AGENDA
STATE EMPLOYEE BENEFITS COMMITTEE MEETING
February 28, 2022 – 2:00 pm

Until further notice, in the interests of protecting the citizens of this State from the public health threat caused by COVID-19, all State Employee Benefits Committee meetings will continue to be conducted virtually without a physical location. Members of the public may participate virtually or by phone using the information provided. Meeting materials will be posted in advance on the Public Meeting Calendar and the SEBC webpage.

https://www.webex.com/
Meeting number (access code): 2690 883 8132 Meeting Password: SEBC
or Join by Phone Toll Free: 1-866-205-5379

1. Call to Order

2. Approval of January 24, 2022 SEBC meeting minutes*

3. Director's Report/Subcommittee/Legislative Updates

4. 2021 Health Third Party Administrative Services RFP Award Recommendations*

    a. Active/non-Medicare Care Management Programs
    b. Aetna HMO Model
    c. Medicare Plan Effective January 1, 2023

5. CVS Drug Savings Review Recommendation*

6. Financials

    a. January 2022 Fund Report
    b. FY22 Qtr 2 Financial Reporting
    c. FY23 GHIP Projections

7. FY23 Health Plan Premium Recommendations*

8. Other Business

9. Public Comment

10. Adjournment

Visit the SEBC website at dhr.delaware.gov/benefits/sebc for further details. Meeting materials are posted after each meeting.

***Agenda items may require action and approval by the Committee.**
The Committee may move into Executive Session for the purpose of discussing confidential financial information and trade secrets or the content of documents excluded from the public record pursuant to 29 Del.C. §10004(b)(6), and to receive legal advice pursuant to 29 Del.C. §10004(b)(4) relating to pending or potential litigation. The Committee may move into Executive Session for one or more of these reasons.

MINUTES FROM THE MEETING OF THE STATE EMPLOYEE BENEFITS COMMITTEE
JANUARY 24, 2022

The State Employee Benefits Committee (the "Committee") met at 2:00 p.m. on January 24, 2022. The meeting was held at 97 Commerce Way, Suite 201, in Dover; however, in the interests of protecting the citizens of this State from the public health threat caused by COVID-19, this meeting was presented via WebEx, and participants were encouraged to attend virtually.

Committee Members Represented or in Attendance:

Director Cerron Cade, Office of Management & Budget ("OMB"), SEBC Co-Chair
Secretary Claire DeMatteis, Department of Human Resources ("DHR"), Co-Chair
The Honorable Colleen Davis, State Treasurer, Office of the State Treasurer ("OST")
The Honorable Trinidad Navarro, Insurance Commissioner, Department of Insurance ("DOI")
The Honorable Chief Justice Collins Seitz, Delaware Supreme Court
Controller General Ruth Ann Jones, Office of the Controller General ("OCG")
Secretary Molly Magarik, Department of Health & Social Services ("DHSS")
Ms. Judy Anderson, Delaware State Education Association ("DSEA") OBO Appointee of the Governor, Mr. Jeff Taschner, Executive Director, DSEA
Mr. Keith Warren, Chief of Staff, Office of the Lieutenant Governor (OBO The Honorable Bethany Hall-Long, Lieutenant Governor)

Others in Attendance

Director Faith Rentz, Statewide Benefits Office ("SBO"), DHR
Deputy Director Leighann Hinkle, SBO, DHR
Deputy Attorney General Adria Martinelli, Dept. of Justice ("DOJ"), SEBC Legal Counsel
Mr. Chris Giovannello, Willis Towers Watson ("WTW")
Ms. Jaclyn Iglesias, WTW
Ms. Rebecca Warnken, WTW
Mr. Peter Bandarenko, MetLife
Mr. Lance Bartles, United Concordia Dental
Ms. Wendy Beck, Highmark Delaware
Ms. Christina Bryan, Delaware Healthcare Association
Ms. Rebecca Byrd, ByrdGomes
Ms. Michelle Carpenter, PHRST
Ms. Julie Caynor, Aetna
Mr. Tim Constantine, Highmark Delaware
Dr. Jessilene Corbett, Deputy Secretary, DHR
Mr. Steven Costantino, Dir. Healthcare Reform, DHSS
Ms. Cherie Dodge Biron, Deputy Principal Asst., DHR
Ms. Sara Dunlevy, CVS Health
Mr. Mark Engleman, BeneCare
Ms. Jacqueline Faulcon, READAA
Mr. Greg Fisher, United Concordia Dental
Ms. Julie Greenwood, University of Delaware
Ms. Jeanette Hammon, Sr. Fiscal Policy Analyst, OMB
Ms. Sandy Hart, IBM Watson Health
Deputy Attorney General Loren Holland, DOJ
Ms. Rachel Hollis, United Concordia Dental
Ms. Charlene Hrivnak, CVS Health
Ms. Katherine Impellizzeri, Aetna
Ms. Heather Johnson, Controller, DHR
Mr. Jamie Johnstone, Deputy Principal Assistant, Dept. of Finance ("DOF")
Mr. Todd Kreider, United Concordia Dental
Ms. Lizzie Lewis, 302 Strategies
Ms. Lisa Mantegna, Highmark Delaware
Mr. Walt Mateja, IBM Watson Health
Ms. Mary Kate McLaughlin, Barnes & Thornburg LLP
Mr. Sean McNeeley, Director of Bond Finance, DOF
Mr. Paul Miller, BeneCare
Mr. Nick Moriello, Highmark
Mr. Michael North, Aetna
Ms. Kim Pinkerton, United Concordia Dental
Ms. Carrie Schiavo, Delta Dental
Mr. Robert Scoglietti, Deputy Controller General, OCG
Mr. Lee Serota, BeneCare

Mr. Charles Simons, Highmark Delaware
Ms. Carrie Schiavo, Delta Dental
Ms. Judy Shock, Deputy Principal Assistant, OMB
Ms. Martha Sturtevant, Exec. Sec., SBO, DHR – Recorder
Ms. Ashley Tucker, Deputy State Court Administrator, Admin Office of the Courts

CALLED TO ORDER – DIRECTOR CADE, CO-CHAIR
Director Cade called the meeting to order at 2:00 p.m.

APPROVAL OF MINUTES – DIRECTOR FAITH RENTZ, DHR, SBO
A MOTION was made by Secretary Magarik and seconded by Controller General Jones to approve the minutes from the December 13, 2021, meeting of the State Employee Benefits Committee.
MOTION ADOPTED UNANIMOUSLY

DIRECTOR'S REPORT – DIRECTOR FAITH RENTZ, DHR, SBO
Affordable Care Act 1095 Reporting for CY2021
The deadline for IRS Forms 1095-C and 1095-B is March 2, 2022. Form 1095-C is for state employees who are full-time and/or enrolled in the GHIP. Form 1095-B is for state retirees and participating group employees/retirees enrolled in health coverage.

Testing has been approved for both forms. PHRST is working through its data validation process and once completed, will send production files to the print vendor. The State is on schedule to meet this requirement.

GHIP Coverage of Over the Counter COVID-19 Tests
On January 10, the Biden Administration finalized guidance for commercial insurance coverage of over-the-counter (OTC) COVID-19 tests, for personal use only, without a prescription at a $0 member cost-share, effective January 15, 2022. The guidance requires plans to cover the cost of FDA-approved OTC COVID-19 diagnostic tests without a prescription. Group Health Insurance Plan (GHIP) members must be reimbursed for up to eight FDA-approved OTC tests per month.

This requirement applies only to the GHIP commercial population (active and non-Medicare retirees); however, the GHIP has the option to include the Medicare retirees in coverage. With approval by the SEBC Co-Chairs, the GHIP will comply with this requirement by providing coverage to both the commercial (active/non-Medicare) and Medicare populations and only through the GHIP CVS pharmacy benefit (not through Aetna/Highmark coverage) as this will allow the SBO to track and ensure reimbursement by a member does not exceed the required number of tests per month.

Members may submit for Direct Member Reimbursement for OTC COVID-19 tests without a prescription after purchase, starting January 15, 2022, until the end of the Public Health Emergency (PHE). Members can upload a copy of their receipt of the OTC COVID tests purchased via Caremark.com to submit for reimbursement or submit a paper claim. Member will be reimbursed, and the plan will pay the full retail price paid by the member.

CVS/SilverScript Medicare Retiree Transition Update
The status of the transition is tracking as expected. There were 25,633 State of Delaware and 2,084 participating group Medicare pensioners impacted by the change effective January 1, 2022. The only notable plan design issue uncovered was a coding discrepancy related to $0 diabetic products. Several diabetic supply categories were not coded for processing at the point of sale with no copay. CVS Health is working to update the system coding which is expected to be completed by February 1, 2022. Any member that was incorrectly charged a copay will be refunded.

IBM Sale of Watson Health Business

IBM announced on January 21, 2022, a deal to sell the healthcare data and analytics assets from its Watson Health business to a venture capital firm Francisco Partners. This directly impacts the GHIP which entered into a new contract on July 1, 2021, with IBM for these services. Updates will follow as SBO learns more about the transition.

Treasurer Davis joined the Meeting

SEBC Subcommittees Update

Both Subcommittees met on January 20, 2022, to review and discuss the care management offerings included in the Aetna and Highmark Request for Proposals ("RFP"). There was also a review of the Medicare plan options with further discussion on the Medicare products scheduled for the February and March meetings.

DENTAL PLAN RFP CONTRACT AWARD RECOMMENDATIONS – MS. JACLYN IGLESIAS, WTW

There was a recap of the Dental Plan RFP recommendation from the Proposal Review Committee ("PRC"):

Eligible GHIP plan participants have the option to enroll in two dental plans, a DHMO administered by Dominion Dental and a DPPO administered by Delta Dental. Current contracts with both dental carriers will expire on June 30, 2022.

