outpatient surgery copay
  - 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 top 10 surgical procedures that have been conducted in both outpatient hospital and ambulatory surgery center (ASC) settings; total number of procedures was adjusted to reflect estimated number performed on an in-network basis under PPO and HMO plans only
  - Range of copays selected for modeling ($125-$175) intentionally set below the maximum inpatient copay ($200)

Hospital outpatient surgery (non-preferred site of care)	Current	Option 1	Option 2	Option 3	Benchmark[1]
Copay	$100	$125	$150	$175	$150
Potential cost avoidance (n = 2,075 outpatient surgeries conducted at hospitals that could have been conducted at ASCs)	$0	($51,875)	($103,750)	($155,625)	($103,750)

These copays have not been increased in multiple years. Outpatient facility was the most expensive medical service category in both FY21 and FY22[2]

Member access to ambulatory surgery centers (ASC) throughout Delaware is comparable to inpatient hospital access, with at least 1 ASC in each Delaware county

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).
2 Source: Merative Incurred Claims Reporting through FY22 Q4.

Illustrative modeling: copay changes for high-tech imaging

- Cost avoidance to the GHIP was modeled based on FY22 utilization and reflects the impact of increasing the non-preferred copay
  - Range of potential cost avoidance: about $37,000 to $183,000 annually with an increase to 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
  - Utilization of high-tech imaging services across all sites of care have declined in FY22 compared to FY20; however, given the high net cost of these procedures, consider additional copay changes for non-preferred sites of care
  - Range of copays selected for modeling ($80-$100) intentionally set below the maximum inpatient copay ($200) and at or below the current hospital-based outpatient surgery copay ($100)

High-tech imaging (non-preferred site of care)	Current	Option 1	Option 2	Option 3	Benchmark[1]
Copay	$75	$80	$90	$100	$300
Potential cost avoidance (n = 7,316 high-tech imaging services)	$0	($36,580)	($109,740)	($182,900)	($1,646,100) (would increase cost beyond IP/OP hospital copays – not recommended)

The average cost/visit paid by the plan was $1,982 during FY22.

From FY20 to FY22, there was a modest reduction in use of non-preferred site of care relative to overall use of outpatient high-tech imaging services.

1 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.

Highlights copay change

Summary of site-of-care steerage copay changes and next steps

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)[1]
Emergency / Urgent Care ▪ Urgent Care ▪ Emergency Room	▪ $15 HMO / $20 PPO ▪ $200 copay *(+$50 from FY19)*	▪ $15 HMO / $20 PPO ▪ $225 - $275 copay (not recommended – see below)	$264,000 to $792,000
Outpatient Surgeries (through medical carrier network provider) ▪ Ambulatory Surgery Center ▪ Hospital	▪ $50 copay ▪ $100 copay	▪ $50 copay ▪ $150 - $250 copay (*)	$52,000 to $156,000[2]
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 (*)	$37,000 to $183,000

Total cost avoidance (annual, first year following changes): $0.4M - $1.1M

(*) WTW-recommended changes only: $0.1M - $0.3M

- 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
- ***ER copays:*** Instead of considering additional increases to ER copays, consider recommending to the SEBC that the medical carriers be required to assist in supporting a focused ER utilization and education campaign that includes a target reduction over FY22 by the end of FY24
- ***Either in addition to or in lieu of any copay changes for FY24:*** Consider recommendation that SEBC negotiate actual utilization performance guarantees with Highmark/Aetna as part of the GHIP's care management programs for FY24

1 Assumes future utilization is consistent with FY22 experience.
2 Does not reflect any change in utilization to a preferred site of care, but would expect some utilization to shift to ambulatory surgery centers.

