

FINAL REPORT OF THE STATE EMPLOYEES HEALTH PLAN TASK FORCE

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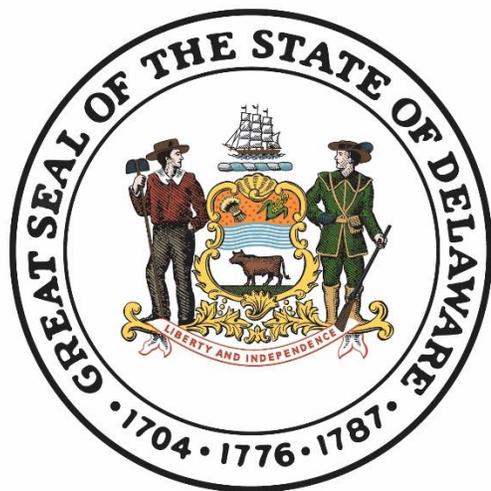


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Executive Summary

The Task Force was created at the request of the Joint Finance Committee Co-Chairs through Epilogue contained in the FY2016 State Operating Budget Bill (Section 73, House Substitute No. 1 for House Bill 225). The Task Force was established to identify cost savings and efficiencies in the State Group Health Program (the GHIP) as a result of a significant increase in GHIP costs in FY14 and FY15 and a continued increasing trend. The Task Force findings include improving the health of the population, member/patient understanding and usage of the healthcare system, payments to providers, need for deeper analysis on data and research regarding further changes, and overall “bending of the cost curve” to mitigate the long-term trend experienced by health plans.

Historically, the GHIP has experienced a 6% to 7% annual trend -- that is the underlying cost of the program, per member -- prior to plan changes or other mitigation techniques. There has been significant volatility in this figure, ranging from a low of near 0%, to a high of more than 10%. Relatively low trend in FY12 and FY13 was a contributing factor to an under-estimation of anticipated expenses in FY14 and FY15. Other contributors were a spike in high cost claimants (somewhat unique to this plan from a historical perspective), and greater prescription drug costs (being experienced by many plan sponsors). Due to a strong desire on the part of the Task Force to gain an understanding of the reason for the increase in GHIP costs, a Request for Proposal was released November 23, 2015, to determine any cost recovery and /or program integrity concerns.

Of significant concern to the Task Force is the comparison of medical trend to state revenue increases. State revenues in the near past, and projected to the near future, have increased 3% to 4%. Having a medical trend of 6% to 7% requires that the GHIP allocation consume a greater share of the state budget, and/or a consistent increase in cost-shifting to participants, absent other mitigation techniques. The Task Force understands the difficulty in both of these approaches; and hence spent considerable time and effort on identifying permanent mitigation techniques. These techniques involve improving the health of the population, member/patient understanding and usage of the healthcare system, modifying payments to providers, deeper analysis on data and research regarding further changes to the plan of benefits, operations, and efficiencies – all designed to “bend the cost curve” to mitigate the long-term trend experienced by the GHIP.

Truven, the data warehouse to the GHIP, presented some disturbing statistics on the GHIP population. The State of Delaware’s health risk in 2014 was higher than the nationwide average, indicating a higher than average illness burden in the State of Delaware population. Additionally, the risk score of the population increased 20% for 2014 versus 2013. Another concerning finding from Truven is the State’s prevalence for key chronic conditions such as diabetes and hypertension were approximately 10% greater in the GHIP population compared to the state benchmark. The presentation of the Delaware Center for Health Innovation (DCHI) also commented that the health of the entire state demographics contribute to the issue. Per capita costs are 25% greater than the national average, with more than 30% of Delawareans obese (including morbidly obese), and diabetes incidence levels at 11% and climbing. Improving the health of the population, particularly those members with chronic conditions, should be an important long term focus of the GHIP – and should put downward pressure on the cost curve.

Anecdotal in nature, the Task Force felt it likely that the population did not have a firm understanding on the cost of services and workings of the GHIP. About 95% of the membership is in the PPO and HMO options. These options have no deductible and do not as a result promote consumerism and informed decision making by the participants. They are also of fairly substantial actuarial value, approximately 90%, richer than the benchmarks presented by the consultants. The other 5% of the population is in the Consumer Directed Health Plan (CHDP) and the First State Basic (FSB) plan, which have some coinsurance features, and deductibles, providing somewhat greater insight into the cost of services. These plans are also fairly rich, as compared to the benchmarks, with actuarial values of 86% to 87%. There was considerable discussion and lack of agreement regarding the appropriateness of the benchmarks presented and a call for a more thorough

benchmarking – including appropriate peers – prior to drawing conclusions. Additionally, there was considerable call for contemplation and benchmarking of the health benefits package in the context of overall compensation of the state worker, which was outside the scope of the Task Force. As an additional impetus here, the participant contributions, which average between 9% and 10% of total GHIP expenditures, appear rich in the context of the benchmarking as well.

These factors precluded the Task Force from contemplating any significant plan design or participant contribution recommendations – as these actions are viewed as simply a cost-shifting onto state employees, with no real appetite to do so. There was acknowledgment by the Task Force members that many to all of the findings discussed below would likely not be able to have a measurable impact on the FY17 budget process.

Considerable research and time was invested in presentations and discussion regarding payments to providers – there is considerable detail in Section V - Findings. The Task Force believes significantly more effort should be placed into paying providers, particularly hospitals, differently than today's method of negotiated discounts off retail prices. While there is recognition that the industry as a whole is moving away from "discounts", it appears Delaware is moving more slowly – perhaps due to the limited number of hospitals in the state. Furthermore, Highmark asserts that hospital costs in Delaware are greater than appropriately-adjusted surrounding states. Paying differently could involve methods such as reference or metric based pricing of services, bundled or episodic payment methods, cost-based methods (based on "true cost of care"), or even regulatory approval for payment rates. Some Task Force members felt very strongly that this line of modification be pursued diligently and primarily compared to other methods.

Reducing spend, while improving quality without negative repercussions, was a general concept agreed to by the Task Force. Specifics behind this general concept did not rise to the level of a consensus. The only area for which there was general agreement was for expanding Centers of Excellence. More controversial presentations that resulted in members paying considerably more out of pocket if they did not make the preferred choice (such as traditional Referenced Based Pricing) did not achieve consensus. Emerging mainstream items such as High Deductible Health Plans with HSAs were viewed by some members as mostly cost-shifting rather than transparency and smart-shopping imperatives. An example of improving the spend while not affecting care delivery was the implementation of the prescription drug Employer Group Waiver Plan for Medicare Primary retirees with the identical plan of benefits implemented which resulted in a reduction in cost to the GHIP. A similar concept was presented on Medicare Primary retirees for medical, a Medicare Advantage Employer Group Waiver plan, but no real discussion was focused on any particular retiree presentation.

Related to this concept of improving the spend; there was general consensus on creating plan provisions and programs that improve the health of the member. Similarly, specifics behind this general concept did not reach a consensus. Tobacco utilization, obesity, diabetes, hypertension, and depression could be focal points, in addition to general chronic condition management improvement. Motivating the members to effectively deal with their particular chronic issues and to be smarter purchasers and consumers of healthcare will likely be challenging but a necessary endeavor.

Introduction

The Task Force was created at the request of the Joint Finance Committee Co-Chairs through Epilogue contained in the FY2016 State Operating Budget Bill (Section 73, House Substitute No. 1 for House Bill 225). The Task Force was established to identify cost savings and efficiencies in the State Group Health Program (the GHIP). Areas of inquiry were broad and complex and ranged from plan design and premium rate setting to plan management and program eligibility. The Epilogue required that the Task Force engage a consultant to assist in conducting an operational review from an actuarial and benefits perspective. A report was due to the Governor and General Assembly by December 1, 2015. This date was subsequently changed, by extension, to December 15.

During the FY16 budget process an unexpected and significant rise in the expenditures of the GHIP became the focal point of the State Operating budget process and the overlap in the State and GHIP budget cycles resulted in the State Employee Benefits Committee being unsuccessful for the first time in their history to balance the GHIP's budget in the timeframe necessary to meet the requirement to offer GHIP participants a single annual opportunity to elect changes in their health benefit coverage (known as Open Enrollment). Consequently, a subsequent enrollment opportunity for GHIP participants was necessary after changes in plan offerings and increases in health premium rates were implemented after the Open Enrollment period was underway. Forecasts for FY17 indicate a similar expenditure forecast greater than revenue. Policymakers, recognizing the GHIP has risen to be the primary cost driver in the State Operating budget process, established the Task Force to identify cost savings and efficiencies.

This report is separated into five components. The first section provides an overview of the GHIP including specific details related to the GHIP's historical and projected trend. Section II contains a summary of information provided to the Task Force in the area of benchmarking and trends experienced by other health plans and self-insured employers. Section III seeks to articulate the discussions and contemplations of the Task Force related to payment reform and how market forces have impacted the financial performance of the GHIP. Section IV addresses the majority of the areas of inquiry defined in the Epilogue and explains the basic concept and objective of each. Section V attempts to summarize the findings of the Task Force related to the areas of inquiry as well as the additional discussions on concepts outside of the epilogue requirements.

Section I – Framework and Context

The Task Force work began with an introduction to the structure of the GHIP as a basic understanding of the benefit programs, participant demographics and mechanisms under which the GHIP operates was a necessary foundation before the premise of the epilogue content could begin. Several Task Force members focused on the need to thoroughly investigate how the financial health of the GHIP had deteriorated so quickly. Several members who also serve on the State Employee Benefits Committee (SEBC), the group charged with control and management of all current and future employee health benefits coverage, supported the need for a full overview including a historical review to better understand past trends as they compare to what has recently occurred with the GHIP's drastic increase in expenditures.

While not specifically addressed with the Task Force, it is important to begin with a brief synopsis of the State Operating Budget and the GHIP budget cycles. The State Operating Budget process led by the Office of Management and Budget, begins shortly after the start of the fiscal year. Agencies are required to submit their budget proposals in mid-October for consideration and evaluation. Decisions related to agency budgets for the upcoming fiscal year and which are supported by the Governor are included in the Governor's recommended operating budget released in late January. Any appropriation increase for State employee and retiree health benefits is included in the recommended budget. The operating budget is then reviewed and considered by the General Assembly's budget writing committee, known as the Joint Finance Committee (JFC). Mark-up of the Governor's budget, including additions and changes, by the JFC occurs in May followed by consideration by the General Assembly in June and approval by the Governor during the same month.

The GHIP budget process functions inside of the State Operating Budget process and must be concluded months ahead of the passage of the State budget. December marks the earliest view of the GHIP's quarterly claim (expenditure) experience for the current fiscal year. Preliminary projections of the upcoming fiscal year GHIP expenditures are developed based on the claims incurred by GHIP participants through September 30th. These preliminary projections become the basis for any appropriation increase recommended in the Governor's budget.

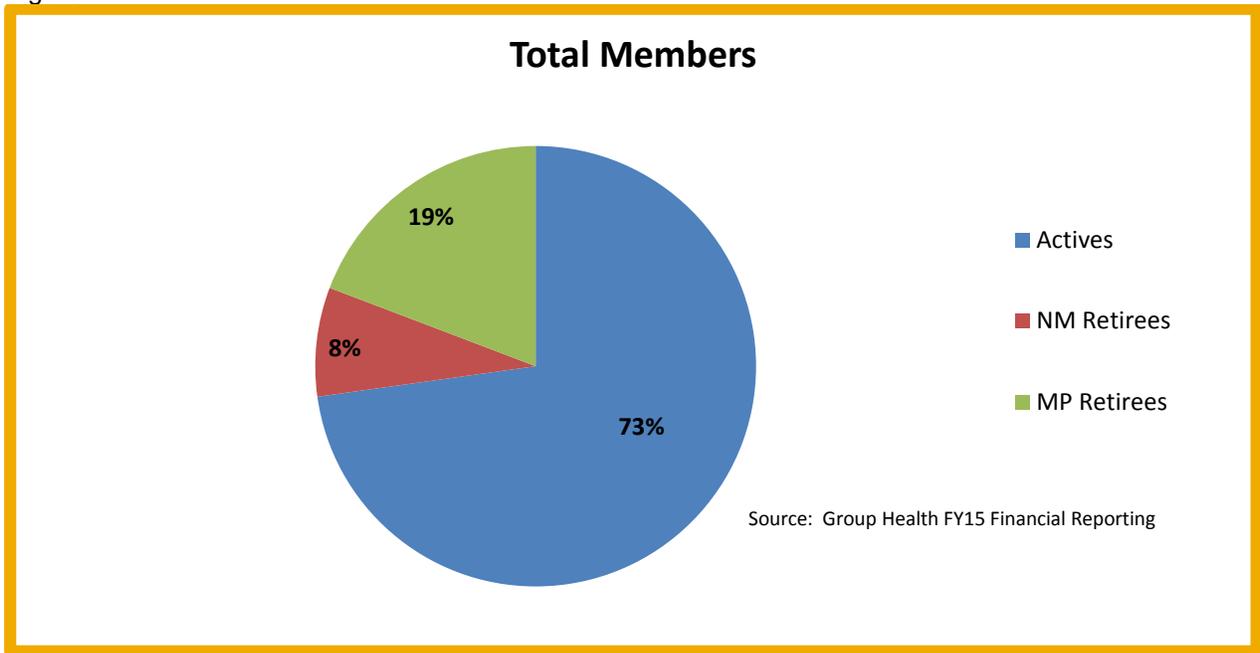
The SEBC also uses the preliminary projections to begin considerations on the upcoming GHIP budget which must be finalized before the end of March to meet requirements to notify GHIP plan participants of changes in benefits and/or premiums 60 days prior to the start of the benefit plan year, July 1st. The SEBC does not have authority to appropriate State funding; however, their deliberations take into account any recommended increase in funding included in the Governor's budget even though any such recommended increase is subject to change prior to the end of the State budget process. Further adding pressure to the work of the SEBC is the release of an update in the GHIP's expenditure experience in mid-February. If the updated projection increases expenditures for the upcoming fiscal year, the SEBC is faced with how best to balance the GHIP budget through plan design modifications as the State budget cycle does not conclude until months later. Regardless of the deficit faced by the SEBC, the Committee is forced to make significant and impactful decisions in a finite period of time.