The Dental benefit is voluntary and 100% of the premiums are paid by employees/pensioners; there is no cost-share with the state.

Since FY17, enrollment in the DHMO Plan has decreased incrementally each year and enrollment in the DPPO has increased incrementally each year.

The Dental RFP evaluated several key elements of the State's dental plan offerings including the optimal mix of dental plans offered to participants (e.g., offering alternatives such as an option for DPPO with reduced coverage for a lower premium), opportunities to offer enhanced plan provisions without significant increases to plan premiums, clinical integration and focus on broader health topics such as opioid prescription drug management and enhanced benefits for certain conditions (e.g., diabetes), and innovative use of technology engagement solutions for virtual dentistry. The impact on plan participants in terms of premium cost, and potential provider disruption were also important considerations.

Assignment of Benefits ("AOB") was a key area that was evaluated in the DPPO Plan. The Dental RFP explored potential future implications of retaining this provision on the state's contract with a dental carrier and the plan premiums.

The Committee reviewed a high-level summary of feedback from participants and potential participants of the state's dental plan offerings. Highlights of the feedback included concern regarding the availability of providers in Sussex County and the adequacy of DPPO plan design provisions relative to the premium cost.

The Dental RFP was posted on September 14, 2021, and bid responses were due by October 15, 2021. Responses were received by five bidders: BeneCare, Delta Dental, Dominion National, MetLife, and United Concordia. The PRC met several times to review responses and interview bidders between November 15 and December 6, 2021, and met on January 10, 2022, to finalize scoring and confirm recommendations.

The PRC voted affirmatively on the following recommendations:

DHMO:
Of a total of 125 points, the scores by bidder were as follows: United Concordia Dental scored 90.3, Dominion National scored 89.1, and BeneCare scored 72.3.

The PRC discussed the potential limitations of awarding the DHMO to the highest-ranked bidder considering the bidder's requirements for other plan options offered alongside the DHMO, which the PRC believed did not align with the best interests of plan participants.

For the second-highest ranked bidder, the PRC agreed that the option to match the current DHMO design was preferable to Dominion National's proposed DHMO alternative plan option, which would reduce orthodontia coverage for children and adults and could create disruption since the alternative DHMO uses a different provider network.

The PRC also considered concerns related to the continued decline in enrollment in the DHMO plan, which may be driven by a variety of factors including a decline in the number of participating dental providers, most notably in Sussex County, the desire among some plan participants to pay for dental services entirely out-of-pocket or using a flexible spending account instead of paying dental insurance premiums, and the availability of other dental coverage for plan participants through a spouse. Further, shifts in employment because of the ongoing COVID-19 pandemic may also influence the availability of other dental coverage through a plan participant's spouse. The PRC recognized that these and other factors influencing participants' enrollment in the DHMO are difficult to quantify and may not be possible to measure.

The PRC agreed that if the State Employee Benefits Committee (SEBC) wishes to continue offering a DHMO plan, then based on all the above factors and the bidders' DHMO proposals, Dominion National may be the strongest candidate for offering a DHMO benefit that matches the current DHMO plan.

Director Cade and Secretary DeMatteis queried how provider participation was scored among each bidder. Ms. Iglesias responded that bidders were asked to submit data about their provider networks, specifically the composition and the scope of their active network in Sussex County. Additionally, Industry Standard Access Parameters were used to evaluate the breadth of the network across various network providers.

Secretary Magarik asked the Committee to consider whether it is administratively practical to continue offering two types of plans noting the dwindling enrollment in the DHMO plan and participant concerns regarding provider access.

Director Rentz offered for consideration the lower cost of premiums and no annual out-of-pocket maximums, and that long-term participants in the DHMO Plan have an established relationship with their provider. She added that DHMO participating providers cannot balance bill members.

DPPO:
Of a total of 125 points, the scores by bidder were as follows: Delta Dental scored 93.4, United Concordia Dental scored 87.3, Dominion National scored 82.5, MetLife scored 77.8, and BeneCare scored 76.0.

Bidders were asked to articulate the conditions in which they would be willing to allow their proposed DPPO plan option(s) to be offered as the sole DPPO dental insurance carrier or alongside another DPPO dental insurance carrier, which the PRC considered in determining its recommendations.

Upon review of the proposed DPPO plan options, while the PRC saw merit in the alternatives proposed by bidders, the PRC agreed that none of the allowable single or multiple carrier options provided a solution that

simultaneously addressed concerns about member cost-sharing (for both premiums and cost at the point of service), provider access and disruption in a manner that was preferable to continuing the current DPPO plan design with the incumbent. While the PRC considered an option of offering two DPPO plans, this was not recommended because the carrier options did not provide a meaningful difference in coverage. Delta Dental agreed to lower current premiums by 3.5% and a network provider recruitment guarantee to bolster the robustness of its provider network in Sussex County. While other bidders proposed lower premiums and/or similar provider recruitment guarantees, the PRC agreed that those elements were not sufficient to warrant the potential limitations in provider access and/or disruption that could result in adopting those proposals.

The PRC also discussed whether to retain the AOB provision in the future DPPO contract, which would allow non-participating dentists to receive AOB for covered services if a signed attestation from a State plan participant is submitted with any claims for covered services. After considering the historical impact of this provision on DPPO network provider participation along with the potential impact on plan participant satisfaction, the PRC was in support of retaining this provision in the future DPPO contract with continued monitoring of the impact on the network.

Based on the above, the PRC recommends awarding Delta Dental a contract to administer a DPPO plan based on the current DPPO plan design. The PRC also recommends retaining the Assignment of Benefits provision in the DPPO contract, with ongoing monitoring of the impact on provider participation in the DPPO network.

For the award of a contract pursuant to the RFP for Group Dental Insurance, the Proposal Review Committee recommends to the State Employee Benefits Committee as follows:

> If the State Employee Benefits Committee wishes to continue offering a DHMO plan, then the PRC recommends a contract award of the DHMO plan matching the current plan design to Dominion National for an initial three-year term effective July 1, 2022, through June 30, 2025, with two optional one-year period extensions. Such award shall be subject to the approval of the Department of Technology and Information and Department of Insurance and a finalized contract which shall include performance guarantees.
>
> The PRC recommends a contract award of the DPPO plan matching the current plan design to Delta Dental for an initial three-year term effective July 1, 2022, through June 30, 2025, with two optional one-year period extensions. Such award shall be subject to the approval of the Department of Technology and Information and Department of Insurance and a finalized contract which shall include performance guarantees and an Assignment of Benefits provision.

The Committee discussed the necessary timing of awards before the expiration of current contracts. The Committee considered the difference in premiums between plan offerings, and that not every employee can pay the out-of-pocket costs for dental benefits considering the diversity of paygrades. The Committee considered that it would be disruptive to DHMO participants to migrate to a DPPO plan.

Chief Justice Seitz queried whether data was available comparing dental benefit premiums against total compensation. Director Rentz responded that a study had not been done.

A MOTION was made by Secretary DeMatteis and seconded by Secretary Magarik to accept the recommendation of the Proposal Review Committee to award the Dental Third-Party Administrator Request for Proposal to:

a) Dominion National an initial three-year term for an effective contract date of July 1, 2022, through June 30, 2025, for the administration of the DHMO Plan with two optional one-year period extensions.
b) Delta Dental an initial three-year term for an effective contract date of July 1, 2022, through June 30, 2025, for the administration of the DPPO Plan with two optional one-year period extensions.

MOTION ADOPTED UNANIMOUSLY

FINANCIALS – MR. CHRIS GIOVANNELLO, WTW

November Fund Report

November revenues included the last Express Scripts ("ESI") rebate payment and the first CVS rebate payment for the Commercial population. CVS rebates are scheduled to be paid a quarter faster than ESI resulting in FY22 receiving five CVS rebate payments, rather than four as seen with ESI; November is the extra CVS rebate month.

The CVS rebate was less than budgeted due to lower than projected prescription claims. The EGWP rebate was higher than budgeted because of higher prescription claims in FY21 Q4. Additionally, a missed performance guarantee payment was received by ESI.

Claims were $3.6M below budget for November and $30.5M below budget YTD. The YTD Fund Equity balance has a positive variance to the budget of $7.2M.

December Fund Report

The $20.0M supplemental bill funding for COVID-19 was received in December. Total claims were higher than budget largely attributable to pharmacy claims; however, YTD claims are $29.3M below budget.

The fund balance is $164.3M and has a positive variance to the budget of $25.6M.

Budget projections will be revised in February to provide a refresh of premium rate recommendations.

Director Cade queried whether the favorable claims experience had been captured in the projections. Mr. Giovannello responded that the projections had not been revised to include the favorable claims experience.

GHIP LONG-TERM PROJECTIONS – MR. GIOVANNELLO, WTW

The long-term projections presented to the Committee in December 2021, reflected an $86.3M projected deficit in FY23; this projection included $15.8M in potential federal COVID-19 funding relief (CARES Act) based on claims through October. This reimbursement has been approved and is expected to be received into the fund on a date to be determined in the next several months. There is potential for additional federal reimbursements for November and December claims.

Secretary DeMatteis stated that the state is prepared to allocate a projecting run rate of federal funding available to assist with increased state employee healthcare costs related to COVID-19.

December projections included savings from initiatives expected to be voted on by the SEBC by February 28, 2022, including, the PRC award recommendations from medical TPA RFP (approved December 13, 2021), the reinstatement of member cost-sharing for telehealth visits with community providers (vote pending) the implementation of CVS Drug Savings Review program (vote pending), and the implementation of CVS Transform Diabetes Care program (vote pending). Any initiative not implemented for FY23 will increase the projected deficit.

Budget projections, and subsequent revisions to the recommended rate action, will be revised after a review of the December and January claims experience. The Committee will vote on FY23 rate action at the meeting on February 28, 2022.