Plan Design Alternatives

Plan design alternatives

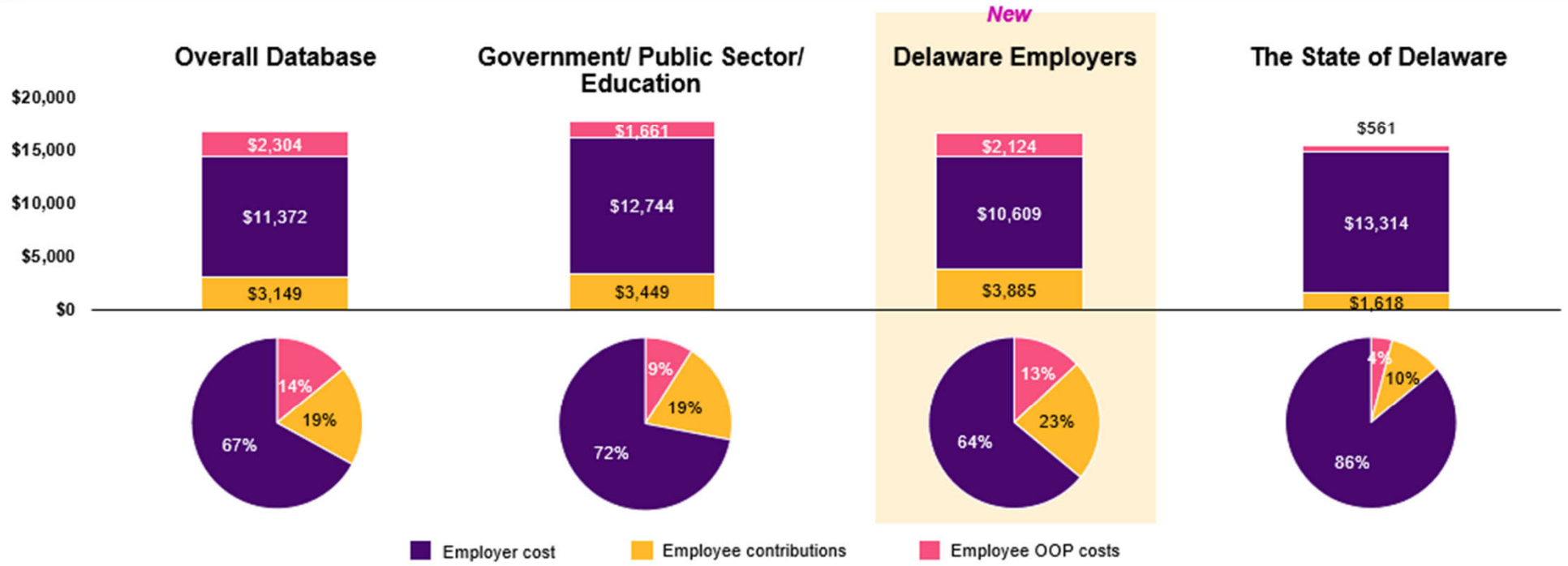
Recap from last month's Subcommittee meeting

- Continued discussion of opportunities to modify plan designs for the GHIP's non-Medicare plan options
  - WTW presented data and observations on:
    - Actuarial values of the four GHIP options relative to benchmarks
    - Aggregate total cost sharing for the State and plan participants relative to benchmarks
    - Observations about current non-Medicare plan options
  - WTW modeled the impact of adding/increasing medical deductibles and increasing Rx copays on plan and participant cost sharing
- Subcommittee members requested additional information on the composition of the benchmarks used for comparison against the aggregate cost sharing for the GHIP, specifically the Government / Public Sector / Education and Delaware Employers benchmarks
- One Subcommittee member also raised a question about the feasibility of implementing medical deductibles that varied by employee salary
- These follow-up items have been addressed on the following pages

Refresher: Data on total cost sharing presented in January 2023

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

Additional detail about total cost share benchmarks

- Due to confidentiality agreements, WTW is unable to list the specific companies included in each benchmark by name, but below is a summary of the Government / Public Sector / Education and Delaware Employers benchmarks

	Government / Public Sector / Education	Delaware Employers
Total Participants	120 organizations, distributed across the country	31 organizations, all headquartered within 50 miles of the Delaware state border
Additional details	47.5% % of total with ≥ 1,000 employees 14 States, counties, and municipalities 51 Schools and educational institutions Other groups: Labor unions, charitable organizations and other non-profits	18 Organizations have >30% of enrolled population within Delaware, or nearby in PA or NJ Top industries represented: ▪ Manufacturing – 29% ▪ Financial Services – 13% ▪ Retail/Wholesale – 10% ▪ General Services – 10%