The conflict that exists with the SEBC's responsibility to manage the GHIP without authority to appropriate funding emerges to varying degrees from year to year. This will become further evident as the GHIP's framework, historical experience and performance is illustrated. Coupled with an inability to modify the GHIP's premium rate structure and eligibility set in statute, the SEBC has had little appetite or capacity to implement changes in plan offerings that can be effective in controlling costs as such changes have significant implications to the GHIP participants. Consequently, the GHIP expenditures have increased by more than 34% in the last five fiscal years (from \$527.4M in FY10 to \$708.1M in FY15) and represented approximately 10% of the State General Fund Operating Budget in fiscal year 2015.

GHIP Overview

The GHIP provides medical and prescription benefit coverage to over 122,000 covered lives. This includes approximately 31,000 active employees, 5,900 non-Medicare retirees and 17,000 Medicare retirees whose benefits are extended to their spouses and dependents. Also, covered and not specifically addressed in the work of the Task Force are approximately 18,000 employees, retirees and their dependents from groups that also participate in the GHIP as permitted through Delaware Code. As shown in Figure 1, active employees and dependents represent over 70% of the GHIP's population with retirees representing the remainder.

Figure 1



The GHIP is self-insured and pays the actual claims (expenditures) incurred by the GHIP participants for services received under the health and prescription plans. Claim expenses represent approximately 96% of the GHIP's total expenditures. The SEBC is responsible for design of the plans available to the GHIP's participants and setting premium rates that can support the projected expenses of the GHIP. The percentage of employee and employer share of the premium rates is established in Delaware Code as are the actual plan offerings available to employees and retirees.¹

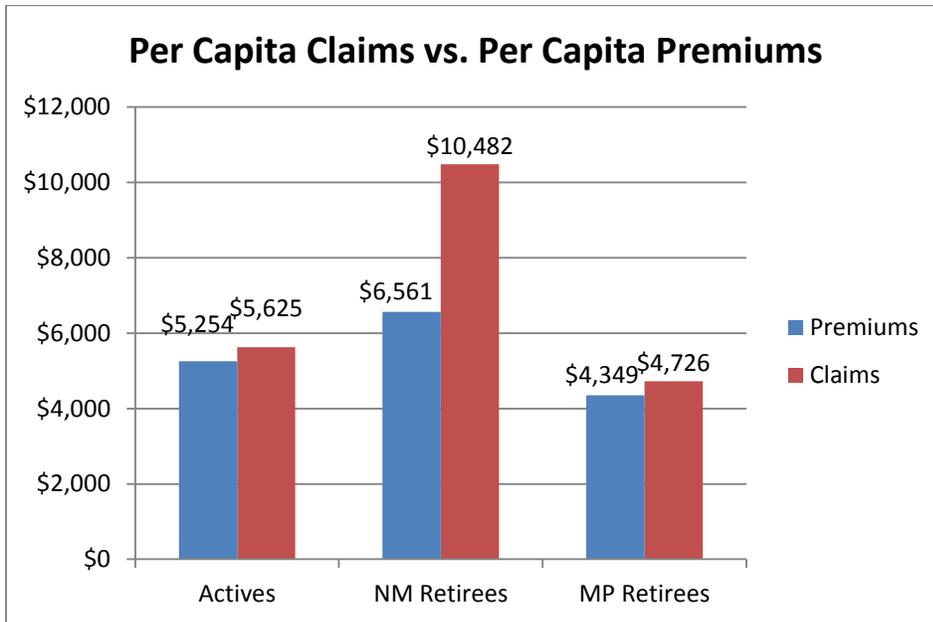
The active and non-Medicare populations have always paid the same premium rates for each plan; however, the actual claims (expenditures) of the non-Medicare retiree population are significantly higher than the active population as illustrated in the chart on page 8. The Medicare population receives secondary medical coverage through the GHIP as well as prescription drug benefits through an Employer Group Waiver Medicare Part D plan implemented in calendar year 2013. The premium rates for the Medicare population are more closely aligned with the actual claims (expenditures) of the population.

	Actives	Non Medicare	Medicare Primary
<i>Premium Cost Share Percentage Split</i>	State/Employee	State/Retiree	State/Retiree
Highmark Comprehensive PPO	86.75%/13.25%	86.75%/13.25%	
Highmark & Aetna HMO	93.5%/6.5%	93.5%/6.5%	
Highmark & Aetna Consumer Directed	95.0%/5.0%	95.0%/5.0%	
Highmark First State Basic	96.0%/4.0%	96.0%.4.0%	
Highmark Special Medicfill Supplement			100%/0%* 95.0%/5.0%**

*Retirees with full state share who retired before July 1, 2012

** Retirees with full state share who retired after July 1, 2012

¹ Delaware Code, Title 29, Chapter 52 Web Address: <http://delcode.delaware.gov/title29/c052/index.shtml>



- Source: Group Health FY15 Financial Reporting

In terms of evaluating the value of the plans as they may compare against other employer plans or perhaps plans available on the open market, it is helpful to understand the concept of actuarial value. The term has become an industry standard since the passage of the Affordable Care Act and is referred to when illustrating the percentage of total average costs for covered benefits that a plan, as opposed to what the participant will cover. Plans available through the Marketplace² are valued as follows: 60% (bronze), 70% (silver), 80% (gold) and 90% platinum. To appreciate how expenditures have risen at such a rapid pace, it is important to understand the actuarial value of the existing GHIP plans. The combination of the large amount of premium paid by the State (91.4% on average) coupled with the overall high actuarial value of the plans available to GHIP participants are the primary contributors of the growth. The following table outlines the actuarial value of each plan based upon in-network benefits as determined by Segal, consultant and actuary for the GHIP, compared to a few sample plan designs available through the Marketplace.

² Health Insurance Marketplace Web Address: <https://www.healthcare.gov/get-coverage/>

	Sample Gold Plan**	Highmark First State Basic Plan	Highmark & Aetna CDHP (with HRA)	Sample Platinum Plan**	Highmark PPO*	Highmark & Aetna HMO
Actuarial Value (Segal for GHIP)	80%	86.1%	87.0%	90%	90.4%	90.6%
Deductible (Single/Family)	\$900/\$1,800	\$500/\$1,000	\$1,500/\$3,000 +1,250/2,500 HRA	None	\$0/\$0	\$0/\$0
Out-of-Pocket Maximum (Single/Family) <i>Medical Only</i>	\$4,500/ \$9,000	\$2,000/\$4,000	\$4,500/\$9,000	\$4,500/\$9,000	\$4,500/\$9,000	\$4,500/\$9,000
In-Network Coinsurance	25%	10% Coinsurance	10% Coinsurance	10%	0%	0%
Primary Care	\$30	10% Coinsurance	10% Coinsurance	\$20	\$20	\$15
Specialist	\$50	10% Coinsurance	10% Coinsurance	\$40	\$30	\$25
Inpatient Facility	25% coinsurance	Deductible & coinsurance	Deductible & coinsurance	10% coinsurance	\$100/day up to 2 copays	\$100/day up to 2 copays
Emergency Room	\$300	Deductible & coinsurance	Deductible & coinsurance	\$200	\$150	\$150
Out-of-Network Coinsurance	40%	30%	30%	30%	20%	N/A
Prescription Drug Benefit						
30-day Retail	\$10/\$40/\$80	\$8/\$28/\$50	\$8/\$28/\$50	\$5/\$20/\$50	\$8/\$28/\$50	\$8/\$28/\$50
90-day Retail & Mail	\$25/\$100/\$200	\$16/\$56/\$100	\$16/\$56/\$100	\$10/\$50/\$125	\$16/\$56/\$100	\$16/\$56/\$100
Out-of-Pocket Maximum (Single/Family)	\$2,100/\$4,200	\$2,100/\$4,200	\$2,100/\$4,200	\$2,100/\$4,200	\$2,100/\$4,200	\$2,100/\$4,200

*Actuarial Value based on in-network benefits only, out- of network feature increases value slightly

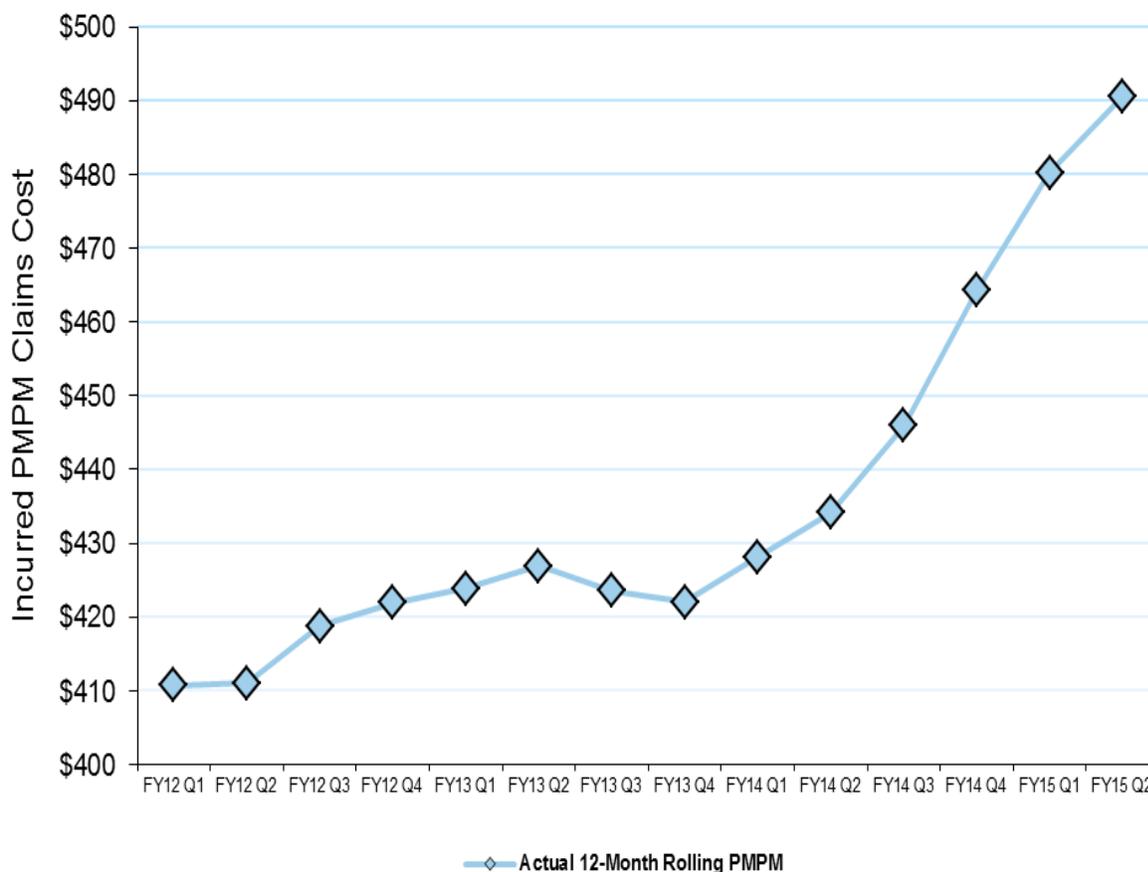
**Sample plan designs with split out of pocket maximums, medical and drug, and not specific to Delaware marketplace

GHIP Historical Review

Important to note is the passage of House Bill 81 during the 146th General Assembly. This legislation marked the first and only significant change in State employee and retiree benefits since the onset of rising healthcare costs experienced nationally at the turn of the century. It represented the collective work of the administration, legislature and unions representing the majority of State employees, all of whom recognized the changing landscape and financial hardships being faced by public sector employers with regards to controlling costs and preserving health and pension benefits. The impetus behind House Bill 81 was the \$80M deficit and contentious FY11 GHIP budget process. The cost sharing structure outlined previously was one of many

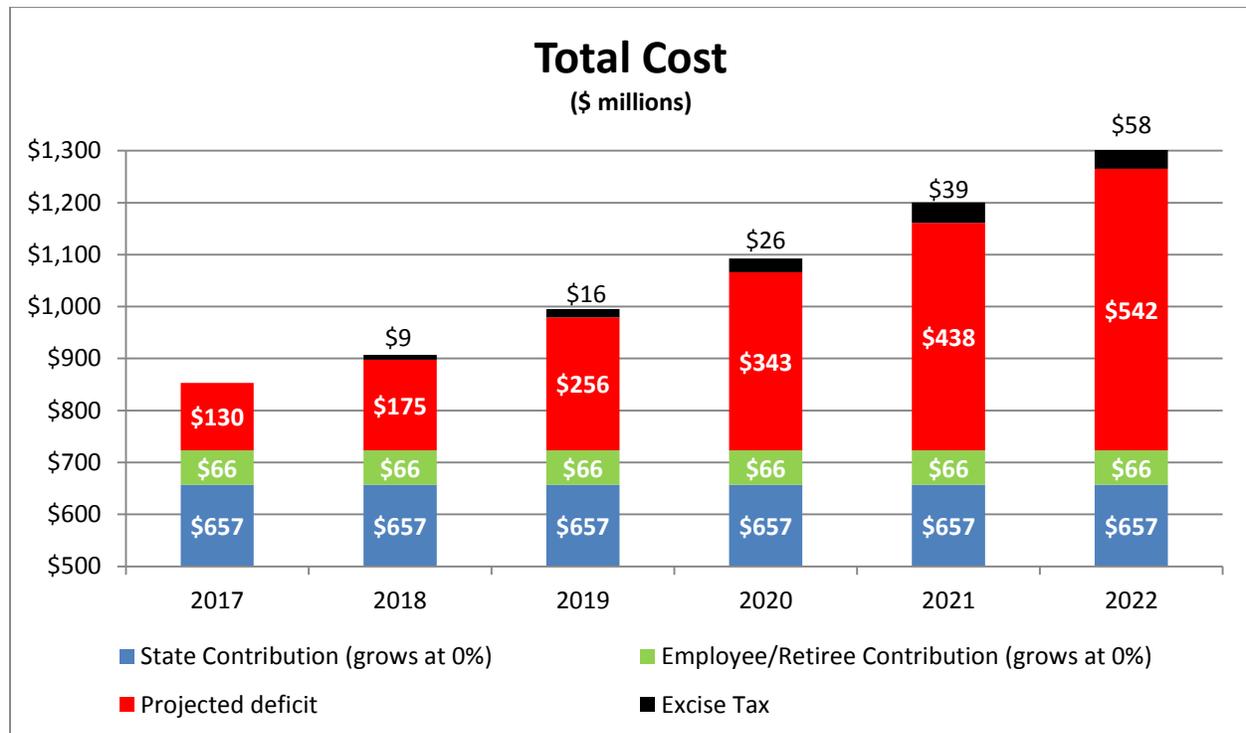
outcomes of the legislation. Other changes included elimination of a free health plan replaced with a 4% cost share for employees and non-Medicare retirees enrolled in the First State Basic plan and a 5% cost share for Medicare retirees enrolled in the Medicare supplement plan after July 1, slight increases in the number of service years required to vest for specific percentage of the State share for retiree health benefits, the elimination of Double State Share for new employees as well as a flat \$25 per month per contract for employees who remained eligible for Double State Share. Prior to the passage of House Bill 81, the SEBC's authority and responsibilities were the same; however, the absence of a set employee/retiree cost share left the SEBC with the added responsibility of balancing the GHIP budget through *either* plan design changes or increases in the employee/retiree share of the total premium rates. Often this led to much discord among the SEBC members who felt that it was inappropriate to be tasked with responsibility for determining what employees and retirees would have to pay for medical and prescription benefits with no authority or influence over what, if any, additional costs would be paid by the State or employer for these benefits.