Director Cade queried what impact the Medicare Advantage vote would have on the budget projections. Mr. Giovannello responded that the vote regarding what plan will be offered to the Medicare population will not take place until the Committee meets on March 14, 2022; however, projections are being prepared for the meeting on February 28, 2022, to illustrate the potential savings for each option being considered by the Committee.

The trend assumption is 5% medical and 8% pharmacy, and 5.7% net overall.

Sec Magarik queried whether record numbers of hospitalizations being reported would be factored into the revised projections. Mr. Giovannello responded that experience has not reflected a larger increase in COVID-19 claims but funding is expected through CY22; however, long-term costs remain largely unknown.

Potential rate action should also consider the following factors not reflected in GHIP long-term projections:

- the Governor's Recommended Budget to be released January 27, 2022, and any implications it may have on potential rate action
- potential additional COVID-19 funding relief through CARES Act or ARPA funds (cost decrease TBD)
- cost associated with coverage of OTC COVID-19 testing (cost increase TBD)
- outstanding medical TPA RFP decisions (cost impact TBD) including care management models through Aetna/Highmark non-Medicare plans, including whether to retain or waive the PCP referral requirement for HMO plan, adoption of any add-on/buy-up programs and potential implementation of Everside Health primary clinics for Aetna plans
- Senate Substitute 1 for Senate Bill 120 regarding primary care investments and affordability standards (cost increase TBD)
- Senate Bill 25 regarding chiropractor reimbursement (cost increase TBD)
- enhanced coverage for anti-obesity medications (cost increase TBD)

There was a recap of the budget presented in December.

Current long-term projections reflect a one-time $23.3M COVID-19 expense reimbursement payment received in June 2021. Based on IBM Watson Health reporting of COVID-19 expenses through October 2021, an additional $15.8M in COVID-19 expense reimbursements is expected to hit the Fund in FY22 or FY23. The long-term projections on the following pages reflect an additional $15.8m in COVID- 19 relief, projected to be received in FY23 that reduces the projected FY23 deficit to $86.3M. If no other program changes, a 10.2% premium increase will be needed on July 1, 2022, to solve for the projected FY23 deficit of $86.3M

A 10.2% premium increase yields approximately $63M in State share revenue and $8M in employee/pensioner revenue for the active/pre-65 retiree population.

Targeting a $0 deficit by the end of FY25 requires an annual premium increase of 7.2% in FY23, FY24, and FY25 (in this scenario, the Fund would end FY23 and FY24 in deficit position after reserves). A 7.2% premium increase yields approximately $44M in State share revenue and $5M in employee/pensioner revenue for the active/pre-65 retiree population.

Secretary DeMatteis expressed her preference to smooth any required increase over three years.

Assuming no premium increases, FY22 would end with a surplus of $17.6, and FY23 would end with a deficit of $86.3M, increasing each additional year.

To fully solve for the deficit in FY23, a 10.2% increase effective July 1, 2022, results in employee contribution increases of $2.84 - $27.83 per employee per month ($34.08 - $333.96 per year) and a state subsidy increase of $68.09 - $183.70 per employee per month ($817.08 - $2,204.40 per year).

A 7.2% increase smoothed over three years effective July 1, 2022, results in employee contribution increases of $2.00 - $19.65 per employee per month ($24.00 - $235.80 per year) and a state subsidy increase of $48.07 - $129.67 per employee per month ($576.84 - $1,556.04 per year).

CY22 GOALS AND PRIORITIES – DIRECTOR CADE, OMB

In Q1 of CY22, the Committee aims to finalize FY23 budget and program decisions including, the outstanding decisions from the Medical TPA RFP, decisions on other items recommended by Subcommittees and are pending SEBC vote, FY23 rate action to balance FY23 budget and review and finalize any changes to Medicfill plan (effective 1/1/2023).

In Q2-Q4 of CY22, the Committee aims to improve communications to members and stakeholders regarding the importance of aligning increases in health premiums with growth in health care spending. The Committee will also revisit progress toward SEBC goals for the State Employee Group Health Insurance Plan including, increasing the allocation of medical spending to providers who are compensated for the quality, not quantity, of care delivered, reducing costs for plan participants with diabetes, limiting health care cost inflation through targeted reduction in high cost, low-value services, and providers, and offer and increase engagement in tools that help plan participants use their health care benefits effectively.

OTHER BUSINESS
No new business was presented.

PUBLIC COMMENT
The public did not present further comments.

EXECUTIVE SESSION
A MOTION was made by Secretary DeMatteis and seconded by Secretary Magarik to move into Executive Session at 3:14 p.m. to discuss a Disability Appeal.
MOTION ADOPTED UNANIMOUSLY

ADJOURNMENT
A MOTION was made by Secretary DeMatteis and seconded by Secretary Magarik to adjourn the Public Session at 3:49 p.m.
MOTION ADOPTED UNANIMOUSLY

Respectfully submitted,

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Martha Sturtevant, Executive Secretary, Statewide Benefits Office, Department of Human Resources
Recorder, State Employee Benefits Committee, and Subcommittees

State of Delaware Health Fund

Monthly Statement

January 2022

OPERATING REVENUES	January	%	January Budget	%	Variance	%	YTD Actual	%	YTD Budget	%	Variance	%
Premium Contributions												
Highmark	$ 54,839,574	63.04%	$ 54,889,835	63.01%	$ (50,261)	-0.09%	$ 383,149,637	63.78%	$ 383,002,504	63.52%	$ 147,134	0.04%
Aetna	$ 14,787,392	17.00%	$ 15,345,456	17.62%	$ (558,063)	-3.64%	$ 104,935,460	17.47%	$ 107,075,343	17.76%	$ (2,139,883)	-2.00%
Total Premium Contributions	$ 69,626,967	80.03%	$ 70,235,291	80.62%	$ (608,324)	-0.87%	$ 488,085,097	81.25%	$ 490,077,847	81.28%	$ (1,992,750)	-0.41%
Other Revenues												
Medicare Retiree RX Prog. (EGWP) Direct Subsidy	$ (120,886)	-0.14%	$ -	0.00%	$ (120,886)	0.00%	$ 173,770	0.03%	$ 226,733	0.04%	$ (52,962)	-23.36%
Federal Reinsurance	$ 1,819,927	2.09%	$ 1,582,978	1.82%	$ 236,949	14.97%	$ 9,908,163	1.65%	$ 9,571,311	2%	$ 336,852	3.52%
Prescription Drug Rebates (Commercial)	$ -	0.00%	$ -	0.00%	$ -	0.00%	$ 34,730,263	5.78%	$ 37,731,961	6.26%	$ (3,001,698)	-7.96%
Prescription Drug Rebates (EGWP)	$ -	0.00%	$ -	0.00%	$ -	0.00%	$ 18,723,842	3.12%	$ 16,722,693	2.77%	$ 2,001,148	11.97%
Prescription True Up/Yr End Recon Pymts	$ 8,682,043	9.98%	$ 8,378,267	9.62%	$ 303,776	3.63%	$ 8,682,043	1.45%	$ 8,378,267	1.39%	$ 303,776	3.63%
Medicare Part D Coverage Gap Discount	$ 6,491,052	7.46%	$ 6,408,073	7.36%	$ 82,979	1.29%	$ 15,991,654	2.66%	$ 16,693,018	2.77%	$ (701,364)	-4.20%
Participating Group Fees	$ 469,749	0.54%	$ 510,362	0.59%	$ (40,613)	-7.96%	$ 3,454,200	0.58%	$ 3,561,134	0.59%	$ (106,934)	-3.00%
Other Revenues	$ 27,589	0.03%	$ -	0.00%	$ 27,589	0.00%	$ 20,941,051	3.49%	$ 20,000,000	0.00%	$ 941,051	0.00%
Total Other Revenues	$ 17,369,476	19.97%	$ 16,879,681	19.38%	$ 489,795	2.90%	$ 112,604,984	18.75%	$ 112,885,116	18.72%	$ (280,132)	-0.25%
Total Operating Revenues	**$ 86,996,442**		**$ 87,114,972**		**$ (118,529)**	**-0.14%**	**$ 600,690,081**		**$ 602,962,963**		**$ (2,272,881)**	**-0.38%**
OPERATING EXPENSES												
Claims												
Highmark	$ 39,891,874	47.42%	$ 41,569,734	46.19%	$ (1,677,860)	-4.04%	$ 288,731,208	49.28%	$ 304,162,268	49.10%	$ (15,431,060)	-5.07%
Aetna	$ 15,761,572	18.73%	$ 16,569,556	18.41%	$ (807,984)	-4.88%	$ 88,632,256	15.13%	$ 100,304,356	16.19%	$ (11,672,100)	-11.64%
Express Scripts/CVS (non-Plan D)	$ 14,756,017	17.54%	$ 15,482,452	17.20%	$ (726,435)	-4.69%	$ 90,602,524	15.46%	$ 100,628,208	16.24%	$ (10,025,683)	-9.96%
Express Scripts/CVS (Plan D)	$ 9,851,295	11.71%	$ 12,684,838	14.09%	$ (2,833,543)	-22.34%	$ 88,047,514	15.03%	$ 88,326,425	14.26%	$ (278,911)	-0.32%
Surgery Plus	$ 239,336	0.28%		0.00%	$ 239,336		$ 2,335,344	0.40%		0.00%	$ 2,335,344	
Total Claims	$ 80,500,094	95.68%	$ 86,306,580	95.90%	$ (5,806,486)	-6.73%	$ 558,348,847	95.30%	$ 593,421,257	95.79%	$ (35,072,410)	-5.91%
Other Expenses												
Program Fees and Costs (Vendor ASO Fees)	$ 3,172,959	3.77%	$ 3,214,414	3.57%	$ (41,455)	-1.29%	$ 23,629,833	4.03%	$ 22,429,083	3.62%	$ 1,200,750	5.35%
Office Expenses	$ 197,612	0.23%	$ 258,670	0.29%	$ (61,058)	-23.60%	$ 1,657,571	0.28%	$ 1,810,689	0.29%	$ (153,119)	-8.46%
Employee Assistance	$ 34,541	0.04%	$ 33,598	0.04%	$ 942	2.80%	$ 254,111	0.04%	$ 235,188	0.04%	$ 18,923	8.05%
Data Warehouse	$ 39,917	0.05%	$ 54,332	0.06%	$ (14,416)	-26.53%	$ 309,029	0.05%	$ 380,326	0.06%	$ (71,297)	-18.75%
Consultant Fees	$ 181,710	0.22%	$ 125,000	0.14%	$ 56,710	45.37%	$ 1,298,312	0.22%	$ 875,000	0.14%	$ 423,312	48.38%
COBRA Fees	$ 6,513	0.01%	$ 6,620	0.01%	$ (107)	-1.62%	$ 74,537	0.01%	$ 46,340	0.01%	$ 28,197	60.85%
ACA Fees	$ -	0.00%	$ -	0.00%	$ -	0.00%	$ 326,114	0.06%	$ 326,469	0.05%	$ (356)	-0.11%
Total Other Expenses	$ 3,633,251	4.32%	$ 3,692,634	4.10%	$ (59,384)	-1.61%	$ 27,549,507	4.70%	$ 26,103,094	4.21%	$ 1,446,413	5.54%
Total Operating Expenses	**$ 84,133,344**		**$ 89,999,214**		**$ (5,865,870)**	**-6.52%**	**$ 585,898,354**		**$ 619,524,351**		**$ (33,625,997)**	**-5.43%**
Net Income	**$ 2,863,098**		**$ (2,884,243)**		**$ 5,747,341**		**$ 14,791,728**		**$ (16,561,388)**		**$ 31,353,116**	
Balance Forward	$ 164,260,861		$ 138,655,086				$ 152,332,231		$ 152,332,231			
Fund Equity Balance	**$ 167,123,959**		**$ 135,770,843**		**$ 31,353,116**	**23.09%**	**$ 167,123,959**		**$ 135,770,843**		**$ 31,353,116**	**23.09%**
Average Members	129,689		130,427		-738	-0.57%						