Considerations: salary-based medical deductible

- One Subcommittee member raised a question about the feasibility of implementing medical deductibles that varied by employee salary
- Any medical benefit provision that could vary by salary – including deductibles, out-of-pocket maximums and premiums – will be very difficult for the GHIP to administer
- There are about 80 non-State participating groups that currently participate in the GHIP as allowed by Delaware Code; these groups, plus others that are eligible but not currently participating, may opt in or out of participation in the GHIP annually
  - Salary information for plan participants from each group is not currently collected
  - A mechanism for capturing this information would need to be implemented in order to administer a salary-based component of the medical plan
- While salary information is available for State agency employees, WTW does not recommend creating a separate set of medical plans with a salary-based medical deductible for that population only

Prescription drug cost and utilization

- Rx cost and utilization trends continue to increase for the GHIP as well as other plans nationwide

GHIP Experience

Non-Medicare plans only

Prescription Drug Detail[1]

Previous Period: Sep 2020 - Aug 2021 (Incurred)
Current Period: Sep 2021 - Aug 2022 (Incurred)
Paid Through: Nov 2022

Annual Trend

	Previous	Current	% Change
Total			
Allowed Amt PMPY Rx	$1,841	$1,991	8.1%
Net Pay PMPY Rx	$1,727	$1,805	4.5%
Out of Pocket PMPY Rx	$99	$104	4.5%
Pats Per 1000 Rx	751.9	780.7	3.8%
Allowed Amt Per Day Supply Rx	$4.04	$4.15	2.8%
Days Supply PMPY Rx	456.0	479.5	5.1%

Specialty drugs comprised **42.4%** of FY22 total pharmacy cost (before rebates) but were only **1.3%** of all prescriptions filled[1]

Generic drugs comprised **14.9%** of FY22 total pharmacy cost (before rebates)[1]

Specialty Drug Detail	Allowed Amount Med and Rx			Patients Med or Rx			Allowed Amount Per Pat		
	Previous	Current	% Change	Previous	Current	% Change	Previous	Current	% Change
Medical Specialty	$58,415,744	$59,392,318	1.7%	3,687	3,620	-1.8%	$15,844	$16,407	3.6%
Pharmacy Specialty	$93,195,958	$109,658,151	17.7%	5,474	6,566	19.9%	$17,025	$16,701	-1.9%

National Trends

94% of employers indicate **managing healthcare costs** is a key priority over the next two years[3]

1% to 2% of Rx's are for specialty drugs, yet account for **over 50%** of pharmacy spending

Specialty spend could reach **$373 billion** by **2025**[4]

1 Source: CVS Health Annual Review, FY22.
2 Source: Merative Key Trends Report.
3 WTW 2022 Emerging Trends Survey.
4 CVS Health 2022 Marketplace Outlook
https://payorsolutions.cvshealth.com/updates/consultant-briefing-december-2021 . Accessed 2.7.2023.

Prescription drug copay changes

- GHIP prescription drug copays have not been updated since at least 2016
- WTW modeled the cost impact of increasing prescription drug copays for the four non-Medicare medical plans using an alternative design based on the Governmental Benchmark from WTW 2022 Financial Benchmark Survey
- Estimated GHIP savings does not factor in the potential addition of PrudentRx
  - If PrudentRx is adopted, estimated savings would be about $35K less (total: $0.5M)

Rx Plan Design	Current	Alternative
Up to 30-day supply		
Generic	$8	$10
Formulary	$28	$32
Non-Formulary	$50	$60
Up to 90-day supply		
Generic	$16	$20
Formulary	$56	$64
Non-Formulary	$100	$120
Specialty	n/a	$100
Estimated savings to GHIP		**$0.6M**

Question for Subcommittee members: **Is there support to consider making a recommendation to the SEBC to implement these changes for FY24?**

Inclusive Benefits Review

The rapid evolution of Diversity, Equity and Inclusion in HR and Total Rewards

2017-2019

To attract/retain more women and achieve gender equity commitments, companies introduced and expanded parental leave and family-friendly benefits

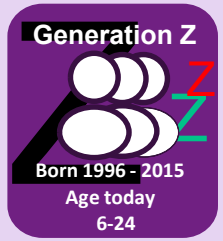
2020-2021

The triple crises of 2020 (pandemic, recession, and social disruption) accelerated HR and benefits trends that had begun previously – wellbeing, racial equity, ESG.

2022

The “great resignation” continues, and mental health remains a critical concern. Employers consider evolving total rewards based on flex work and inflation challenges.

What’s Next



Eimployers prepare for the entry of Gen Z, who will be 25%+ of the workforce by 2025 and are the most diverse generation in U.S. history.