While House Bill 81 did make marginal changes and accomplished the intended objective of bringing the State employee and retiree health benefits in line with what was more common in the public sector environment, the growth rates experienced by the GHIP have continued to far exceed the State Operating budget growth and without additional change, appear to be unsustainable. Expenditures accelerated in FY14 after two years of relatively stable per member costs; however, this was not confirmed until updated expenditure projections became available in early February 2015 and as the SEBC began to deliberate over options to balance the FY16 GHIP budget. The following table was used during discussions with the SEBC and exemplifies the dramatic uptick in per member per month costs.



Source: Group Health FY15 Financial Reporting

As the projected deficit ballooned to \$116.3M, the increase provided in the Governor’s 2016 recommended budget fell \$60M short of the amount needed to fund the premium rates at a level equal to the expected GHIP expenditures. A similar scenario to that which the SEBC experienced during the FY11 GHIP budget process emerged and it was not until additional money was appropriated by the Joint Finance Committee and approved by the legislature as part of the State Operating budget process that the SEBC was able to approve a balanced budget for FY16. Employee and retiree healthcare was the largest cost driver in the State Operating budget for the current year. Applying the most recent two years of GHIP costs in future trend projections, the estimated GHIP deficit for FY17 is significant. If expenditures continue to rise at the recent pace, without the implementation of changes in plan design or other options to slow down the increase in expenditures, GHIP costs will rise by another 41% over the next five years and exceed \$1 billion by fiscal year 2020.

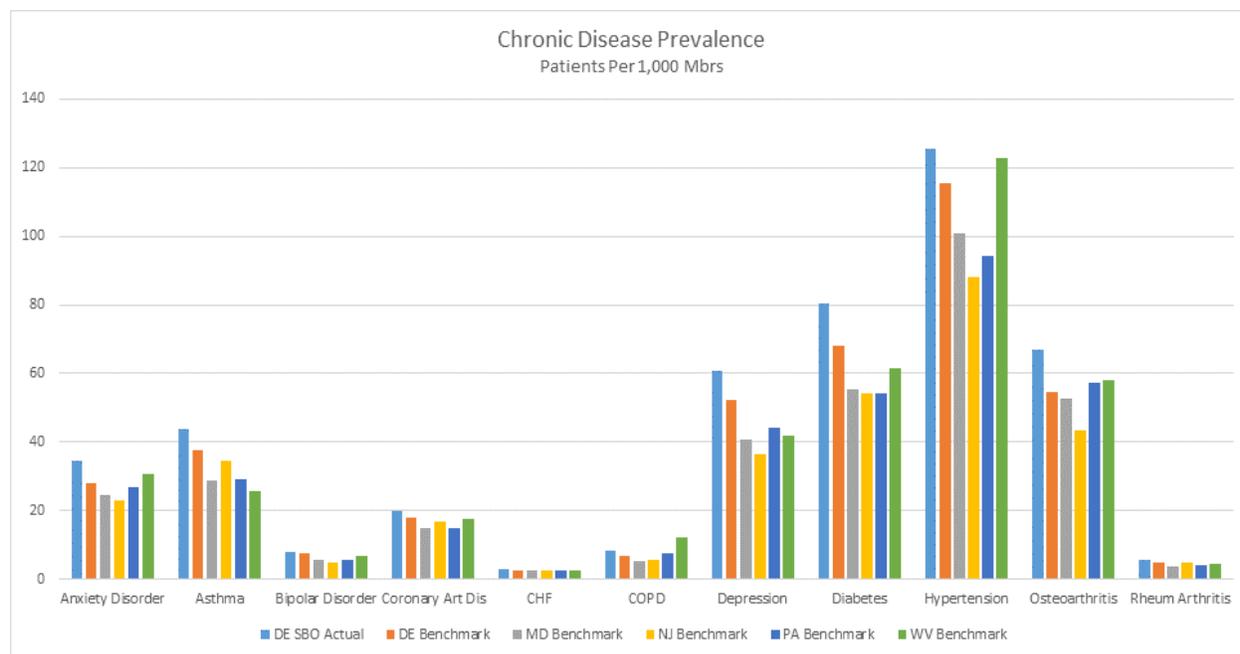


Drivers of GHIP Expenditures

In order to effectively assess options to drive down the GHIP expenditures, the Task Force needed to comprehend the underlying drivers of the recent GHIP experience. Using data from the Truven Health Analytics (Truven) GHIP database and comparing medical and prescription drug claims incurred by GHIP plan participants for the time periods of May 2013 through April 2014 and May 2014 through 2015, a number of noticeable changes contributed to the rapid acceleration of expenditures.

Despite the stable demographic make-up of the GHIP population, the population’s aggregate health risk score increased 20% in the most recent year. Using a licensed risk adjustment tool, Truven analyzed the GHIP population and calculated concurrent and prospective risk scores for each plan participant that reflected age, gender and medical conditions noted in each participant’s medical claims. The aggregate risk score for the entire GHIP was then calculated and compared against the risk scores of individuals in a national database. As the score is developed by individual, which population attributes drive the GHIP aggregate score of 161 for the most recent period versus 100 for the base population is difficult to identify; however, the below chart compares chronic disease prevalence for the GHIP population compared to surrounding state benchmarks and even after adjustments for demographic differences, the GHIP population’s chronic condition prevalence is noticeably highest for all conditions except COPD (Chronic Obstructive Pulmonary Disease). Demographics

likely contribute to a high population risk score; yet the GHIP's chronic disease prevalence clearly indicates an overall adverse risk pool and drives the GHIP's high costs.



- Source: Truven Health Analytics

In the most recent year, GHIP net payments per employee/non-Medicare retiree increased 9%. Outpatient care trended at 6% and accounted for 52% of the net medical payment spend. Inpatient care trended at 11%. Combined medical trend (inpatient and outpatient) was 7%. Prescription drug spend trended at 13%.

Medical expenditures represented 78% of the net payments in the most recent period. High cost claimants were the mitigating driver of the overall increase as prevalence rose 21% and chronic conditions accounted for 61% of high cost claimants medical net payments. Inpatient price per admission increased by 3% with high cost claimants accounting for 1%. The 3% inpatient price increase was driven by surgical procedures, primarily musculoskeletal surgical admissions. Outpatient price increased 2% with surgery and office services accounting for 1%.

In the most recent period, prescription expenditures accounted for 22% of the net payments. A 10% increase in prescription drug price was driven primarily by high cost claimants; however, overall prescription drug price was favorably impacted by increased utilization of generic prescriptions by the GHIP employee/non-Medicare plan participants. Removing the impact of high cost claimants, prescription drug price was the biggest driver of GHIP trend for the employee/non-Medicare population.

The GHIP Medicare primary population, not unlike the employee/non-Medicare population, experienced a 26% aggregate health risk score increase in the most recent year, as well as a 12% change in net medical payments (27% inpatient and 5% outpatient) and a 19% change in net prescription drug payments. High cost claimant net payments increased 38% and chronic conditions accounted for 63% of high cost claimant net medical payments. Inpatient acute admission costs decreased while long term care costs increased substantially and were the primary driver of inpatient costs. Outpatient price did not play a significant role in driving GHIP Medicare expenditures. The prescription drug increase was driven in part by high cost claimants as well as a much higher utilization of brand medications by this population.

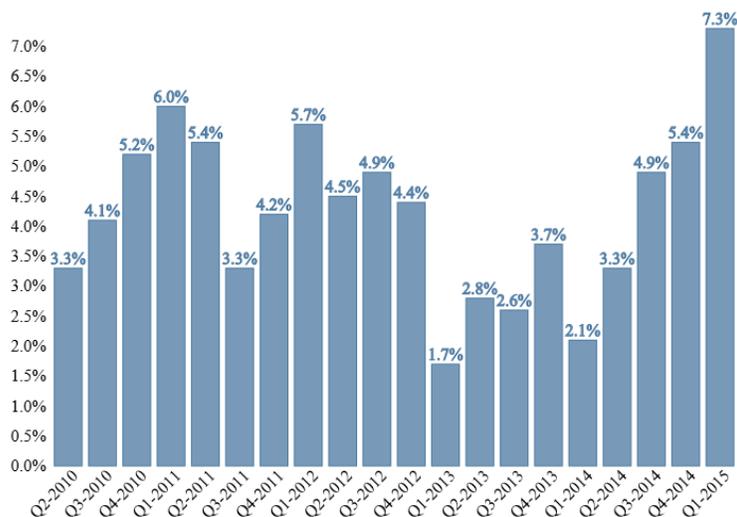
Section II – Benchmarking & Trends

As the Task Force considers options for mitigating costs outlined in the Epilogue, the Task Force needed to have a broader context for understanding the actions other employers (private and public) are taking to mitigate trends. Of particular interest were trends among public employers as well as specific programs undertaken by state governments in surrounding states. Aon provided trend information from a variety of external surveys that included private and public employers as well as some focused survey information on state governmental entities. Additionally, Aon offered findings for several public employers that have undertaken innovative changes in their health benefits programs with demonstrable results.

Trends reported by external surveys

Aon provided information from recent external surveys that highlight overall employer trends as well as trends among public employers. Across the various surveys, there are a number of consistent findings around cost drivers as well as actions being taken to address particular areas of increasing costs as well as the impact of the Affordable Care Act.

- While there were ranges in medical costs trend reported by external sources one trend consistently noted between 2014 and 2015 was an uptick in medical costs from historically low levels. A recent Kaiser Foundation health care services spending report shows health services spending grew from 5.4% in the third quarter of 2014 to 7.3% in the first quarter of 2015.



Health Services defined as: The latest figures from the Quarterly Services Survey (QSS), conducted by the U.S. Census Bureau, While the QSS does not cover all health spending – leaving out, for example, pharmaceuticals and medical devices, which are not considered services – it includes the vast majority of the health care spending.

Source: Kaiser Family Foundation analysis of Quarterly Services Survey

Overview of External Survey Findings:

- Cost drivers: the surveys reported one of the main reasons for the recent increase in rising health care costs is due to the rapid increase in the cost of prescription drugs and the introduction of costly specialty drugs, e.g., those for treatment of Hepatitis C.

- Kaiser Family Foundation's Quarterly Services Survey (QSS) also highlighted some other key components of health care costs that have experienced a great deal of volatility in a short period of time. Most notable were increases in hospital spending of 9.2% between 1Q14 and 1Q15. Hospital spending increases were due to a rise in the number of overall hospital days by 3.5% with a corresponding increase in the price of services and intensity of services provided.
- Surveys highlighted actions taken to reduce employer costs include increased consumer accountability for health care decisions and use of online tools; an increasing adoption of high deductible plans and movement toward full replacement with high deductible plans. Additionally, an increasing number of employers are charging dependents (both spouse/domestic partner and children) higher percentages of the premium for plan participation than they are charging for employee participation. Employers continue to adopt programs to control the increasing cost of prescription including preauthorization, narrower formularies and mandatory enrollment in specialty drug programs. There is also a continued focus on wellness programs and chronic disease prevention and management. More recently, employers are showing an interest in taking advantage of emerging health care delivery changes such as emerging Accountable Care Organizations and centers of excellence for particular elective procedures, e.g., bariatric surgery.

2015 AON Health Care Survey is an annual national survey of 1,000 employers, of which 6% are in the government, public employer category. Highlighted results listed below represent all respondents:

- Employers continue to shift a larger share of health costs onto their employees. Survey respondents reported that employee premium contributions and point of care out of pocket costs will exceed \$5,000 in 2016. The \$5,000 is a combination of the employee's share of annual premium (\$2,635 of a gross cost of \$11,484) and average annual out of pocket costs of \$2,433.
- More than 40% of companies reported they may move to plans that charge employees based on the number of family members on a plan rather than a flat premium in the next 3 to 5 years.
- Full replacement high deductible plans are in place for 16% of the survey respondents in 2016 and 41% are considering doing so in the next three to five years. Health Savings accounts represent the most prevalent funding option for high deductible plans with more 47% of employers offering their high deductible health plans with a Health Savings Account.
- Employers are given serious consideration to adoption of reference based pricing (current 6% next 3-5 years 53%) and centers of excellence (current 23% next 3-5 years 59%). Additionally, there is strong interest in value based design (current 28%, next 3-5 years 49%).