	Target	YTD				End of Year			
		Budget	Actual	Variance		Budget	Forecast*	Variance	
				$	%			$	%
Fund Equity	$ 85,300,000	$ 135,770,843	$ 167,123,959	$ 31,353,116	23%	$ 94,576,268	$ 125,929,383	$ 31,353,116	33%
Claim Liability	$ 61,000,000	$ 61,000,000	$ 61,000,000	$ -	0%	$ 61,000,000	$ 61,000,000	$ -	0%
Minimum Reserve	$ 24,300,000	$ 24,300,000	$ 24,300,000	$ -	0%	$ 24,300,000	$ 24,300,000	$ -	0%
Surplus/(Deficit)	$ -	$ 50,470,843	$ 81,823,959	$ 31,353,116	62%	$ 9,276,268	$ 40,629,383	$ 31,353,116	338%

*Forecast = Actual + Remaining Budget

State of Delaware - Quarterly Financial Reporting

FY22 Q2 Cost Analysis

It is evident that the COVID-19 pandemic will have an impact on health care costs. We have used available information and reasonable estimation techniques to develop health care cost estimates for the GHIP that reflect the impact of COVID-19. However due to the high degree of uncertainty associated with this pandemic, results may vary from the estimates provided.

February 2022

wtw

State of Delaware
Health Plan Quarterly Financial Reporting
FY22 Q2 Plan Cost Analysis

Summary plan information

- FY22 YTD compared to FY21 YTD:

Summary (total)	FY22			FY21			% Change		
	Medical	Rx[4]	Total[2]	Medical	Rx[4]	Total[2]	Medical	Rx[4]	Total[2]
Gross claims[1]	$303.7	$155.5	$459.3	$301.8	$141.2	$443.0	▲ 0.7%	▲ 10.1%	▲ 3.7%
Total program cost ($M)[2]	$329.5	$85.4	$416.4	$326.7	$86.4	$414.3	▲ 0.9%	▼ 1.2%	▲ 0.5%
Premium contributions ($M)[3]	$350.7	$79.3	$420.6	$330.7	$90.6	$421.3	▲ 6.0%	▼ 12.4%	▼ 0.2%
Total cost PEPY	$8,868	$2,328	$11,208	$8,856	$2,364	$11,232	▲ 0.1%	▼ 1.5%	▼ 0.2%
Total cost PMPY	$5,076	$1,320	$6,420	$5,040	$1,344	$6,384	▲ 0.7%	▼ 1.8%	▲ 0.6%
Average employees	74,336			73,807			▲ 0.7%		
Average members	129,755			129,736			▲ 0.0%		
Loss ratio	99%			98%					
Net income ($M)	$4.2			$6.9					

[1] Gross claims include paid medical and pharmacy claims as reported by Aetna, Highmark, CVS, and ESI; excludes capitation

[2] Total program cost includes gross claims, pharmacy rebate and EGWP payment offsets, ASO fees, and office operational expenses

[3] Includes fees for participating non-State groups

- FY22 Actual compared to Original Budget (approved in August 2021):

Summary (total)	FY22 Actual			FY22 Budget			% Change		
	Medical	Rx	Total	Medical	Rx	Total	Medical	Rx	Total
Total program cost ($M)[1]	$329.5	$85.4	$416.4	$380.6	$86.1	$456.6	▼ 13.4%	▼ 0.7%	▼ 8.8%
Total cost PEPY	$8,868	$2,328	$11,208	$9,827	$2,400	$12,268	▼ 9.8%	▼ 3.0%	▼ 8.6%
Total cost PMPY	$5,076	$1,320	$6,420	$5,609	$1,370	$7,002	▼ 9.5%	▼ 3.6%	▼ 8.3%
Net income ($M)	$4.2			($33.7)					

- Summary Plan Information through September 2021:

FY22 Q2	Aetna	Highmark	Active	Non-Medicare Retiree	Medicare Retiree	Total
Summary (total)						
Total cost ($M)	$89.8	$326.5	$297.4	$57.6	$61.4	$416.4
Budgeted cost ($M)[1]	$91.0	$329.6	$298.5	$43.1	$79.1	$420.6
Loss ratio	99%	99%	100%	134%	78%	99%
PEPY	$14,148	$10,596	$15,228	$17,376	$4,284	$11,208
# of enrolled employees	12,702	61,634	39,067	6,630	28,639	74,336

[1] Budgeted cost (premiums) are the product of monthly budget rates and quarterly average tiered contract counts provided by the medical vendors; budget rates are calculated based on pooled experience across all vendors, plans and statuses; loss ratios should therefore be evaluated in aggregate

Plan performance dashboard - key observations for total GHIP population: January 2021 - December 2021 (compared to January 2020 - December 2020)

- The COVID-19 pandemic has had a significant impact on GHIP utilization and claims. Due to the timing of suppressed care, utilization of services is generally higher than in the prior period. The IBM Watson Health plan performance dashboards highlights the following program trends:
- Variation in well care and preventive visits: decrease of 8.6% well child, increase of 11.4% preventive adult
- Increased screening rates for colon cancer, breast cancer, cervical cancer and cholesterol
- 0.5% increase in inpatient admits with a 5.8% increase in LOS and 2.8% increase in cost per admit; 5.1% increase in ER visits
- Pharmacy claims have been consistent through the pandemic; 7.0% increase in cost and 1.4% increase in utilization of all prescriptions
- Specialty medications now make up 49% of pharmacy spend, with a 0.9 increase in utilization

Additional notes

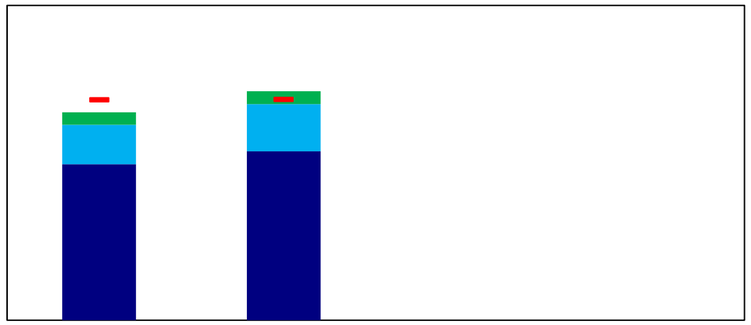
- Claims and expenses are reported on a paid basis
- FY22 budget rates were held flat from FY21
- Paid claims and enrollment data based on reports from Aetna, Highmark, CVS, and ESI; costs include operating expenses
- Expenses are broken down into two categories:
  - ASO Fees: includes fees for vendor administration, COBRA administration, ACA-related (PCORI), IBM Watson data analytics, EAP, and WTW consulting fees
  - Office Operational Expenses: includes expenses for items such as staff salaries, supplies, etc.
- Rx rebates and EGWP payments are shown based on the period to which offsets are attributable, rather than actual payment received in a given period
- No adjustments made to cost tracking for large claims as the State does not have stop loss insurance
- HRA dollars are assumed to be included in the reported claims
- Participating groups (such as University of DE) are included in the cost tracking, but are assumed to be 100% employee paid; as a result, reported net cost and cost share percentages may be skewed; participating group fees are included in premium contributions

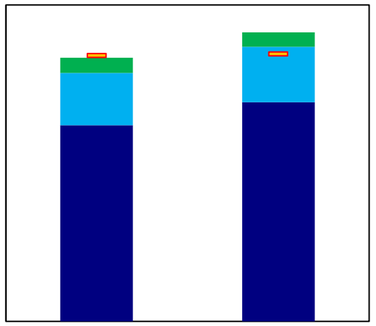
State of Delaware
Health Plan Quarterly Financial Reporting
FY22 Q2 Plan Cost Analysis