There is strong desire for DEI in the current state of the workforce

Employees are experiencing **major burnout**

Engagement, retention and productivity are top risks for employers as employees are adapting to new ways of working

Mental health stigma is slowly breaking and employees are identifying issues and looking for support

Managers and leaders are overwhelmed in how to lead and support their employees in these types of vast change

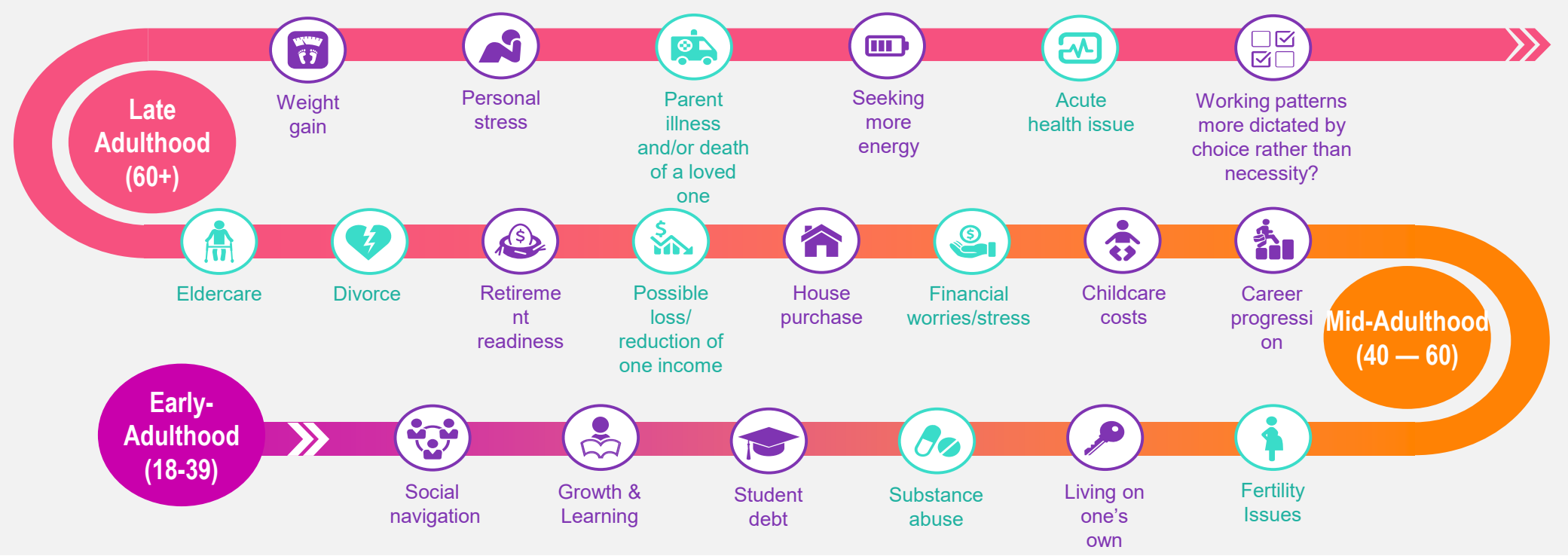
It is difficult to maintain cultures from pre-pandemic. Creating a **culture of wellbeing** is imperative but has become more difficult

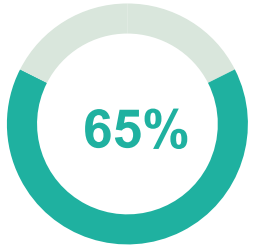
Employee **needs and expectations** have shifted greatly — caregiving, financial wellbeing, flexible work