The PWC 2014 Touchstone Survey reported that Offering plans with narrow networks, investing in wellness programs and contracting directly with centers of excellence and participating in private exchanges are steps being taken by employers to reduce health care costs. The survey also noted that 44% of employers across all industries are considering high deductible plans as the only insurance option for their employee during the next three years.

The 2014 Towers Watson/National Business Group on Health Employer Survey on Purchasing Value in Health Care results confirmed findings from other surveys most notably. Employers are increasing employee contributions for dependent coverage; 49% reported having increase contributions for dependent tiers in 2014 with another 19% expected to do so in 2015 and the rate of ABHP total replacement has more than doubled between 2012 and 2015 with 16% of respondents offering total replacement ABHP in 2015. Additionally, the survey reported that almost one quarter of employers is applying spousal surcharges when other coverage is available to the spouse.

The Compensation and Benefits Report (sponsored by the State of Colorado and conducted by Milliman) with data from 39 public entities as of February 2015 found that:

- The average monthly premium for employee only coverage and family coverage paid by the employer was 87% and 77% respectively or 13% and 23% for employee and family contributions respectively.
- PPOs continue to be the most prevalent plan type among public employers with more than 84% (33 of the 39) offering a PPO and the average in network deductible is \$993 for single coverage and \$2173 for family coverage.
- Almost half 18 of 39 of the respondents offered a high deductible plan with a health savings account and 15 of the 18 provide a contribution to the health savings account. The average contribution to the savings account is \$756 for single coverage and \$1390 for family coverage.

The survey of State Employee Health Plan Spending represents the first report from the study commissioned by the Pew Charitable Trusts and the MacArthur Foundation in conjunction with Milliman to develop a national benchmark against which states can compare the costs and characteristics of the plans offered to state employees. Key study findings are highlighted below:

The actuarial value of state health plans is, on average, about 92% or equivalent to a platinum plan on the public health plan exchanges offered. In 42 states, the average actuarial value was at least 88% and 8 states had averages ranging from 80 to 87%.

In 2013, 19 states offered plans with a deductible of at least \$1500 for employee only coverage, representing an increase of 3 states from 2011. However, only 7 percent of employees in those states offering a plan with a deductible enrolled in those plans. Most state government employees enrolled in plans with no annual deductible (48%) or in plans with a deductible of less than \$500 (32%). In 2013, only 8 percent of enrollees were in plans with deductibles of \$1,000 or more.

In 2013, the average employee contribution was 20% of dependent tier premiums, 7 percentage points higher than the average share paid for employee only coverage. Delaware and 16 other states do not vary the contribution percentage by tier; employees pay the same percentage/tier regardless of the tier. The wide range of premiums among state sponsored plans suggests that variation in provider prices and physician practice patterns impact price.

Benchmarking of Plan Costs (Employee and Employer)

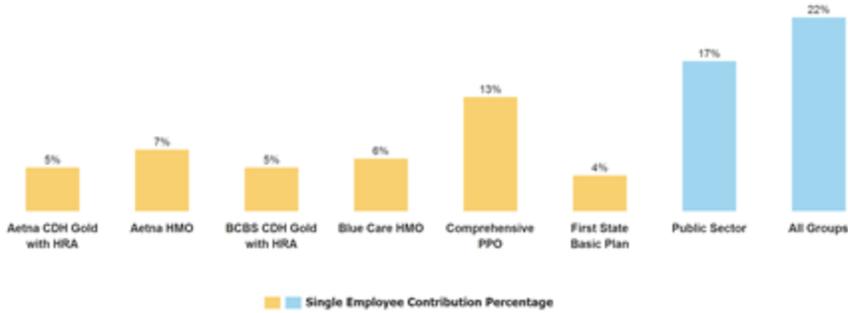
As part of the benchmarking analysis, Aon input key cost and design metrics for the GHIP health plans and compared the results against two benchmarks: a national industry group of 46 public employers and more than 1,000 national employers in the database. Of the 46 public sector organizations more than 102 various benefit plans representing a wide array of designs and cost sharing arrangements are offered and compile the database.

Key findings are represented on the charts below:

- Contributions from state employees to participate in any GHIP offered plan, on either a single or family basis are lower than the public sector benchmark group or the national employers' comparator group. The survey results also show that the plan design features resulting in out of pocket costs at the point of care are generally higher in the GHIP plans than among the comparator industry group. However, out of pocket costs resulting from higher deductibles are offset by the State of Delaware's funding of the accounts which offset much of the cost sharing impact of the higher deductible.

Single Employee Contributions

Percentage of Total Premium, Weighted Average



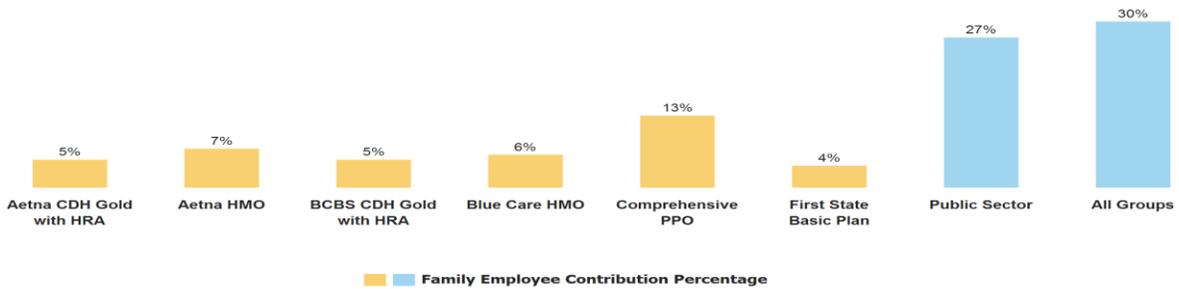
NOTE: This report was generated on September 15, 2015 and includes 48 public employers. The benchmark industry group is based on 46 employers offering 102 various benefit plans. Aon continually refreshes the plan data and results may change as new clients and plans are added to the database.

Aon Hewitt | Health and Welfare
September 24, 2015



Family Employee Contributions

Percentage of Total Premium, Weighted Average



Benchmarking of Prescription Drug Plan Costs

At the request of the State Employee Health Plan Task Force, GHIP’s Prescription Benefit Manager, Express Scripts, Inc. conducted a benchmarking analysis of the State of Delaware’s employee plan results compared with other public employer groups. A comparison of the State of Delaware’s commercial population (non-Medicare) compared with ESI’s government employer business under 65 population is highlighted due to the comparable average age of members (State of Delaware 35.4 and the benchmark group 36.2).

ESI reported the following comparisons across key metrics:

	State of Delaware	ESI Govt under 65
PMPM plan cost/ *	\$108/9.1%	\$106/13.2%
Plan cost/rx*	\$138/9%	\$107/8.9%
Generic fill rate*	79.9%/3.3%	81%/2.1%
Home delivery use*	12.3%/3%	18.3%/-2.3%
Member cost*	9.4%/-1.4%	11.8%/-0.6%%
Specialty percent of plan cost*	25.5%/5.2%	26.8%/2.9%
Specialty Plan cost PMPM*	\$27.53/37.4%	\$28.53/26.7%

*Represents change from 2014 to 2015

Key observations:

While the State Plan's increase of 9.1% between 2014 and 2015 was lower than the Government benchmark increase of 13.2%, the underlying costs of a prescription are significantly higher in the State Plan versus the benchmark plan (\$138 vs. \$107 per script). The following metrics are likely contributing to the higher cost of prescriptions under the state health plan as compared to the benchmark:

- The State of Delaware has a lower generic fill rate than the benchmark (79.9% vs. 81%)
- Home delivery in the Delaware plan is significantly lower than the benchmark (12.3% vs. 18.3%)
- Member out of pocket costs on a per prescription basis are lower and are declined more rapidly than the benchmark (9.4% vs. 11.8% and 1.4% vs. 6%)

Medical and Prescription Drug Cost Trends: Public Sector Comparison (Geographically Closest States)

The Task Force requested information on the emerging medical and prescription drug trends of other state sponsored employee health plans and/or Delaware based employers. Based on Aon's experience with several of the state plans and the use of publicly available information, historical and emerging trends reveal an uptick in spending for the State of New Jersey, and State of New York. Additionally the trend of a large Delaware employer was also shared.

- National trends 2013 to 2014: medical 2.2%, prescription drug 10.8%, total 3.7%, State of NJ (Active) – historical average medical (5.9%), prescription drug (11.9%), rating trend medical (7.5%) prescription drug (18%)
- State of NY (Active) – historical average medical (3%), prescription drug (3%), rating trend medical (7.5%) prescription drug (18%)
- Large Delaware employer: historical average trend (medical and drug) 3.7%. Emerging trend 12.4% as a result of rising prescription drug costs.

Innovation among Public Employers: Population Health/Health Plan Management

The members of the Task Force were particularly interested in what other public employers (state governments) were doing to control the increase in health care and prescription drugs for their active employee populations. Research showed a variety of approaches has been taken at the state level to mitigate increasing cost trends.

State of Connecticut

Facing a projected budget gap of \$3.8 billion in FY12, the Governor's office and representatives for labor unions across the state formed a task force to study options for reducing unsustainable health care costs. The Health Enhancement Program was adopted in 2011 for FY12.

The plan rewards members (active employees, select retirees and dependents) for managing their health as long as they complete the following key activities specified age and gender appropriate health risk assessments, evidence based screening (mammograms) and preventive physical and vision exams; undergo 2 dental cleanings per year if enrolled in dental coverage and participate in targeted chronic disease management services if the enrollee has diabetes, high cholesterol, high blood pressure, heart disease, asthma and/or COPD.

Those enrolling in the program receive not only lower monthly payroll deductions for participation but also a plan of benefits without a deductible and waiver or reduction of copays for medication to manage chronic conditions and/or visits to treat chronic conditions. After one year of the program, early results showed virtually all employees enrolled in the program (90%) and almost all of those (99%) completed the program requirements. Program utilization showed an increase in less costly primary care visits with a decrease in costly specialist and ER visits, improvements in preventive screening rates and a reduction in medical trend from 13% in FY11 to 3.8% in 2012 after one year of new program.

California Public Employees' Retirement System (CalPERS) implemented reference pricing for hip and knee replacements in 2011. Working with Anthem, it was determined that 10-% of CalPER's total costs for joint and muscle conditions were for routine hip and knees replacements. Anthem's data showed significant variation in price by facility for the same procedure, almost a difference of 10 times between the lowest and highest cost facilities.

A threshold of \$30,000 in payments to hospitals for each surgery was established. This amount was based on median costs in the community and represents the amount of payment made to designated hospitals where enrollees could get care at or below that price. Enrollees opting for care at a non-designated hospital were responsible for both the typical cost sharing and all allowed amounts in excess of \$30,000. Amounts in excess of the threshold were not applicable to satisfaction of the out of pocket maximum. First year results were savings of close to \$3 million for CalPERS and \$300,000 in out of pocket costs for enrollees. The program was extended to outpatient colonoscopies, cataract surgeries, and arthroscopies in 2013. An independent research subsidiary of Anthem did a comparative analysis of post-operative patients after 30 days for general complication rates and 90 days for readmission rates. No significant difference in quality outcomes was noted between the group in 2010 (before reference based pricing was implemented) versus those patients that were subject to reference based pricing for procedures performed in 2011.

State of Kentucky

The State of Kentucky offers a comprehensive wellness program through Vitality (a specialty wellness vendor) and Anthem (health carrier). This gated approach to design requires enrollees to complete LivingWell program components – a health assessment or a biometric screening- prior to May 1st in order to receive the plan with lower cost sharing at the point of service (coinsurance of 15% versus 30%).

Other programs offered to the state plan enrollees include:

- A diabetes prevention program including no copayments for preventive drugs
- Onsite health care services delivered by third party employed Nurse Practitioners at various locations
- Health coaching for all members including smoking cessation and weight management programs
- Point accumulation for completion of health activities that can be used for discount purchases including healthy food at Walmart

- Introduction of a new health care transparency tool (Compass) which rewards members for using a lower cost health care provider (\$25-\$500) within 45-60 days after the service rendered

Results for The State of Kentucky health plan demonstrate a sizable reduction in PMPY claims costs between the same period 2014 versus 2015 in key areas including: allowed amount for outpatient lab (-11%); outpatient radiology (-9%) and out of pocket Rx costs PMPY (-5%). In contrast, the out of pocket per member per year amount increased by 15%. Additionally, utilization metrics decreased between 2014 and 2015, including inpatient days per 1,000 and visits to outpatient facilities.

The State of New Jersey is offering a Tiered Network plan to all active employees in 2016. Both of the State's health plan vendors – Horizon BCBS and Aetna – will offer a Tiered Plan Option. The purpose of this program is to financially incent members to use the lower cost, narrower network option. The key program elements are outlined below:

- The premium equivalent rates for the Tiered Network plan (Tier 1) will be 25% less than the medical premium equivalent rates for New Jersey's current most popular plan option – the \$15 copay plan.
- Many of the Tier 1 providers and facilities will be operating as Patient Centered Medical Homes (PCMHs) or Accountable Care Organizations (ACOs). As part of this designation, Tier 1 providers and facilities are expected to provide an enhanced patient experience and improve population health including extended office hours and preferred scheduling, among other enhancements. However, the Tiered Network plan will offer no out-of-network coverage.
- Tier 2 providers and facilities will be those in-network providers for the Aetna and Horizon PPO products offered to the State of New Jersey employees.
- Tiered Network Plan enrollees who use Tier 1 providers will have lower out-of-pocket cost-sharing than enrollees who use Tier 2 providers. Hospice, delivery of a baby and inpatient mental health/substance abuse services are offered free of charge when provided by a Tier 1 provider/facility.

Section III – Payment Reform and Hospital Contracting

The scope of this section will be to discuss the medical component of the GHIP and the process by which hospitals, physicians and other providers are paid; including possible incentives, penalties, and risk-related payment influences. Prescription drugs, paid through the pharmacy benefit manager Express scripts Inc., are not included in this section.