Total GHIP Results

Legend

- **Medical/Rx Budget**
- **Fees and Op. Expenses**
- **Rx (incl. Rebates and EGWP)**
- **Medical (incl. capitation)**





	Q1 2022	Q2 2022	Q3 2022	Q4 2022	FY22 YTD Actual	FY22 YTD WTW Budget[7]	Difference vs. Budget
Total Program Cost	**$198,276,306**	**$218,112,027**			**$416,388,334**	**$456,570,472**	▼ 8.8%
- Paid Claims	186,367,672	206,104,405			392,472,078	434,160,013	▼ 9.6%
- Medical (includes capitation[1])	148,709,130	160,976,484			309,685,615	346,327,334	▼ 10.6%
- Rx (Including Rebates and EGWP)	37,658,542	45,127,921			82,786,463	87,832,679	▼ 5.7%
- Rx Paid Claims	71,283,072	84,220,528			155,503,600	160,787,343	▼ 3.3%
- EGWP[2]	(12,236,133)	(13,729,669)			(25,965,802)	(18,500,010)	▲ 40.4%
- Direct Subsidy	(193,337)	(80,173)			(273,510)	(226,733)	▲ 20.6%
- CGDP	(6,491,052)	(8,063,352)			(14,554,404)	(10,284,945)	▲ 41.5%
- Catastrophic Reinsurance	(5,551,744)	(5,586,145)			(11,137,889)	(7,988,333)	▲ 39.4%
- Rx Rebates[3]	(21,388,397)	(25,362,938)			(46,751,335)	(54,454,654)	▼ 14.1%
- ASO Fees	11,245,182	11,211,115			22,456,297	20,858,440	▲ 7.7%
- Operational Expenses	663,452	796,507			1,459,959	1,552,019	▼ 5.9%
Medical/Rx Premium Contributions[4]	**$210,171,526**	**$210,454,651**			**$420,626,177**	**$ 422,893,327**	▼ 0.5%
- Net Income	11,895,220	(7,657,376)			4,237,844	(33,677,145)	
- Total Cost as % of Budget	94%	104%			99%	108%	
Current Year Per Capita							
- Total per employee per year[5]	10,680	11,724			11,208	12,268	▼ 8.6%
- Total % change over prior	-2.6%	2.2%			-0.1%		
- Medical per employee per year	8,544	9,180			8,868	9,827	▼ 9.8%
- Medical % change over prior	-1.1%	1.6%			0.3%		
- Rx per employee per year	2,196	2,520			2,328	2,400	▼ 3.0%
- Rx % change over prior	-5.2%	4.0%			-1.8%		
- Medical per member per year	4,896	5,268			5,076	5,609	▼ 9.5%
- Rx per member per year	1,248	1,428			1,320	1,370	▼ 3.6%
- Total per member per year[5]	6,120	6,720			6,420	7,002	▼ 8.3%
Prior Year Results	**Q1 FY21**	**Q2 FY21**	**Q3 FY21**	**Q4 FY21**	**FY21**		
- Total Program Cost	202,268,399	211,738,529			414,006,928	-	-
- Total Program Cost $ Change	-3,992,092	6,373,498			2,381,406	-	-
- Total per employee per year[5]	10,968	11,472			11,220	-	-
- Medical per employee per year	8,640	9,036			8,838	-	-
- Rx per employee per year	2,316	2,424			2,370	-	-
EE Contributions[6]	**$40,912,653**	**$40,898,795**			**$81,811,448**	-	
- Net SoD	157,363,653	177,213,232			334,576,886	-	-
- SoD Subsidy %	79%	81%			80%	-	-
Headcount							
- Enrolled Ees	74,245	74,428			74,336	74,430	▼ 0.1%
- Enrolled Members	129,640	129,871			129,755	130,404	▼ 0.5%
- Member/EE Ratio	1.7	1.7			1.7	1.8	

[1] Capitation payments apply to HMO plan only
[2] Direct subsidy and catastrophic reinsurance prospective payments reflect actual payments received during quarter; CGDP estimated based on payment attributable to quarter; projected EGWP PMPM amounts provided by ESI
[3] Reflects estimated rebates attributable to FY22; prior quarters to be updated with actual FY22 rebates when received; estimated rebates based on WTW analysis of expected rebates under CVS contract effective July 2021
[4] Premium contributions include fees for participating non-State groups
[5] Total per employee per year (PEPY) and per member per year (PMPY) values include operational expenses; these expenses are excluded from medical and Rx PEPY/PMPY splits
[6] Participating groups are assumed to be 100% EE funded, and Medicare retirees are assumed to be fully subsidized
[7] WTW Budget based on final FY22 Budget approved by SEBC

It is evident that the COVID-19 pandemic will have an impact on health care costs. We have used available information and reasonable estimation techniques to develop health care cost estimates for the GHIP that reflect the impact of COVID-19. However due to the high degree of uncertainty associated with this pandemic, results may vary from the estimates provided.

State of Delaware
Health Plan Quarterly Financial Reporting
FY22 Q2 Reporting Reconciliation (WTW vs DHR Fund Equity Report)

FY21 YTD Reporting Reconciliation	WTW FY22 Q2 Financial Report	DHR Dec. 2021 Fund Equity Report
Total Program Cost	**$416,388,334**	**$501,765,009**
Paid Claims	392,472,078	477,848,753
Medical Claims	309,685,615	323,806,027
Rx Claims[1]	82,786,463	154,042,727
Rx Paid Claims	155,503,600	154,042,727
EGWP	(25,965,802)	(17,883,493)
Direct Subsidy	(273,510)	(294,656)
CGDP	(14,554,404)	(9,500,602)
Catastrophic Reinsurance	(11,137,889)	(8,088,235)
Rx Rebates	(46,751,335)	(53,454,104)
Total Rx Claim (Offsets)/Revenue[2]	(72,717,137)	(71,337,597)
Total Fees	23,916,256	23,916,256
ASO Fees	22,456,297	22,456,297
Operational Expenses	1,459,959	1,459,959
Premium Contributions/Operating Revenues[3]	**$420,626,177**	**$513,693,639**
Net Income	4,237,844	11,928,630
Total Cost as % of Budget	99%	98%

[1]WTW Rx claims shown net of EGWP revenue and Rx rebates; DHR Rx claims reflect gross claim dollars excluding additional revenue (EGWP and rebates)

[2]WTW reflects EGWP revenue and Rx rebates as offsets to Rx claims; DHR reflects these items as additions to operating revenues

[3]DHR premium contributions represent total operating revenues, including premium contributions, Rx revenues (EGWP and rebates), other revenues totaling $42,118, and participating group fees totaling $1,496,860; WTW premium contributions represent FY22 budget rates and headcounts (net of Rx revenues), including participating group fees; DHR premium contributions alone total $209,146,747

State of Delaware
Health Plan Quarterly Financial Reporting
Assumptions and Caveats

Claim basis and timing

1 All reporting provided on a paid basis within this document.

2 FY22 represents the time period July 1, 2021 through June 30, 2022 for all statuses; note Medicfill plan for Medicare eligible retirees runs on a calendar year basis. Therefore, FY22 financial results span two plan years for the Medicare eligible population.

Enrollment

3 Medical and Rx enrollment based on quarterly tiered enrollment data from Highmark and Aetna; Medicare enrollment provided separately for retirees enrolled in medical (Highmark) and Rx (ESI).

Benefit costs/fees

4 Medical quarterly paid claims from Highmark and Aetna; Rx quarterly paid claims from ESI and CVS; EGWP subsidies and Rx rebates (Active, non-Medicare eligible retiree, and Medicare eligible retiree) from DHR

5 Administration fees and operational expenses from DHR-provided September 2021 Fund Equity Report; total quarterly fees are assigned to each plan on a contract count basis.

a. ASO Fees: includes fees for vendor administration, COBRA administration, ACA-related (PCORI), IBM Watson data analytics, EAP and WTW consulting fees.

b. Operational Expenses: includes expenses for items such as staff salaries, supplies, etc.

6 Pharmacy drug rebates are shown based on the period to which rebates are attributable; prior quarters to be updated with actual FY22 rebates when received; estimated rebates reflect projected improvements in Rx rebates based on result of PBM award to CVS Health; active/non-Medicare eligible retiree rebates assigned to each plan on a contract count basis; may differ from actual payments received during FY22 due to payment timing lag.

7 EGWP payments based on actual and expected payments attributable to the period July 1, 2021 through June 30, 2022; reflects actual direct subsidy, prospective reinsurance and coverage gap discount payments received through September 2021; remaining payments attributable to FY22 estimated based on projected amounts provided by ESI; may differ from actual payments received during FY22 due to payment timing lag.

8 Prior year costs calculated from WTW's FY21 Financial Reporting.

9 FY22 Projected based on long-term projections presented to SEBC in December 2021; reflects experience through October 2021 and projected FY22 average enrollment based on headcounts through October 2021; EGWP revenues and prescription drug rebates projected based on the period revenues are payable; includes estimated improvements in Rx rebates and reduction in pharmacy claims based on result of PBM award to CVS Health; 5% medical/8% pharmacy trend; assumes 1% enrollment growth

It is evident that the COVID-19 pandemic will have an impact on health care costs. We have used available information and reasonable estimation techniques to develop health care cost estimates for the GHIP that reflect the impact of COVID-19. However due to the high degree of uncertainty associated with this pandemic, results may vary from the estimates provided.