Shifting demographics and **labor shortages** in the public sector

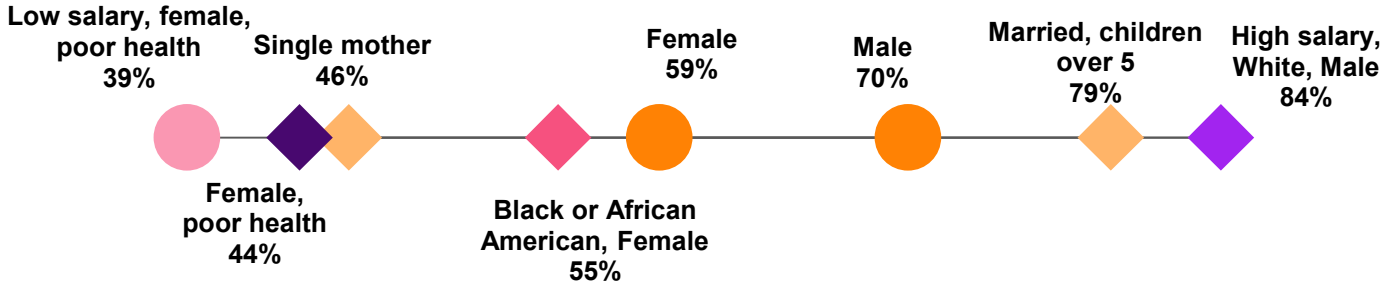
The attention to **diversity, equity and inclusion** has never been greater — employees are looking for action and change

Modernizing benefits to meet employees where they are





of employees say their benefits meet their needs – but varies significantly by demographic cohort



Source: 2022 WTW Global Benefits Attitudes Survey, United States

Framework for reviewing benefits through a DEI lens

Access and participation

Affordability

Health and financial risk

Vendor collaboration

Inclusive/equitable plan design

Employee preferences

Alignment with Division of Diversity & inclusion

Inclusivity of benefit communications

Focus area for today's Inclusive Benefits Review

Potential populations of focus

 Generation	 Neurodiversity	 Income Level	 Gender	 Race/Ethnicity	 LGBT+	 Location

Inclusive benefits review – goals and objectives

- Do our current benefit programs meet the needs of a diverse workforce?
- How do benefits impact our ability to attract and retain employees?
- Does the current benefits package support an inclusive and diverse culture, and align with the State's Diversity, Equity, and Inclusion goals?
- Are there opportunities to improve the wellbeing of State employees (financial, physical, and/or emotional wellbeing)

Support Development of GHIP Future State

- Incorporate into updates to the GHIP Strategic Framework goals

Big Picture:	*Goal language approved by SEBC in February 2020:*
Increase proportion of medical spend to providers who are compensated for the quality, not quantity, of care delivered	Using the Alternative Payment Model (APM) Framework and FY2021 medical spend as a baseline, increase GHIP spend through advanced APMs to be at least the following by the end of FY2023 (as % of total spend): ▪ Category 3: 40% ▪ Category 4: 10%
Reduce cost for plan participants with diabetes	Reduction of GHIP diabetic cost per-member-per-month (PMPM) by 8% by the end of FY2023, using FY2021 spend as a baseline
Limit health care cost inflation through targeted reduction in high cost, low value services and providers	Limit total cost of care inflation for GHIP participants at a level commensurate with the Health Care Spending Benchmark by the end of FY2023 by focusing on specific components, which are inclusive of, but not limited to: ▪ Outpatient facility costs ▪ Inpatient facility costs ▪ Pharmaceutical costs
Offer and increase engagement in tools that help plan participants use their health care benefits effectively	In light of the GHIP's changing demographic profile, strive for an incremental increase in unique users utilizing a specific point-of-enrollment and/or point-of-care engagement platform / consumerism tool by at least 5% annually

Inclusive benefits review – process and timing

Health benefits under review	Areas for potential future study/review
• Family forming benefits • Transgender coverage • Maternity/pregnancy • Women's health • Behavioral health & substance abuse • Wellbeing support • Dental	• Disability plan and policies • Leave/time off programs • Retirement readiness and benefit offerings • Caregiving benefits • Perks/ancillary benefits • Benefits education, communications and resources

Benefits are reviewed on a "good, better, best" scale for select provisions through a DEI lens, using:

- Corporate indices, such as Human Rights Campaign's Corporate Equality Index
- Published clinical guidelines and best practices (e.g., WPATH)
- Employer prevalence data and surveys
- Employee surveys and input

Inclusive benefits review findings will be evaluated in the context of compliance requirements (e.g., Mental Health Parity and Addiction Equality Act) and other Benefits Modernization efforts (e.g., employee survey)

Next steps

1. Review findings with key stakeholders in DHR, then Aetna and Highmark
2. Present findings and opportunities for additional benefit categories at an upcoming Health Policy & Planning Subcommittee meeting
3. Discuss recommendations and areas for further exploration with the Health Policy & Planning Subcommittee to take to SEBC, as appropriate

Appendix

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.