As discussed, the GHIP provides benefits to Active employees, Non Medicare retirees, and Medicare Primary retirees. The Active and Non Medicare retiree plan has identical contracting and plan provisions, while the Medicare Primary Plan is governed by the payment rules set forth by Medicare. The GHIP uses Highmark BCBS and Aetna as vendors, including responsibilities related to provider contracting (which providers are “in-network” vs. not), payment rates for providers and services, and any risk- or incentive- based payments.

The primary payment mechanism for the GHIP to its providers of care is discounted fee for service (FFS). In this system providers are paid based on their retail charges (akin to MSRP), with the negotiated discount (by Highmark or Aetna) applied to create a net charge to the GHIP. This net charge is used in the claim adjudication process to allocate the payment responsibility to the member and the GHIP. This is not so with Medicare; Medicare has created a number of bundled or episodic payment methods including bundled payments to Accountable Care Organizations (ACOs), DRG-based payments for inpatient care (Medical Severity Diagnosis Related Group), and APC-based payments for outpatient care (Ambulatory Payment Categories for prospective payment). Medicare Advantage programs bring even more cost management and innovative payment approaches to the hospitals and physicians than Original Medicare.

Medicare ACOs: <https://www.medicare.gov/Pubs/pdf/11588.pdf>

MS-DRG Payments: <https://www.medicare.gov/hospitalcompare/Resources/Glossary.html>

APC payments: <https://www.medicare.gov/Pubs/pdf/02118.pdf>

The payment process for the non-Medicare population is beginning to use the concepts already in place for Medicare participants using some type of risk-taking, bundled approach to payments. Collectively, this is known as Pay for Value, or P4V. P4V attempts to create incentives for providers to deliver only the proper care at the bundled price, as compared to FFS where every service generates a payment to the provider. The P4V programs currently being implemented by Highmark and Aetna include Patient Centered Medical Home (PCMH), ACOs and bundled/episodic payments such as DRGs, APCs, and similar bundles.

PCMH: <https://pcmh.ahrq.gov/>

Highmark reports 20% of their total commercial membership participates in their P4V programs of PCHMs and ACOs. While more than 28% of Aetna’s spend nationally is in P4V programs, the state of Delaware lags their book of business. The Delaware Center for Health Innovation asserts an aspirational goal of more than 50% of relevant spending being channeled to P4V in 2016, and both Highmark and Aetna agreed this was aspirational and very aggressive.

One possible driver of the lag in Delaware compared to other venues is the perceived lack of competition in the hospitals. With 8 facilities statewide, some of which are highly specialized, patients have at most two, and often only one, facility within a reasonable travel radius. This perceived lack of competition was further bolstered by the Highmark data, statewide, of case-mix adjusted costs for Delaware Hospitals being between 101% and 146% of the Pennsylvania average. Additionally, Medicare Advantage programs, which as stated above bring even more cost management and innovative payment mechanisms to hospitals, physicians and other providers, are under-represented in Delaware compared to national averages.

There was considerable discussion and interest by the Task Force in payment reform as a means to lower cost, as this is perceived to bend the cost curve and not shift costs to members, nor force further cost

absorption by the State. The Task Force requested considerable financial analysis of hospital payments, particularly compared to Medicare, but the necessary data in the detail and format necessary to facilitate this analysis was not available in the short duration of the Task Force lifespan.

Opportunities for cost savings and efficiencies to the GHIP in a spectrum of possible pathways, set forth below are discrete steps which may be pursued by the legislature. The vast majority of these may or will require enabling legislation; as the aim of this section is not to simply suggest plan design changes in the GHIP but major payment reform pathways that were discussed by the Task force. These are characterized as:

- Episodic care (bundled) payments – member responsibility
- Episodic care (bundled) payments – vendor responsibility – negotiated case rates
- ACO capitation
- Full cost of care development, eliminate “discount off charges” as payment metric
- Can be FFS or P4V
- External to tradition vendor provider relations
- Governmental Determination of payments – creation of Hospital Services Cost Review Commission in Delaware

Episodic care (bundled) payments – member responsibility

General Construction:

For this payment reform, the responsibility of provider choice for particular episodes of care is placed on the member. Because of this, the episodes are typically characterized by the following characteristics: Procedures (typically surgeries) for non-urgent care; significant variations in cost, ability to be performed at a variety of facilities. Facilities or providers must create an episodic cost for each procedure subject to the episodic care payment mechanism, and a maximum payment threshold is then established. If a member chooses to have the procedure at a facility whose charge is above the maximum, the amount above the maximum becomes a “balance bill” item that is the member’s responsibility to pay. Quality measurement is implemented to assure high quality, cost efficient care.

Why it works:

Members are incented to use efficient and effective providers and to move care away from high cost and possibly inefficient providers.

Application:

This process has wide-sweeping variations, from simplistic procedures (e.g. specific imaging procedures) to more comprehensive surgeries (e.g. specific joint replacements). The key determinant is that the member must have the time, staging and information to effectively evaluate alternatives. For example, in a joint replacement, site selection must be chosen prior to selecting a particular surgeon, as the choice of surgeon may significantly limit the options of the member.

Medical vendors and/or providers must be significantly involved to create the staging and information necessary for the member to make an informed decision in a timely fashion.

Episodic care (bundled) payments – vendor responsibility

General Construction:

For this payment reform, the responsibility of provider reimbursement is placed on the vendor to negotiate an appropriate case rate. Facilities or providers must create an episodic cost for each procedure subject to the episodic care payment mechanism, and a maximum payment threshold is then established. Providers must then accept this determined payment, but no more than the maximum. If the provider does not agree to this determined payment, they are deemed to be either “out of network” for this particular procedure. If a member chooses to have the procedure at a facility whose charge is out of network, the amount above the maximum becomes a “balance bill” item that is the member’s responsibility to pay. Quality measurement is implemented to assure high quality, cost efficient care.

An alternative to the “out of network” issue is the current status of provider contracting currently in process with both Aetna and Highmark. Vendors negotiate some type of bundled approach where mutually agreeable terms and conditions are agreed to by vendor and provider, then the episodic care payment process is implemented. Fee for Service is utilized while negotiation is in process, or if mutually agreeable terms are not reached. This approach leaves piecemeal contracting of some fee for service, and some episodic payment processes.

Why it works:

Members are incented to use efficient and effective providers and to move care away from high cost and possibly inefficient providers. Providers are incented to accept the determined payment rather than be deemed “out of network” for the given procedure, and improve care coordination and efficiency once the bundled approach is implemented. Vendors are deeply involved to negotiate with providers to keep the procedure in-network.

Application:

This process has wide-sweeping variations, from simplistic procedures (e.g. specific imaging procedures) to more comprehensive surgeries (e.g. specific joint replacements). The key determinant is that the Medical vendors and/or providers must be significantly involved to finalize negotiated payment rates for all the episodes to be utilized in this option.

Accountable Care Organization – At Risk Payments

General Construction:

For this payment reform, ACOs agree to take a payment for more services than are included in the Episodic Care method. These services can be a full treatment spectrum once a prospective patient is identified, or even a full capitation amount for all potential services a member may incur in a year. The approaches reinforce key Pay for Value themes of 1) Rewards and incentives for quality, positive health outcomes, and patient satisfaction 2) Care coordination between primary care, specialists, hospitals, other providers, and 3) Integration of patient care across the care continuum.

ACOs in this approach must begin to approach integrated delivery systems, with effective care management protocols, significant data-sharing and efficiency feedback loops that allow decision-makers to identify and implement efficient processes, while eliminating inefficient processes at the particular provider level.

Payment mechanisms can be full risk transfer to the ACO, or partial risk transfer with gain-sharing or loss-sharing parameters implements.

Why it works:

ACOs in this approach are incented to deliver care in a coordinated and very efficient manner, across the entire continuum of care. The Integrated Delivery System approach is a proven methodology, with proven 5-star models such as Kaiser and Geisinger.

Application:

This method is a substantial move in the pay for value spectrum, prompting responsibility of care delivery to ACOs. Substantial infrastructure must be assembled by the ACOs for this method to work appropriately.

“Elimination of Discounts” Provider Contracting**General Construction:**

Reliance on current FFS level “charges” and “discounts off charges” are eliminated. In place, a different system is utilized to create the payments to providers. Two particular themes were discussed in detail.

The first theme was to base the provider charges on some level of established governmental payments, such as Medicare and/or Medicaid. There was recognition that governmental programs likely do not provide full coverage of fixed cost, variable cost, and reasonable “profit” for some providers, hence a multiple of the governmental payments would be utilized. No data was analyzed to achieve an understanding of what that multiple might be.

The second theme was to base the provider charges on a determination of the underlying cost of the particular service, providing full coverage of fixed cost, variable cost, and a reasonable “profit” for services. This “from the ground up” analysis information is clearly a massive undertaking, and would require a specialized contractor to facilitate.

In both of these situations, current vendor’s provider contracting skills may, but would not definitely be, utilized for the negotiation with the providers. In one variation, the provider charges are established without a negotiation with the providers, and an infrastructure is put in place to negotiate with providers to eliminate the excess charges between the current method, and this new methodology, creating substantial disruption to the current system of provider negotiations and in-network payments, which have no balance billing issues.

Why it works:

Provider charges are lower, as the assumed coverage of costs and reasonable profit is less expensive than the discounted fee for service payments currently. Pay for value concepts are not necessarily utilized here, this is a method focused on cost per service. As such, the potential for service increase exists to keep revenue at current levels for providers.

Application:

This method has the capacity to be seriously disruptive to both the member and the provider contracting of the existing vendor establishment, as it contemplates a complete overhaul of the payment process methodology. As such, understanding the data and methodology to be utilized will be critically important to a successful implementation.

Governmental Oversight and Setting of Payment Rates

General Construction:

A newly-established Health Services Cost Review Commission would be charged with the responsibility to set the payment rates to providers (facilities: hospitals and perhaps some outpatient facilities such as surgical centers or imaging) to be utilized by all “commercial” plans in the state. The methodology to do so would likely be premised on the **“Elimination of Discounts” Provider Contracting** discussed above.

Incorporating pay for value concepts would be at the discretion of the Commission.

Why it works:

Provider charges are lower, as the assumed coverage of costs and reasonable profit is less expensive than the discounted fee for service payments currently. Pay for value concepts are not necessarily utilized here, this is a method focused on cost per service.

Application:

This method has the capacity to be seriously disruptive to both the member and the provider contracting of the existing vendor establishment, as it contemplates a complete overhaul of the payment process methodology. As such, understanding the data and methodology to be utilized will be critically important to a successful implementation.

Section IV – Areas of Inquiry

Section IV discusses potential changes to the GHIP for short-term and long-term savings, involving cost sharing at the point of utilization (sale), premium sharing on a per-paycheck basis, directing care to specific providers, and creating incentives and disincentives for certain behaviors.

These opportunities for cost savings and efficiencies to the GHIP were presented in four dimensions:

- Redesign Plans / Plan Design
- Review Premium Cost-Sharing Structure
- Enhance Population Health / Health Plan Management
- Options for Retirees

Additionally, some specific suggestions from Express Scripts on administration of the prescription drug program are woven into the above categories.

Redesign Plans / Plan Design

Concept involves reshaping the Benefit Plan options (Comprehensive (high Option) Preferred Provider Organization (PPO), Health Maintenance Organization (HMO), Consumer Directed Health Plan (CDH), and First State Basic (FSB) PPO Plan) in some fashion. Reshaping the Benefit Plans inherently involves changing the form and amount of cost-sharing at point of sale for various services purchased by the participant. The overall cost-sharing is captured in the concept of Actuarial Value.

Actuarial Value is a health care industry term used to represent the percentage of total average costs for covered benefits that a plan will cover. Actuarial Value is not tied to a predetermined plan design, but should be reflective of the total population that could utilize the benefit plan option.

The current plan options have actuarial values in two groupings: a) PPO and HMO: 90 to 91%; and b) CDH and FSB: 86 to 87%. For example, if an average participant utilized \$1000 in services for a month, we would expect on average that a 90% Actuarial Value plan would have a plan payment of \$900, and the “patient responsibility” would be \$100. Patient Responsibility is another term for member cost sharing.

Budget Savings is generated, in general, by reducing the Actuarial Value of the Benefit Plan offerings, generating greater cost sharing by the participant. Secondly, most of the Redesign Plan options have inherent attributes that should reduce overall plan spending; and these secondary issues are discussed herein. The Secondary Issues “bend the cost curve”. Furthermore, reducing the Actuarial Value of the plan, and the cost increases by bending the cost curve, are two features that assist in mitigating the High Cost Employer Plan Excise Tax.

One option in this dimension simply adds cost-sharing to the existing Benefit Plan offerings to achieve savings, while the others involve significant reshaping of the Benefit Plan offering. As such, the options involving significant reshaping will likely require enabling legislation to be implemented.

Status Quo:

Trend Mitigation of current plans (HMO, PPO = 90% AV; CDHP, FSB = 87% AV)

- Continue all current benefit plans
- Change plan designs by increasing the cost-sharing – notably change/add deductible or other significant cost-sharing additions.

Adding cost-sharing reduces the Actuarial Value of the plan, and hence the overall plan cost. Sample action: adding \$500 to the deductible (or adding a deductible if none exists) of each plan option.

This Option does not require enabling legislation, and is very similar to prior incremental efforts to lower plan costs.

The remaining plan options, discussed below, require enabling legislation. The final cost savings for any new plan implementation would involve a variety of parameters and implementation items; one important item is the related contribution strategy. Contribution strategies in general are discussed in the following section.

As the options below are considerably different than the current benefit offering, the change management requirements (after enabling legislation) may make implementation for July 1, 2016 challenging. Having a linkage to one of the current benefit options mitigates this challenge somewhat. To be clear, these options eliminate all the current options, and replace them with the described benefit options.