Budget/contributions

10 Active and non-Medicare eligible retiree budget rates and contributions reflect rates effective July 1, 2021. Medicare eligible retiree budget rates reflect rates effective January 1, 2021 for FY21 Q1 and Q2, and rates effective January 1, 2022 for FY21 Q3 and Q4. Budget rates include FY22 risk fees for Participating groups (excludes $2.70 PEPM charge). FY22 budget rates were held flat from FY21.

11 Premiums and employee contributions are the product of monthly budget rate/contribution and quarterly average tiered contract counts provided by the medical vendors; assumes 1% enrollment growth during FY22.

12 Highmark quarterly reports do not provide enrollment data split by retirement date. All Medicare eligible retirees are assumed to have retired prior to July 1, 2012, and therefore do not contribute towards the cost of premiums. As a result of this conservative assumption, the healthcare program's net cost to the State may be overstated.

13 Participating groups are assumed to be 100% employee paid in order to estimate the healthcare program's net cost to the State; actual employee contributions vary and are difficult to capture since each group pays premiums at different times; participating group fees are included in premium contributions.

14 While COBRA enrollment and claims are reflected in the expenses, all medical/Rx participants are assumed to pay active contributions since COBRA participants make up less than 0.1% of the total population.

15 HRA funding for CDH plans are included in the paid claims reported in this document.

State of Delaware
Health Plan Quarterly Financial Reporting
Glossary of Important Health Care Terms

Terms directly tied to cost tracking

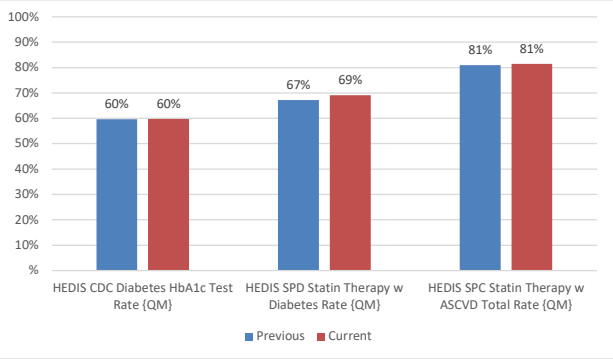
Terminology	Acronym	Definition
Administrative Services Only	ASO	When an organization funds its own employee benefit plan, such as a health insurance program, and it hires an outside firm to perform specific administrative services. Also referred to as "self-funded". Currently, the GHIP has ASO contracts with Aetna, Highmark and Express Scripts.
Capitation	n/a	Fixed payment amount (per member) to a physician or group of physicians for a defined set of services for a defined set of members. Fixed or "capitated" payment per member provides physician with an incentive for meeting quality and cost efficiency outcomes, since the physician is responsible for any costs incurred above the capitated amount. May be risk adjusted based on the demographics of the member population or changes in the member population. Often used for *bundled payments* or other *value-based payments* .
Consumer Driven Health Plan	CDHP	Allows members to use health savings accounts (HSA), health reimbursement accounts *(HRA)* , or other similar medical payment products to pay routine health care expenses directly. GHIP currently offers a CDHP with *HRA* .
Coverage Gap Discount Program	CGDP	One of the funding components of an *EGWP* . Manufacturers provide discounts on covered Part D brand prescription drugs to Medicare beneficiaries while in the coverage gap.
Employee	EE	A person employed for wages or salary.
Employer Group Waiver Plans	EGWP	A Center for Medicare Service (CMS) approved program for both employers and unions. An employer may contract directly with CMS or go through an approved TPA, such as ESI, to establish the plan. They are usually Self Funded, are integrated with Medicare Part D, and sometimes include a fully insured "wrapper" around the plan to cover non-Medicare Part D prescription drugs. GHIP currently contracts with ESI as the TPA and includes a "wrapper," which is referred to as an enhanced benefit.
Fiscal Year	FY	A year as reckoned for taxing or accounting purposes. GHIP fiscal year runs from July 1st through June 30th.
Health Maintenance Organization	HMO	A form of health insurance combining a range of coverages in a group basis. A group of doctors and other medical professionals offer care through the HMO for a flat monthly rate. However, only visits to professionals within the HMO network are covered by the policy. All visits, prescriptions and other care must be cleared by the HMO in order to be covered. A primary physician within the HMO handles referrals.
Health Reimbursement Account	HRA	Employer-funded account that reimburses employees for out-of-pocket medical expenses. Employees can choose how to use their HRA funds to pay for medical expenses, but the employer can determine what expenses are reimbursable by the HRA (e.g., employers often designate prescription drug expenses as ineligible for reimbursement by an HRA). Funds are owned by the employer and are tax-deductible to the employee. GHIP only offers HRA to employees and non-Medicare eligible retirees who enroll in the CDH Gold plan.
High Cost Claimant	HCC	An insured who incurs claims over a catastrophic claim limit during the plan year. For purposes of cost tracking, this threshold is $100K.
Per Employee Per Month	PEPM	A monthly cost basis measured on an employee/contract/subscriber level
Per Employee Per Year	PEPY	A yearly cost basis measured on an employee/contract/subscriber level
Per Member Per Month	PMPM	A monthly cost basis measured on a member level
Per Member Per Year	PMPY	A yearly cost basis measured on a member level
Patient-Centered Outcomes Research Trust Fund Fee	PCORI	The Patient-Centered Outcomes Research Trust Fund fee is a fee on plan sponsors of self-insured health plans that helps to fund the Patient-Centered Outcomes Research Institute (PCORI). The institute will assist, through research, patients, clinicians, purchasers and policy-makers, in making informed health decisions by advancing the quality and relevance of evidence-based medicine. The institute will compile and distribute comparative clinical effectiveness research findings. This fee is part of the Affordable Care Act legislation.

Terms directly tied to cost tracking

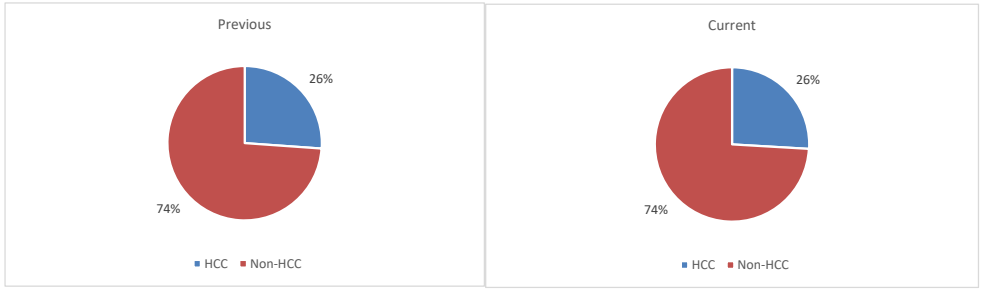
Terminology	Acronym	Definition
Point-of-Service	POS	A type of managed care plan that is a hybrid of HMO and PPO plans. Like an HMO, participants designate an in-network physician to be their primary care provider. But like a PPO, patients may go outside of the provider network for health care services. GHIP only offers this type of plan to Port of Wilmington employees.
Preferred Provider Organization	PPO	A health care organization composed of physicians, hospitals, or other providers which provides health care services at a reduced fee. A PPO is similar to an HMO, but care is paid for as it is received instead of in advance in the form of a scheduled fee. PPOs may also offer more flexibility by allowing for visits to out-of-network professionals at a greater expense to the policy holder. Visits within the network require only the payment of a small fee. There is often a deductible for out-of-network expenses and a higher co-payment.
Transitional Reinsurance Fee	TRF	Fee collected by the transitional reinsurance program to fund reinsurance payments to issuers of non-grandfathered reinsurance-eligible individual market plans, the administrative costs of operating the reinsurance program, and the General Fund of the U.S. Treasury for the 2014, 2015, and 2016 benefit years. This fee is part of the Affordable Care Act legislation, and ends after the 2016 benefit year.
Year to Date	YTD	A period, starting from the beginning of the current year (either the calendar year or fiscal year) and continuing up to the present day. For this financial reporting document, YTD refers to the time period of July 1, 2019 to June 30, 2020

Medical and Prescription Drug Dashboard - Total GHIP Population
Previous Period: Jan 2020 - Dec 2020 (Paid)
Current Period: Jan 2021 - Dec 2021 (Paid)

1. Quality Metrics



2. High Cost Claimants



	Previous	Current	Trend
Patients	1,162	1,266	9.0%
Patients per 1,000	9.0	9.8	8.6%
Payments (in Millions)	$229 M	$252 M	9.9%
Payments per Patient	197,205	198,877	0.8%

3. Well Care and Preventive Visits

	Previous	Current	Trend	Benchmark
Visits per 1000 Well Baby	5602.1	5506.8	-1.7%	5507.4
Visits per 1000 Well Child	908.6	830.6	-8.6%	786.6
Visits per 1000 Prevent Adult	368.0	410.0	11.4%	379.0

4. Medical Eligibility

	Previous	Current	Trend
Average Employees	73,556.8	74,207.1	0.9%
Average Members	128,928.9	129,311.1	0.3%
Family Size	1.8	1.7	-5.6%
Member Age	43.0	43.2	0.5%
Members % Male	45.0%	45.0%	0.0%

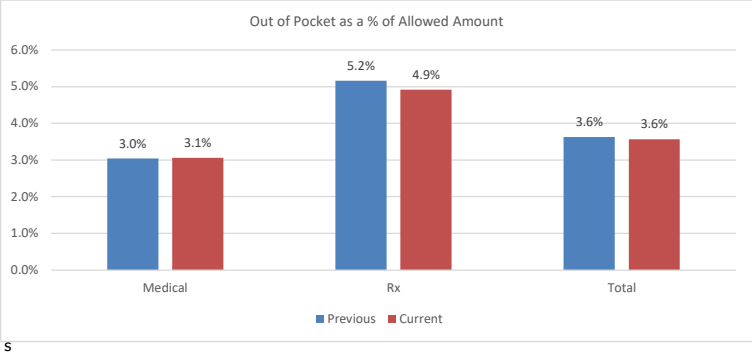
5. Risk Score

	Previous	Current
Member Risk Score	229.9	235.7

6. Price and Use

		Previous	Current	Trend	Benchmark
Inpatient	Allowed per Admit	$24,480	$26,918	10.0%	$30,217
	Admits per 1000	75.0	75.3	0.5%	54.1
	Days LOS	5.6	5.9	5.8%	4.5
Outpatient	Allowed per Service	$133	$136	2.8%	$130
	ER Visits per 1000	288.9	303.7	5.1%	229.1
Non-Specialty Rx	Allowed per Days Suppy	$2	$2	2.7%	n/a
	Days Supply PMPY	665	675	1.4%	n/a
Specialty Rx	Allowed per Days Supply	$88	$99	12.5%	n/a
	Days Supply PMPY	13	13	0.9%	n/a
All RX	Allowed per Days Supply	$4	$4	7.0%	$4
	Days Supply PMPY	679	688	1.4%	365

7. Cost Sharing



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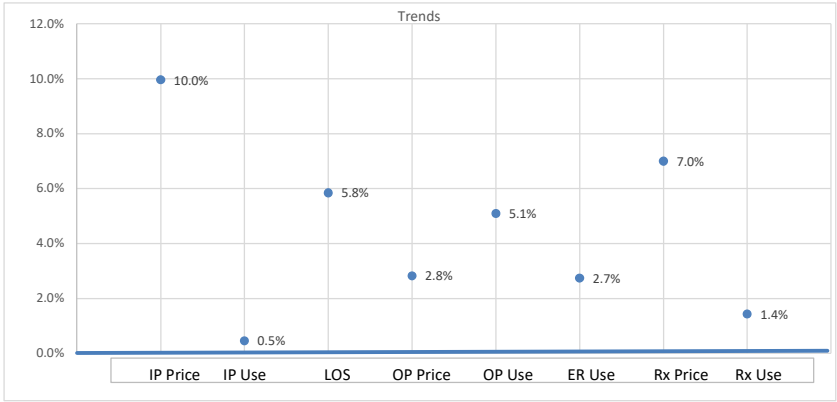
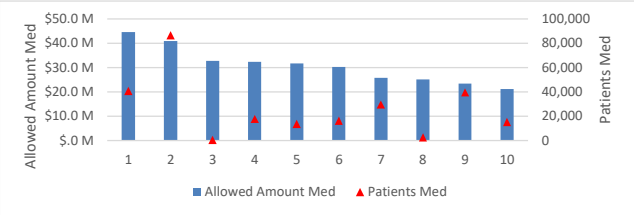


IBM Watson Health

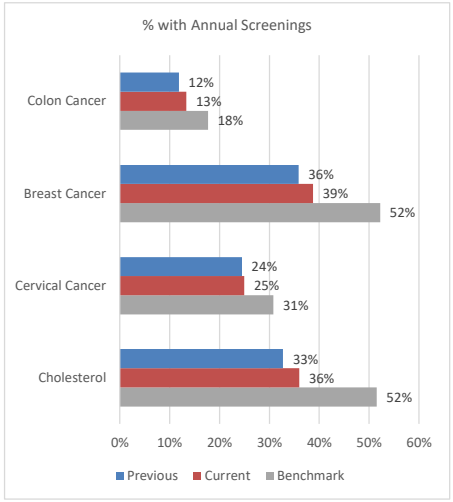
Medical and Prescription Drug Dashboard - Total GHIP Population
Previous Period: Jan 2020 - Dec 2020 (Paid)
Current Period: Jan 2021 - Dec 2021 (Paid)

8. Top Medical Conditions (by cost)

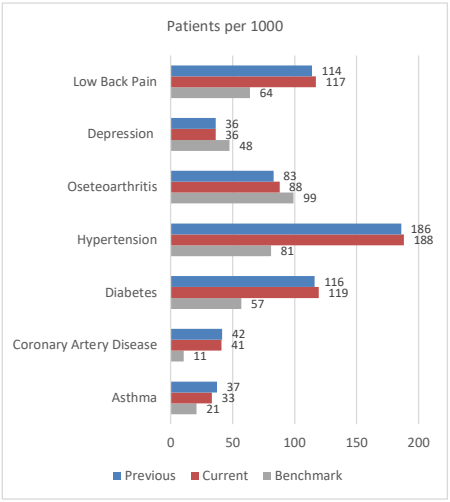


	Condition	Allowed Amount Med	Patients Med	Med Allowed per Patient
1	Signs/Symptoms/Oth Cond, NEC	$44,651,680	40,896	$1,092
2	Prevent/Admin Hlth Encounters	$40,958,409	86,699	$472
3	Chemotherapy Encounters	$32,822,399	658	$49,882
4	Infections - Respiratory, NEC	$32,424,406	17,792	$1,822
5	Osteoarthritis	$31,713,400	13,867	$2,287
6	Spinal/Back Disord, Low Back	$30,275,056	16,411	$1,845
7	Arthropathies/Joint Disord NEC	$25,879,044	29,718	$871
8	Pregnancy without Delivery	$25,246,457	2,793	$9,039
9	Infections, NEC	$23,411,480	39,749	$589
10	Respiratory Disord, NEC	$21,165,878	15,376	$1,377

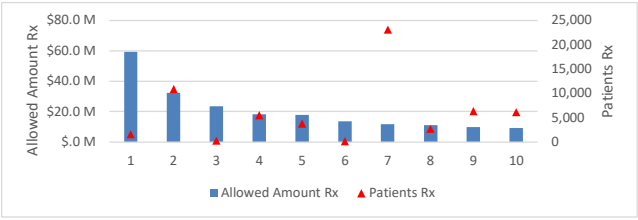
9. Screening Rates



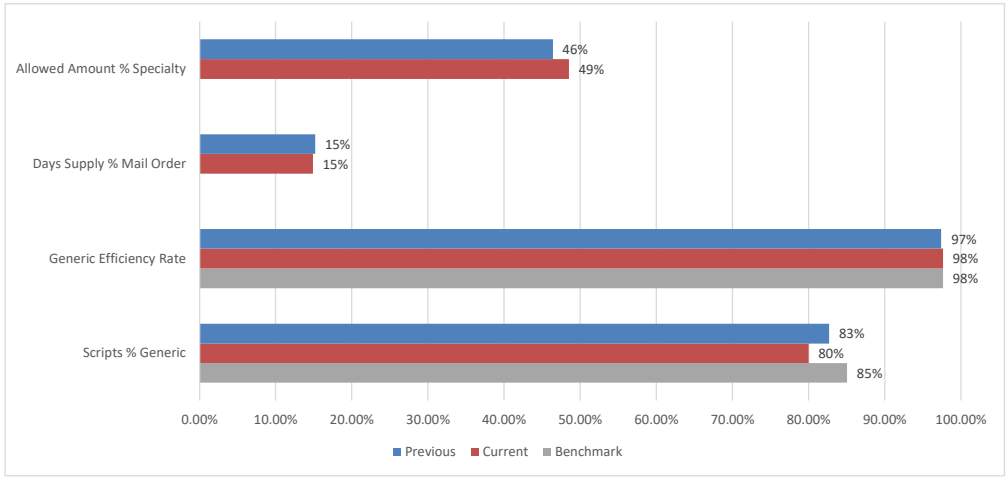
10. Chronic Condition Prevalence



11. Prescription Drug Metrics



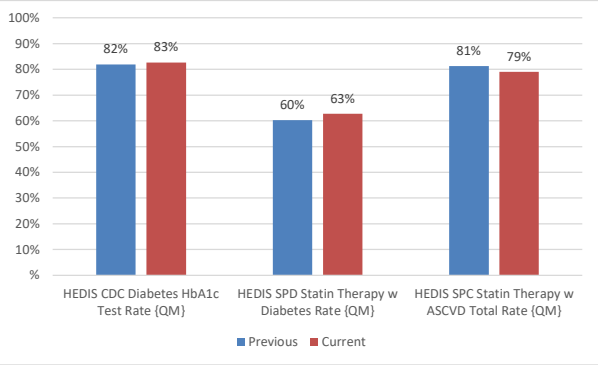
	Therapeutic Class	Allowed Amount Rx	Patients Rx	Rx Allowed per Patient
1	Immunosuppressants, NEC	$59,316,375	1,574	$37,685
2	Antidiabetic Agents, Misc	$32,424,399	10,893	$2,977
3	Molecular Targeted Therapy	$23,540,528	248	$94,921
4	Coag/Anticoag, Anticoagulants	$18,241,776	5,491	$3,322
5	Antidiabetic Agents, Insulins	$17,685,814	3,755	$4,710
6	Biological Response Modifiers	$13,437,977	153	$87,830
7	Adrenals & Comb, NEC	$11,639,888	23,091	$504
8	Antidiabetic Ag, SGLT Inhibitr	$11,021,916	2,678	$4,116
9	Misc Therapeutic Agents, NEC	$9,901,971	6,350	$1,559
10	Stimulant, Amphetamine Type	$9,193,429	6,084	$1,511



IBM Watson Health

Medical and Prescription Drug Dashboard - Active Employees
Previous Period: Jan 2020 - Dec 2020 (Paid)
Current Period: Jan 2021 - Dec 2021 (Paid)

1. Quality Metrics



2. High Cost Claimants

	Previous	Current	Trend
Patients	771	866	12.3%
Patients per 1,000	8.5	9.6	12.7%
Payments (in Millions)	$146 M	$165 M	12.6%
Payments per Patient	189,437	189,989	0.3%

3. Well Care and Preventive Visits

	Previous	Current	Trend	Benchmark
Visits per 1000 Well Baby	5603.0	5509.2	-1.7%	5507.4
Visits per 1000 Well Child	909.7	829.6	-8.8%	786.6
Visits per 1000 Prevent Adult	419.2	469.5	12.0%	341.4