Plan Design 1:

- Two Option CDH plans – Sample plan designs in Delaware context
 - High Option: Current CDHP – \$1,500 / \$3,000 deductible, with \$1,250 / \$2,500 Health Reimbursement Account funding, \$ 90%/10% coinsurance (87% AV)
 - Low Option: new Low Option CDHP – \$2,000/\$4,000 deductible with \$1,000 / \$2,000 Health Savings Account (HSA) Funding by State, 80/20% coinsurance (80% AV). HSA-compliant HDHP, implies compliant benefit design (prescription drugs subject to the deductible, with compliant integrated Out-of-Pocket Maximum)
 - Member to pay the difference in premium cost between the low and the high option, in addition to the base contribution on the low option (such as 5% of cost)
- Why It Works: CDH Plans are supported with transparency tools that allow participants to become better, wiser consumers of health care

Plan Design 2:

- Two Option “gated” plan design
 - High and Low Option
 - High Option only available if key health management / biometric tasks performed (the “gate”)
- Two Option CDH plan is likely plan offering
 - High and Low Option
 - High Option: lower deductible, 10-15% coinsurance
 - Low Option: greater deductible, 20-30% coinsurance
 - Marginally greater contribution (premium share) rate for High Option plan
- Why It Works: Gates identify and risk-mitigate trend pressure
- Gate(s) to receive access to High Option
 - Biometric screening or detailed Health Assessment
 - Participation in risk management program or wellness program depending on outcome of assessments (reduces participants overall cost)
 - Specific, personalized goals to get and stay healthy
 - Could dovetail onto plan design 1 – a next phase

Plan Design 3:

- Managed Care Plans – open-ended HMOs. Specifications:
 - HMO platform, like current HMO, with various cost-sharing changes to achieve differing AVs between the plans
 - PCP is required and very focused on care management and pay for value (P4V)
 - Modest Out-of-Network benefit, consistent with the CMS definition of open-ended HMO (typically formulated to assure 90+% in-network utilization)
- High & Low Option - Sample plan designs in Delaware context
 - High Option: Current GHIP offering with 90% AV, add modest Out-of-Network benefit

- Low Option: 80-85% AV offering, modest Out-of-Network benefit
- Sample Plan Design for Low Option Plan at 85% AV:
 - \$500 deductible
 - \$200 copay per day on hospital stay – with maximum
 - Greater Physician and Emergency Room copays
- Member to pay the difference between the low and the high option
- Why it Works: significant Pay For Value and “managed care effect” should risk-mitigate trend pressure – expect considerable participation by participants as well (in care management programs)

Plan Design 4:

- Active Exchange: 2-4 vendors offer identical benefits designs set by the Exchange Vendor to participants, with a fixed dollar subsidy per coverage tier. Rates are specific to the group.
 - Applicable to active employees and family members
 - Can be insured or self-insured, depending on the exchange vendor
 - Typically offer Silver (70% AV), Gold (80% AV) and Platinum (90% AV) as directed by the Exchange vendor – Exchange Vendor has total control of plan design
 - Not unlike what is offered today with CDHP and HMO options with Highmark & Aetna
 - Private exchange vendors will establish plan design and network coverage with Highmark, Aetna and possibly other carriers
 - Bronze, Silver, and sometimes Gold Plans are CDHP, otherwise traditional PPO or HMO/EPO plan designs
- Why It Works: Direct competition between Insurers creates incentives for them to reduce costs, provide most efficient plan inner-workings; administrative exchange platform provides shopping tools and transparency, and administrative infrastructure; plan sponsor relieved of plan design change burden year over year

Premium / Cost-Sharing Structure

Concept involves differing methods to share in the monthly cost of the Benefit Plan offerings, which are currently legislated as follows: Comprehensive (high Option) Preferred Provider Organization (PPO) – 13.25%, Health Maintenance Organization (HMO) – 6.5%, Consumer Directed Health Plan (CDH) – 5.0%, First State Basic (FSB) PPO Plan – 4.0%. The percentages reflect the amount of premium the (state) participants must pay via payroll deduction to participate in the plan. The complement, the amount paid for by the State, is known as the State Share. Note that outside groups and many specific state groups with collective bargaining agreements (such as educational employees) likely are not subject to these contribution amounts. Note that the percentages above are charge on all dependent tiers of coverage.

Base contribution strategies are difficult to discuss without a firm establishment of the Plan Design discussed in the above-section. As such, there was considerable discussion about the amount of any plan offerings Actuarial Value should or could be covered by the State Share. Currently, on average, the State Share covers approximately 80 of the 86 to 91 Actuarial Value points inherent in the Benefit Plan offerings. That is, the State Share pays about 90% of the premium cost.

Budget savings is generated by having the participant pay more of the cost.

Status Quo Option:

One option in this dimension simply adds cost-sharing to the existing Benefit Plan offerings to achieve savings, while the others involve significant reshaping of the structure of the contributions. It appears that all options to change contributions will likely require enabling legislation to be implemented.

- Implementation: Increase contribution percentages
 - Currently 4% for FSB, 5% for CDHP, 6.5% for HMOs, and 13.25% for Comp PPO
 - If current designs are maintained, these contribution structures could be consistently changed
 - A 10% savings example:

- FSB at 14%, CDH at 15%, HMO at 16.5%, PPO at 23.25%
- Maintains relative cost differences between plans, absolute dollars increase

Other options focus on specific situations where many plan sponsors have created complexity to achieve their goals. This complexity is implemented to achieve a particular objective. We discuss two of the most popular variations below.

- Implement salary-based contributions – achieves relative fairness of contributions when viewed in the context of percentage of salary
- Subsidize dependents different than employees – achieves allocating more funding to the current (and former, if implemented for retirees) employees, and less to their dependents.

Complex Option 1:

Implement Salary-based Contributions for Active Employees. While most plan sponsors will implement this solely for active employees, it is possible to be done for retirees premised on pension amount.

- Implementation:
 - Create stratification “buckets” of salary bands
 - Implement a different contribution structure (dollar amount or percentage) per salary band
 - Can be phased in over time for change management purposes.
 - Can be implemented in virtually any multiple-option environment
- Why it works
 - Can result in contributions being a stable percentage of pay, resulting in “fair” contributions
 - Would need enabling legislation

There is a sample Contributions Schedule contained in November 5 Task Force presentation, with 9 salary strata (“buckets”) ranging from “less than \$30,000 per year” to “more than \$100,000 per year”, with \$10,000 increments. Percentages of Plan Cost are utilized as contributions in this sample, similar to method used currently. There are consistent increases in the contribution rates, which create a reasonable array of contributions when viewed in proportion to pay.

Complex Option 2:

Subsidize dependents different than employees in each of the three contract tiers with dependents. Currently the GHIP operates on a four tier structure, with each tier containing the same contribution percentage, including those covering dependents. This option creates contributions with greater percentage contribution for tiers covering spouses and/or dependents.

- Implementation:
 - Create target percentage amount to subsidize
 - Can be phased in over time for change management purposes
 - Can be implemented in virtually any multiple-option environment
- Why it works
 - Emerging practice of reducing the additional plan sponsor funding of covering dependents, which doesn’t exist in other compensation-based systems such as pay or retirement income
 - Would need enabling legislation

There is a sample Contributions Schedule contained in November 5 Task Force presentation, with a reduction in State Share percentage, and increase in participant contributions, for the dependent cost of the premium rate. Percentages of Plan Cost utilized in sample, similar to method used currently, with consistent increases in contributions to dependent costs of 10% of premium.

Double State Share:

The Final option discussed in this category (besides surcharges, which are covered later) is the elimination of Double State Share. This phenomenon was eliminated by HB 81 for emerging employees, but “grandfathered” for existing relationships.

Double State Share (DSS) exists when a husband and wife were married, both worked for the State (or were retired from the State), and were enrolled in the GHIP prior to January 1, 2012.

- HB 81 implemented a modest contribution requirement of \$25 for each contract chosen by the DSS eligible employee or pensioner effective July 1, 2012 (previously there was no contribution if one contract was chosen)
- State pays the difference between the \$25 employee contribution and the actual total employee contribution for the plan and tier chosen

Eliminating DSS does not change the amount of funds into the GHIP, but reduces the cost that the State contributes to the GHIP for the DSS eligible employees. Recent estimate of State funding for this feature is approximately \$3.5M General Funds.

- Implementation:
 - DSS would be eliminated and grandfathered Double State Share eligible employees and retirees would pay the full amount for the group health plan and tier in which they were enrolled.

Would need enabling legislation

Enhance Population Health / Health Plan Management

Enhancing participant health through incenting/disincenting certain behaviors, or implementing focused programs to enable more efficient or effective purchasing of certain procedures or episodic events, represents a spectrum of opportunity for plan sponsors. The Concept discussed in the Task Force focuses on specific areas of opportunity, which are described below. In general these opportunities are not mutually exclusive, (meaning that any to all of them could be implemented. Many of the opportunities are optimized with the introduction of plan design steerage or design differential and it appears unlikely that enabling legislation is required to implement any of these design or program changes.

In the November 5th presentation to the Task Force, a number of examples were presented detailing the opportunities pursued by selected States along the spectrum. Additionally, Highmark Blue Cross/Blue Shield and Aetna had previously presented programs available for State Health Plan’s consideration along the spectrum of opportunity. The programs discussed in detail during the November 5th presentation include the following:

- Value Based Plan Design
- Reference Based Pricing
- Tiered Networks for Laboratory services
- Site Selection Review for High Tech Radiology services
- Care Authorization for Physical Medicine services
- Centers of Excellence for certain procedures
- Advanced Utilization Management for Prescription Drugs
- Onsite Healthcare delivery
- Tobacco Free Reward via Surcharge
- Wellness Participation via Surcharge

Value Based Plan Design

- At a macro level, value based design is defined as a design that aligns consumer cost-sharing with the value of health care services and providers. In practice, Value based designs reduce the financial barriers to stand in the way of members getting medically necessary services. e.g., 1) medication/supplies to control diabetes and 2) discourage use of low value care, e.g., payment of higher costs without evidence of better outcomes.
- Many employers are revisiting their current health management and chronic disease programs to ensure greater participation by those that will yield the most savings for the program and themselves. As a result, developing a focused value based design program that targets those at greatest risk for developing chronic conditions and financial incentives/cost share reduction for members with asthma, congestive heart failure, COPD, coronary artery disease, depression, diabetes, high cholesterol, and hypertension are gaining traction. Selection of the target population is done via an analysis of claims data utilization. In order to reduce barriers to care, reduction of cost share may, depending on the results of the data analysis, apply to the following services for those at highest risk for a chronic condition:
 - Pharmacy and supplies
 - Diagnostic testing
 - Office visits to primary care/specialists
 - Additional preventive visits for dental cleaning and vision screening (as applicable)
- In order to qualify for the value based design, some level of elective participation is generally required including:
 - Completion of a health assessment including biometric screening
 - Agreement to work with a health coach and participate in monthly or quarterly check-ins that demonstrate health outcomes are improving or stabilized: e.g., A1C values, BMI, normal blood pressure range, etc.
 - Program opt in and participation for at least 90 days before participant's eligible for incentives

Implementing a value based design at GHIP will require a data analysis on the chronic disease states most prevalent in GHIP and the gaps in care most likely experienced by members with chronic disease. Design of incentives should target increasing the activities/positive behaviors represented in the gaps in care. Member and plan expectations should be established and communicated prior to implementation so as to ensure program accountability.

Reference Based Pricing

- Reference based pricing is an approach where a maximum allowed amount (reference price) is set for a specific medical service or procedure in a local market. Those receiving care at facilities with pricing that exceeds the reference price, are responsible for paying the excess amount out of pocket, without reimbursement from an employer sponsored medical plan.
- Those early adopters of reference based pricing have focused on outpatient diagnostic testing procedures such as : MRIs, endoscopies, CT scans as well as common elective surgeries including hip replacements, knee arthroscopies and knee replacements.
- How it works:
 - A payment threshold based on median payments made to free standing and hospital affiliated facilities in a specific locale, e.g., country, MSA, state
 - Provider reimbursement capped to payment threshold with member responsibility for amounts in excess of the threshold
 - Amounts in excess of the threshold not applicable to the deductible or out of pocket maximum typically (in-network or out of network)

- Implementation
 - In order to develop the procedures that will yield optimal savings for the State plan without impacting quality or access to care, information is needed which easily identifies facilities that are at or under the threshold for each test/procedure and the frequency of each procedure.

Once the threshold price is established, participants may have access to health coaches at both Highmark and Aetna, who can assist in identifying providers that charge the reference price and are accessible to the patient. The health coaches can also help facilitate appointments. Tiered Networks for Laboratory services.

Tiered networks for Outpatient Laboratory Services

One of the areas where there is considerable variation in price and allowable charges is outpatient laboratory services. The least expensive pricing for the vast majority of routine laboratory testing is typically through a national laboratory company that has contracts with medical plan carriers, e.g. Quest Diagnostics or LabCorp. While most in network providers are expected to send lab work to these national organizations, there is typically no requirement to do so. As a result, an increasing number of providers, particularly those that are affiliated with a hospital network, are sending the lab draws to freestanding or hospital affiliated labs that are more costly for the plan and the patient.

- One feature plan sponsors are adopting is a tiered network for laboratory services which discourages plan participants from having lab tests sent to testing facilities outside of the national service providers. In the case of GHIP, members having labs sent to the preferred national vendors will have the same copay as currently applies. Note: lab work done as part of a preventive visit is covered with no copay. Lab work that is processed by facilities outside of the national vendor network will have higher copay applied or have services subject to the deductible and coinsurance.
- Implementation
 - The key to a successful implementation of this program is to educate members on their role in ensuring providers send labs to Quest and LabCorp rather than hospital based labs. Members can be provided with a letter to give to providers about the need to follow this protocol. It should be noted in each member's chart for future reference. Members should remind the provider or staff at the time of the visit also. There might be a sticker that can also be affixed to the ID card providing this reminder. Note: there will be some testing that has to be completed at specialized laboratories including testing done while members are undergoing cancer treatment.

Site Selection Review for High Tech Radiology services

- Currently the State plan has a preauthorization program in place for high tech radiology services (Ct scans, MRIs, etc.). Pre-authorization is designed to ensure providers are ordering testing consistent with evidence based guidelines and not ordering unnecessary tests. The purpose of the site selection program is to assist members in getting medically necessary high tech radiology services at lower cost providers with no impact on quality of the testing.
- The selection of the facility occurs at the same time as the preauthorization process. The third party involved in the preauthorization process works directly with the member to select the lower cost facility most convenient for the member and schedules the appointment. The provider ordering the testing is informed of the approval for the testing as well as the facility, location and time of the patient's appointment. The third party approval organization considers clinical reasons for the selection of a higher cost facility, e.g., use of high tech radiology for treatment instead of diagnosis.
- Implementation
 - There are a number of design options for consideration to ensure use of the recommended facility but the adoption of a tiered network strategy similar to that outlined in laboratory services is a common approach. The current cost sharing for high tech radiology services applies when the member seeks care at the facility provided during the preauthorization process. If the member opts to select a different facility, a higher cost sharing (deductible, coinsurance percentage) will apply.

Care Authorization for Physical Medicine services

The costs and frequency of physical therapy visits, chiropractic visits and other visits in the general category of physical medicine treatment have been increasing in the most recent period accounted for 2 percent of the 3 percent trend increase in outpatient service utilization. Outcomes, efficacy and costs of physical therapy and related physical medicine treatments vary considerably and higher spending doesn't lead to improved outcomes. There is little financial incentive for members or providers to ensure treatment goals are completed in the least amount of time and the lowest costs. As a result, programs have been developed to ensure ongoing treatment leads to improved outcomes.

- Highmark's proposed approach puts the burden of approval on the treating provider. Initially, 8 initial visits are approved each calendar year for treatment of a condition, accident, etc. If the member's care is anticipated to exceed eight (8) visits in a calendar year, additional treatment requires preauthorization through a third party (e.g. Healthways). Before the ninth (9th) visit, care authorization is sought by submitting information about the patient's history, condition, response to prior treatment and treatment plan. If the services are not authorized, treatment is denied.

The implementation of this program is seamless to the member as it is up to the provider to seek initial and ongoing authorization.

Centers of Excellence for certain procedures

Data analysis of patient outcomes has shown repeatedly that not all facilities provide the same level of care and/or results for elective procedures. Additionally, cost and quality are not always correlated. Successful patient outcomes are correlated more frequently with the frequency of services delivered at a facility, rather than the cost of services.

As a result, many insurance carriers have identified facilities as centers of excellence for complex and costly procedures such as transplants. More recently, insurance carriers have expanded their networks of excellence for bariatric surgery, infertility treatment and elective joint surgery. Currently the GHIP uses this approach for bariatric surgery and members receiving services at designated facilities have no out of pocket charges. The plan design discourages use of unauthorized facilities for bariatric procedures by charging 25% coinsurance for an in network, non-designated facility and 45% for an out of network facility.

Both Highmark and Aetna have identified certain facilities as Centers of Excellence for selected procedures. Two most common approaches to implementing this narrower network program are to limit reimbursement for services only rendered at these facilities or to provide members with a financial incentive, e.g., higher reimbursement levels to use these facilities as opposed to facilities in the broader network. Regardless of the incentive/disincentive strategy adopted, it is important that members are educated about the variation in outcomes by facility and encouraged to do their own research on the carrier websites in much the same way as they would do research in shopping for a car or home appliance.

Advanced Utilization Management for Prescription Drugs

Currently the GHIP has a utilization management program in place to ensure members are using the right medication at the most appropriate time through step therapy, prior authorization and drug quantity limit management programs. Express Scripts identified particular enhancements to the utilization management program by implementing a more aggressive utilization management program known as Advance Utilization Management. The expansion of the program to include additional drug classes is estimated to save an additional 2.4 million in fiscal year 2016. ESI estimates 12,800 members are currently being prescribed medication that would be part of the enhanced program. Once implemented, members would be required utilize these particular protocols when obtaining certain prescriptions or therapies.

ESI would provide advance notification to any members impacted by changes to the utilization management program. Savings are optimized if the program applies to all members without grandfathering.

Onsite Healthcare Delivery

Plan sponsors have looked at providing health services through direct contracting of services delivered at or near the workplace (onsite/near-site). Direct contracting with a third party to provide urgent, preventive and primary care services for work related and/or non-work related injuries and illness has gained popularity in recent years. A 2014 survey conducted by the National Association of Worksite Health Centers of 255 employers across 15 industries reported that 9 employers in the public administration industry and 21 in the educational and health care services industry had onsite health centers. The number of organizations providing onsite/near site health care services to employers has grown and represents both local and national organizations. Premise Health is the most dominant player having grown through several acquisitions in the last decade. Local health care systems expanding by acquisition of physician practices, have increasingly demonstrated interest in providing onsite services to employers to meet the growing demand from employers for improved primary care access while allowing the health care system's retention of market share in local communities.

Access to primary care has been demonstrated to reduce the costs of unnecessary specialist visits, laboratory and high tech imaging services as well as emergency room visits. Additionally, increased preventive screening, use of generic drugs and adherence to regimens for chronic condition prevention has also been associated with use of onsite/near site services.

There are several options the State can consider for implementing onsite/near site services. It is recommended that the State conduct a cost benefit analysis of providing onsite services to help determine the expected demand for services, scope of services offered and the location of the service center to optimize access and cost savings. The State can then conduct procurement for potential third party vendors to develop and operated the onsite/near site service center.

Option One: Contract with an independent Third Party entity, e.g., Premise Health, Cerner to establish, and operate an onsite/near site center.

Option Two: Contact directly with a health care system, e.g., to establish and operate an onsite/near site center.

Option Three: Partner with the University of Delaware explore the promotion and integration of service offerings at the University of Delaware's Patient Centered Medical Home and the State of Delaware's health plan

The University of Delaware offers onsite services to employees, dependents as well as to the general public. University employees are not required to use the center and there are no financial incentives to do so.

Current program offering includes:

- Integrated approach to health care-physical and emotional well-being supported by staffing resources and electronic medical records including primary care, laboratory services, mental health and substance abuse treatment
- Tele health capabilities for expert and mental health consults at satellite locations
- Mobile services offered in one location and more contemplated for the future
- Care coordination including follow-up/home outreach
- Nutrition counseling and diabetes education
- Counseling for stress, substance abuse and other mental health issues
- Concierge services – assisting with use of tools, resources, appointment making, advocacy

Delivery of services to State employees by current University of Delaware center staff can be accommodated. Currently, the providers at the facility are considered in network at Highmark and Aetna University of Delaware leadership is interested in further discussions around piloting the program in new locations for the State employees and also staffing a mobile unit to provide services at satellite locations.

Tobacco Free Reward via Surcharge

- One of the State Plan's purposes is to make a healthy difference in people's lives by reducing tobacco use and implementing tobacco free campuses as smoking and tobacco use are major cause of preventable disease and death. At least 25% of states responding to the Pew study have instituted a smoker surcharge. The State of Delaware has supported smoking cessation for its covered members since 2012 including adoption of a tobacco-free workplace 1/1/13 and a \$0 co-pay for tobacco cessation prescription medications as of 7/1/13.
- In spite of these efforts smoking rates among members are largely unreduced. In an effort to drive lower smoking rates among those enrolled in the State plan, the State is looking to incent employees, Non Medicare Retirees and family members to quit tobacco use and by rewarding healthy behavior with lower health insurance premium rates for non-tobacco users.
- The program can rely on self-reported member smoking status for the use of any tobacco product including cigarettes, cigars, chewing tobacco, snuff, e-cigarettes and pipe tobacco within a 6 month period a surcharge (an amount to be determined, typical range between \$50 and \$100 per month per tobacco user) will be applied the monthly premium amount paid by employees for employee only coverage as well as coverage of a tobacco using spouse/domestic partner (if applicable).

Wellness Participation via Surcharge

The State offered incentives for employees to participate in wellness related activities since FY08. Program results demonstrated that increasing incentives had little to no impact on program participation. In fact, in FY08, 21% of employees completed the activities for an employee only cash reward of \$75. In FY15, with an increased reward of up to \$100 for employee/\$200 for family, participation was only 6% of eligible employees. Continuous research on consumer health care behavior has shown that providing incentives doesn't guarantee optimal participation or improvement in health behaviors/health outcomes. However, new research is showing that applying a surcharge for those that aren't participating in certain activities and/or haven't attained a certain health status to be more effective in achieving desired results. Different approaches include charging a monthly surcharge for either failure to take the health assessment and/or biometric screening or stratification of the surcharge based on the attainment of current health status indicators, e.g., BMI, nonsmoker status, etc.

Options for Retirees

Currently the GHIP offers benefit programs to both Non Medicare Retirees and Medicare Primary Retirees. Non Medicare Retirees are offered, as required by statute, the exact same Benefit Plan offerings, at the exact same (blended) rates and contribution levels. Medicare Primary Retirees receive a Medicare Supplement plan, equivalent to a Medicare Supplement standard plan design Plan F, and a prescription drug program that has the identical plan features to the Non Medicare Retiree plan, but is structured as a Medicare Employer Group Waiver Plan (EGWP). The medical plan for Medicare Primary Retirees has an actuarial value of 100%, greater than the Non Medicare Retiree Plan.

Structurally, the Benefit Plan offerings are group-based programs, and four of the options for modifying the plan discussed below continue that fundamental construction. Alternatively, there is an emerging structurally different benefit plan offering available to retirees: the Retiree Exchange. The specifics of a Retiree Exchange for Non Medicare Retirees, and for Medicare Primary Retirees, are discussed below.

- The programs discussed in detail in the November 5th presentation include the following:
 - Plan Design Changes – Separated Non Medicare Retiree plan
 - Plan Design Changes – Medicare Primary Medical Plan
 - Plan Design Changes – Medicare Primary Prescription Drug

- Medicare Advantage Plan – National in nature, PPO plan design
- Non Medicare Retiree Exchange
- Medicare Retiree Exchange

Plan Design Changes – Separated Non Medicare Retiree plan

Separating the Non Medicare Retiree plan from the Active plan would yield greater transparency to the cost of each group, and assumedly impose participant contributions which are consistent with the actual cost of this group of plan participants.

Similar to the overall plan discussion above, the concept involves reshaping the Benefit Plan offerings (Comprehensive (high Option) Preferred Provider Organization (PPO), Health Maintenance Organization (HMO), Consumer Directed Health Plan (CDH), First State Basic (FSB) PPO Plan in some fashion.

Reshaping the Benefit Plans inherently involves changing the form and amount of cost-sharing at point of sale for various services purchased by the participant. The overall cost-sharing is captured in the concept of Actuarial Value.

Non Medicare Retirees may continue to have the same Benefit Plan offerings as active employees, or a reduced or lower-cost portfolio of options. Overall, Plan Sponsors have begun to reduce the actuarial value of their Non Medicare Retiree plans in preparation for the High Cost Employer Plan Excise Tax, which may be particularly burdensome on this group.

Preliminary indications are that the Non Medicare Retiree plan would have rates that are 140% to 160% of the blended plan costs.

- How it works: Actuarial determination of plan costs depending on the Actuarial Value of the chosen plan designs, relative to the existing plans and choices
 - Benefit Plan offerings can mirror (newly modified) active plan choices, or be specifically structured for this group (e.g. HSA-compliant High Deductible Health Plan)
 - Excise tax impact should be a significant influence in Benefit Plan offerings choice
- Implementation
 - Requires enabling legislation
 - Requires substantial member communication
 - Implemented at beginning of plan year, changing to January 1 plan year may be beneficial for Excise Tax testing, and retiree exchange pathway

Plan Design Changes – Medicare Primary Medical Plan

Currently the Medicare Primary medical plan benefit offering is equivalent to a Medicare Supplement plan F, covering all of the cost-sharing the Medicare A&B contains. This yields a total plan that has an Actuarial Value of 100%.

The concept is to create a plan design that integrates with Medicare A&B, to yield retiree cost sharing equivalent to the Non-Medicare Retiree benefit plan offering. As Medicare A&B has an actuarial value of approximately 85%, this is the effective minimum of the plan design options.

- How it works: Actuarial determination of plan costs depending on the Actuarial Value of the chosen plan designs, relative to the existing plans and choices
 - Benefit Plan offerings can mirror Non Medicare Retiree plan choice (high option), or be specifically structured for this group (e.g. a lower cost Medicare Supplement plan, such as Plan K)
 - If a Benefit plan such as the Non Medicare Retiree plan is chosen, a Medicare Integration method assuring some cost sharing by retirees, such as the Carve-out Method, should be utilized.
- Implementation
 - Does not require enabling legislation

- Requires substantial member communication
- Implemented at beginning of plan year, which is January 1 for Medicare Primary retirees

Plan Design Changes – Medicare Primary Prescription Drug

Currently, the Medicare Primary Prescription Drug plan has the same basic plan design as the Non Medicare Retiree Plan, except for a mandatory enhancement to the plan in the “catastrophic layer” of the benefit plan (basically a 95% benefit if the prescription drug Out of Pocket Maximum has not already been reached, if so then the benefit is 100%). Coverage includes both categories of: a) drugs that Medicare Part D provides no coverage for, and b) drugs that are covered under Medicare Part B, often only if certain other conditions apply.

The concept, suggested by Express Scripts, is to tighten the eligibility of these two categories of drugs. First, eliminate any benefit for the non-Part D drugs. Second, require pre-authorizations and make sure the Part B drug is covered at the correct setting, and with the correct correlating information, to qualify for Part B reimbursement.

- How it works:
 - Non-Part D drugs are removed from the covered list. No benefit is adjudicated if the member attempts to have these covered by the plan.
 - Potential Part B drugs are pre-authorized to ascertain if a Part B payment is likely; and if so the benefit is delivered in the proper setting to allow for Part B reimbursement. If the particular situation is found to be external to Part B, and covered by Part D, the drug is dispensed under standard conditions with the standard copay.
- Implementation
 - Does not require enabling legislation
 - Requires substantial member communication
 - Implemented at beginning of plan year, which is January 1 for Medicare Primary retirees
 - Implementation of pre-authorizations and covered list issues is performed by Express Scripts

Medicare Advantage Plan – National in nature, PPO plan design

Currently the Medicare Primary medical plan benefit offering is equivalent to a Medicare Supplement plan F, with members participating in Medicare A&B. The Medicare Supplement plan pays secondary to Medicare.

The concept is to convert this Benefit Plan offering to a Medicare Advantage Plan. In a Medicare Advantage plan, the member moves out of Medicare A&B, into Medicare Part C. Medicare Part C plans are run by Insurance Companies, are insured plans, with the cost to the Plan Sponsor equal to the difference between the total cost of care of the participants, and the Medicare Revenue paid to the Insurer (similar to the prescription drug EGWP revenue received by the GHIP currently).

The standard benefit design that maximizes the value to members – while being practical to implement for the insurer – is a National “PPO” Plan, which is typically offered as “passive” PPO. “Passive PPO” option (that is, the same benefit for in and out of network) allows access to all Medicare providers at same benefit level, with no “steerage” to specific providers. The concept discuss above, of reducing the Actuarial Value of the medical plan, applies here as well, with the benefit needing to be, at a minimum, actuarially equivalent to Medicare A&B.

- How it works:
 - Insurance Vendor is procured, passing coverage area testing and providing attractive fully insured premium rate
 - Members are enrolled in Medicare Advantage Plan (part C), un-enrolling them in Medicare A&B
 - Part B premiums are still due from the member, paid through Social Security (no change)
- Implementation
 - Does not require enabling legislation
 - Requires substantial member communication
 - Implemented at beginning of plan year, which is January 1 for Medicare Primary retirees

- Implementation is performed by Insurance Vendor with assistance from GHIP

Retiree Exchanges

Retiree Exchanges exist to facilitate retirees purchasing Individual Market products with plan sponsor subsidies. The facilitation proposition includes the following attributes: a) a broker/educator to assist the retiree b) decision support tools to assist in choosing a plan during open enrollment c) an administrator to provide the plan sponsor subsidy, which is technically delivered through a Health Reimbursement Account (HRA, or sometimes RRA – Retiree Reimbursement Account) d) advocacy for the participant e) communications/change management.

The RRA is typically used to fund both insurance premiums, and copay/cost sharing features of the medical and prescription drug plans. Budget savings is obtained by setting the RRA at an amount lower than the current State Share amount for retirees.

Separate presentations were made on retiree exchanges for Non Medicare Retirees and Medicare Primary Retirees. Medicare Primary Retirees have been functioning in earnest since 2006, the advent of Medicare Part D. Non Medicare Retiree exchanges have been functioning in earnest since 2015, year 2 of the Affordable Care Act mandatory re-shaping of the non-Medicare Insurance marketplace.

Non Medicare Retiree Exchange

In the Non Medicare Retiree Exchange option, Retiree Exchange mechanics facilitate purchasing Individual-Market products with a plan sponsor subsidy (State Share), and include administration, infrastructure, purchasing tools and concierge service. The State Share would be converted to a stand-alone Retiree Reimbursement Account (RRA), which is primarily used to pay insurance premiums, but can be used for cost sharing such as deductibles and copays. Some Attractive features of Non Medicare Retiree Exchange:

- If RRA is below Excise Tax threshold, Excise Tax is permanently eliminated
- If Retirees have income less than 400% of Federal Poverty Limit, they will qualify for federal assistance, which may be more attractive than RRA (note: for Non Medicare Retirees, using both RRA and Federal assistance is not allowed)
- Wide variety of plan designs to choose from on Individual Market, many are HSA compatible
- Why It Works: Direct competition between Insurers creates incentives for them to reduce costs, provide most efficient plan inner-workings; administrative exchange platform provides shopping tools and transparency, and administrative infrastructure; plan sponsor relieved of plan design change burden year over year
- Implementation
 - Exchange Vendor is procured
 - Plan Sponsor subsidy is chosen
 - Exchange Vendor performs systems and related implementation with assistance from GHIP
 - Requires enabling legislation
 - Requires substantial member communication
 - Implemented at beginning of plan year, which should be January 1

It's relevant to make observations on the Excise Tax specifically for Non Medicare Retirees. The Excise Tax thresholds are only 10-20% greater for Non Medicare Retirees than actives, while costs are 40-60% greater. The Individual-market plans are not subject to Excise Tax, as it is imposed on Employer Plans. The Excise Tax still applies, but instead of the full cost of the program being tested against the Excise Tax thresholds, only the State Share becomes the "plan" to compare to the Excise Tax threshold. Therefore, keeping the State Share below the Excise Tax threshold permanently mitigates Excise Tax on this group. This is a conservative view, and is expected to be applicable irrespective of the guidance which will emerge on retirees and Excise Tax.

Medicare Retiree Exchange

In the Medicare Retiree Exchange Option, Retiree Exchange mechanics facilitate purchasing Individual-Market products with a plan sponsor subsidy (State Share), and include administration, infrastructure, purchasing tools and concierge service. The State Share would be converted to a stand-alone Retiree Reimbursement Account (RRA), which is primarily used to pay insurance premiums, but can be used for cost sharing such as deductibles and copays. Some attractive features of Medicare Retiree Exchange:

- Wide variety of plan designs to choose from on Individual Market
- Attractive low-cost Medicare Advantage plans (as low as \$0 per month)
- Improvement to Standard Medicare Part D plan (required by Affordable Care Act) results in similar drug plan (to current design) in 2020
- Ability to replicate current medical design with Medicare Supplement Plan F
- Why It Works: Direct competition between Insurers creates incentives for them to reduce costs, provide most efficient plan inner-workings; administrative exchange platform provides shopping tools and transparency, and administrative infrastructure; attractive Medicare Advantage plans; plan sponsor relieved of plan design change burden year over year
- Implementation
 - Exchange Vendor is procured
 - Plan Sponsor subsidy is chosen
 - Exchange Vendor performs systems and related implementation with assistance from GHIP
 - Requires enabling legislation
 - Requires substantial member communication
 - Implemented at beginning of plan year, which is January 1

It is relevant to make observations on the Medicare Advantage individual marketplace for Medicare Primary Retirees. The Affordable Care Act revamped (again) the payment systems to Medicare Advantage Plans. While adjusting the payment mechanism to be more in line with the Medicare indemnity costs, extra revenue is available for high quality plans, driving quality in the marketplace. Zero premium plans still abundant nationally, and include some plans in Delaware. Delaware does appear to have lower enrollment in Medicare Advantage plans than the national average, perhaps due to the lack of Highmark offering a Medicare Advantage plan in the state. Nationally, more than 30% of Medicare Participants are in Medicare Advantage, and on average the premiums for Medicare Advantage plans are lower in 2015 than they were in 2010 prior to the passages of the ACA.

Section V – Findings

At the conclusion of the term of the Task Force, there was agreement, although not unanimous, on the findings and the areas for further consideration of the path forward. The task force helped categorize the findings into those that are focused on:

- 1) Bending the cost curve is a critical component of mitigating GHIP's long term trend
- 2) Exploring opportunities to realign provider payments
- 3) Benchmarking GHIP plans and costs on a comparable basis
- 4) Improving the health of the population including enhancing member/patient understanding and usage of the healthcare system.

Strategic/Long Term Findings and Recommended Actions/Considerations

Bending the Cost Curve

Of significant concern to the Task Force is the comparison of medical trend to state revenue increases. State revenues in the near past, and projected to the near future, have increased 3% to 4%. Having a medical trend of 6% to 7% requires that the GHIP allocation consume a greater share of the state budget, and/or a consistent increase in cost-shifting to participants, absent other mitigation techniques. Unexpected and significant cost increases in FY15 resulted in the State's use of both the surplus and reserve funds under the plan. The Task Force reached consensus around the overall finding that opportunities to bend the cost curve need to be reviewed within the context of balancing the FY17 budget as well as the longer sustainability of the plans over the next 3-5 years. This section details the key findings and recommendations discussed in relation to bending the cost curve over the longer term time horizon.

Finding:

The health care delivery and payment system is extremely complex and dynamic. Greater in depth understanding of the system and the way the various components work together is critically important for enacting long term sustainable changes to the GHIP. State Legislators and members of the SEBC acknowledged a need for continued research, analysis and updates as they consider options for impactful long term changes.

Recommendation:

Create a deep dive committee comprised of key stakeholders, e.g., legislators, leaders of the local health care system, the Governor's delegate for health policy, representatives from major payers of health care to serve in an ongoing advisory role to the legislature and the SEBC.

Finding:

Members of GHIP carry a higher burden of health care risks associated with more frequent and more costly use of services as asserted in various presentations to the Task Force from Truven Highmark and Aetna. Not only is the risk burden significantly higher than public employer benchmarks, the burden of risk was reported to be increasing at very high rate, e.g., the risk score of the population increased 20% for 2014 versus 2013. Additionally the DCHI reported that the State of Delaware's population, as a whole, is less healthy than other entities. Improving the health of the population, particularly those members with chronic conditions, should be an important long term focus of the GHIP – and should put downward pressure on the cost curve.

Recommendation:

Conduct additional data analysis and benchmarking to affirm the assertion about members of the State Plan and the health of all Delawareans. 2) Gain access to provider costs to assess impact of provider pricing and contracted rates on use and costs associated with GHIP members 3) Identify opportunities for incenting wellness and health prevention among GHIP members

Finding:

The current plan design does not promote consumerism and/or a need to better understand the costs of care.

Recommendation:

Investigate methods for promoting cost transparency for GHIP members. Consider options for benefit design that creates financial incentives for members to understand the cost of care.

Payments to Providers**Finding:**

Payments to Delaware hospitals for inpatient and outpatient services represent 53.5% of the total GHIP spend (\$379 million out of \$708 total expenses in FY15). However, there is very little information available to the State explaining the payment methodology other than payments made on the basis of negotiated discounts off retail prices. Data shared by Highmark suggests that hospital costs in Delaware are greater than appropriately-adjusted surrounding states. Delaware based hospital leaders shared data in support of higher costs, e.g., higher labor costs in Delaware compared to surrounding state. Highmark also reported that Delaware based hospitals are moving slower than the industry (nationally) in the adoption of alternative payment options resulting in a higher cost burden to GHIP and its members.

Recommendation:

Leverage the significant contribution GHIP makes to each of Delaware hospitals' revenue to support quicker adoption of changes including provider incentives such as pay for performance and/or bundled/episodic payments that balance lower costs with improving quality of care and patient outcomes. Methods for exploration include reference – or metric-based pricing of services, bundled or episodic payment methods, cost-based methods (based on “true cost of care”), or even regulatory approval for payment rates. Any exploration should recognize and coordinate with findings of the DHIC.

Benchmarking**Finding:**

Preliminary data on the value of GHIP plan of benefits suggest the plans are “richer” than those offered by peer entities. Additionally, participant contributions, which average between 9% and 10% of total GHIP expenditures, appear rich in the context of the benchmarking presented.

Recommendation:

Pursue additional benchmarking to ensure inclusion of appropriate peers and validation of the value of plan benefits and comparability of contributions. Initiate benchmarking of the health benefits package in the context of overall compensation of the state worker, which was outside the scope of the Task Force.

Health Improvement**Finding:**

The increasing risk burden and the prevalence of chronic conditions in the GHIP membership supports greater use and understanding of the programs and tools to support use of wellness and preventive services. However, Truven reported decreases in key preventive utilization metrics among GHIP members in spite of financial incentives offered to members of the GHIP.

Recommendation:

Explore other pricing mechanisms to encourage participation in healthy behaviors and the use of surcharges to apply to GHIP members with unhealthy behaviors, e.g., smoking, metabolic syndrome, etc.

Tactical/Short Term Findings and Recommended Actions/Considerations

The findings and recommendations outlined below represent those actions that can be taken within an 18 month timeframe.

Bending the Cost Curve

Finding:

The number of plan options leads to confusion among members and may lead to members selecting plans that result in them “over-insuring”, selecting plans with greater value and higher contributions than needed. Over insurance may lead to continued increases in trend.

Recommendation:

Investigate simplifying plan options and development of a best in class program with a base plan and a buy-up for those desiring additional coverage.

Finding:

Prescription drug trend is growing at a higher trend than general medical cost increases. Trend reflects both increased use as well as costs of prescription drugs. ESI presented reasonable ideas on changes for managing the prescription program for actives and retirees.

Recommendation:

Implement ESI changes after a thorough review and vetting with the SEBC.

Finding:

Highmark, Aetna and other public employer sponsored plans have successfully used Centers of Excellence to provide savings for members and the plan while improving health outcomes.

Recommendation:

Implement programs after thorough review and vetting via SEBC.

Finding:

Cost sharing by copayment, at point of care, does little to promote member interest or understanding in the cost of care.

Recommendation:

Investigate methods and ability of members to understand costs of health care to themselves as well as to the plan. Implement tools and create plan structure to drive members to most cost effective care.

Payments to Providers

Finding:

Reference based pricing for prevalent and high cost elective procedures and diagnostic imaging have shown to have a considerable cost benefit impact in employer sponsored benefit plans, including public employers.

Recommendation:

Investigate a pilot for a select group of high cost procedures or diagnostic tests after a thorough review of all implications.

Finding:

Adoption of tiered network pricing for laboratory testing has led to reductions in overall outpatient laboratory spend in Highmark’s book of business for their insured book of business in the state of Delaware.

Recommendation:

Work with Highmark and Aetna to implement a tiered laboratory pricing after a thorough review of all the implications in making such a change.

Finding:

There is a lack of transparency around provider costs as compared to charges. The Task Force pursued an approach to gain insight into provider costs and issued RFPs to conduct audits of GHIP's health plan payments to providers.

Recommendation:

Select a firm to conduct audits of the health plans and PBM based on responses to RFP issued November 2015.

Finding:

The use of metric based pricing with hospitals has resulted in significant savings for employers (private and public) as reported by ELAP, a firm invited to present to the Task Force and submit a proposal for services.

Recommendation:

Consider adoption of the proposal from ELAP for data collection and analysis in support of metric based pricing.

Health Improvement**Finding:**

Chronic conditions drive a significant amount of costs in the GHIP between medical and prescription drug costs. There was general consensus among Task Force members to focus on creating plan provisions and programs that improve the health of the member. However, there was no consensus on which programs to implement.

Recommendation:

Explore options for driving better participation and engagement in programs targeted at reducing costs and reducing the risk burden including application of surcharges and financial disincentives.