4. Medical Eligibility

	Previous	Current	Trend
Average Employees	39,021.9	39,008.0	0.0%
Average Members	90,201.9	89,935.4	-0.3%
Family Size	2.3	2.3	0.0%
Member Age	32.8	32.7	-0.3%
Members % Male	46.0%	46.0%	0.0%

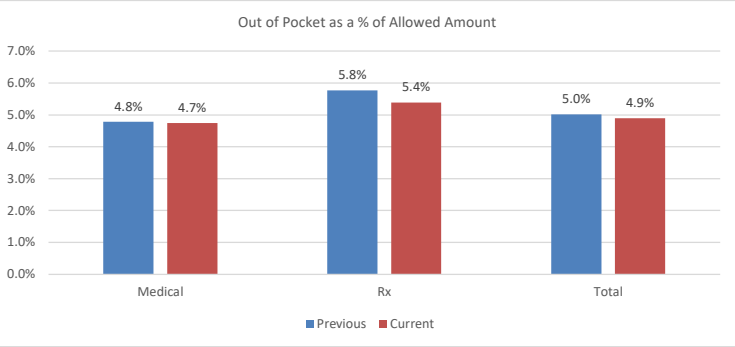
5. Risk Score

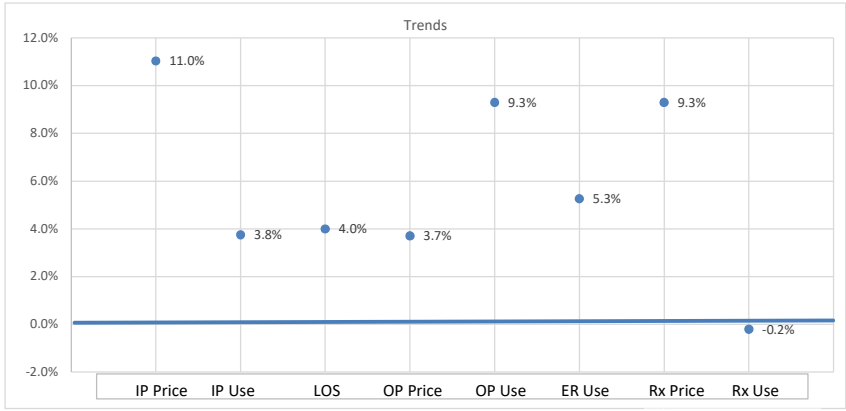
	Previous	Current
Member Risk Score	131.3	137.5

6. Price and Use

		Previous	Current	Trend	Benchmark
Inpatient	Allowed per Admit	$27,758	$30,823	11.0%	$24,439
	Admits per 1000	50.8	52.7	3.8%	52.9
	Days LOS	4.8	5.0	4.0%	4.3
Outpatient	Allowed per Service	$136	$141	3.7%	$130
	ER Visits per 1000	223.2	244.0	9.3%	228.0
Non-Specialty Rx	Allowed per Days Suppy	$2	$2	5.3%	n/a
	Days Supply PMPY	389	389	0.0%	n/a
Specialty Rx	Allowed per Days Supply	$85	$105	24.2%	n/a
	Days Supply PMPY	9	8	-9.1%	n/a
All RX	Allowed per Days Supply	$4	$4	9.2%	$4
	Days Supply PMPY	398	398	-0.2%	365

7. Cost Sharing

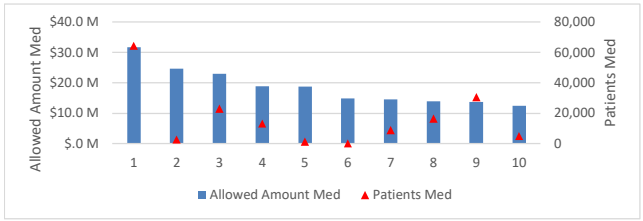




IBM Watson Health

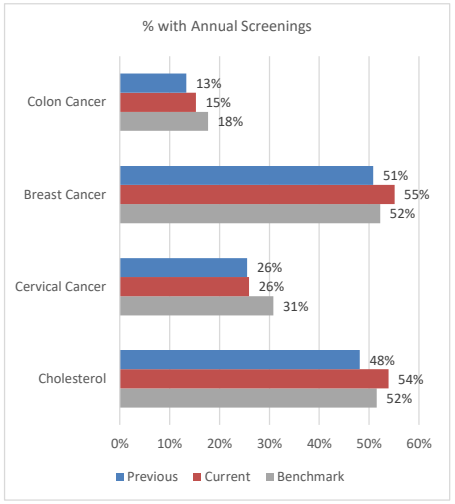
Medical and Prescription Drug Dashboard - Active Employees
Previous Period: Jan 2020 - Dec 2020 (Paid)
Current Period: Jan 2021 - Dec 2021 (Paid)

8. Top Medical Conditions (by cost)

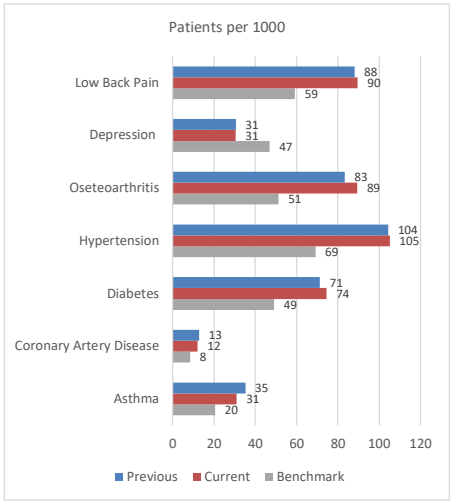


	Condition	Allowed Amount Med	Patients Med	Med Allowed per Patient
1	Prevent/Admin Hlth Encounters	$31,740,707	64,384	$493
2	Pregnancy without Delivery	$24,625,574	2,710	$9,087
3	Signs/Symptoms/Oth Cond, NEC	$22,927,945	22,964	$998
4	Infections - Respiratory, NEC	$18,812,622	13,269	$1,418
5	Newborns, w/wo Complication	$18,746,361	1,340	$13,990
6	Chemotherapy Encounters	$14,867,121	213	$69,799
7	Spinal/Back Disord, Low Back	$14,561,992	8,934	$1,630
8	Arthropathies/Joint Disord NEC	$13,859,322	16,436	$843
9	Infections, NEC	$13,728,657	30,611	$448
10	Osteoarthritis	$12,454,390	5,111	$2,437

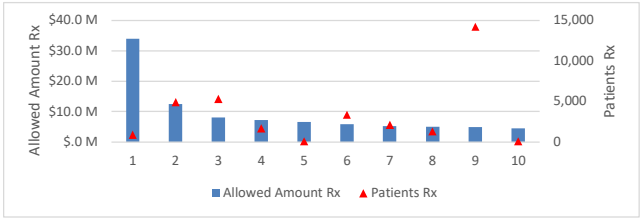
9. Screening Rates



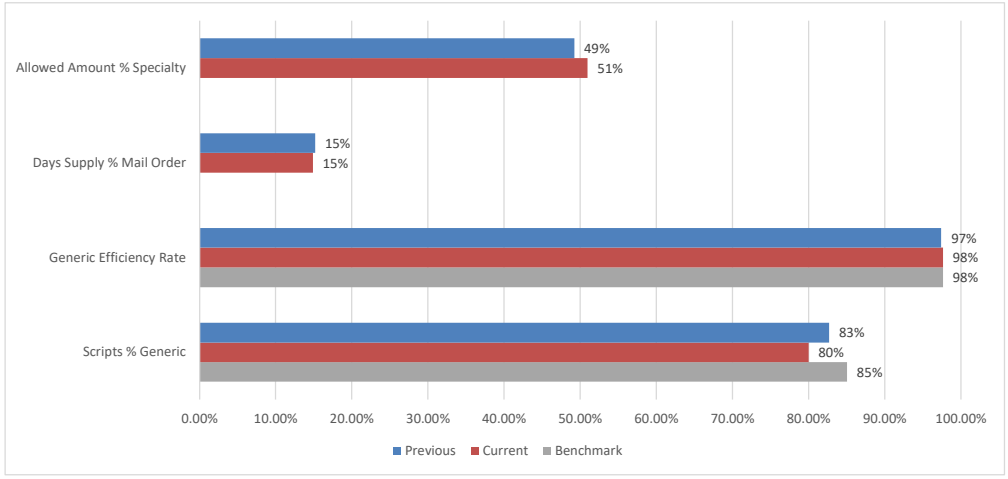
10. Chronic Condition Prevalence



11. Prescription Drug Metrics

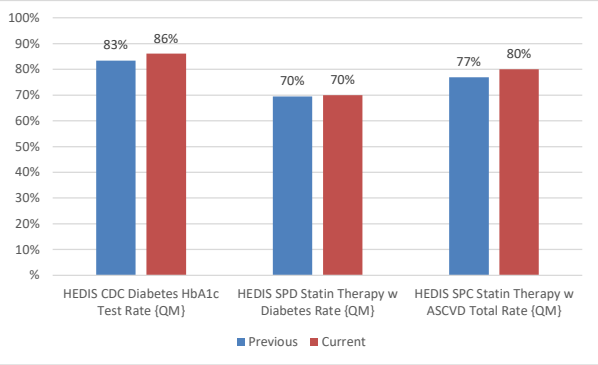


	Therapeutic Class	Allowed Amount Rx	Patients Rx	Rx Allowed per Patient
1	Immunosuppressants, NEC	$33,951,338	901	$37,682
2	Antidiabetic Agents, Misc	$12,467,040	4,902	$2,543
3	Stimulant, Amphetamine Type	$8,086,356	5,300	$1,526
4	Antidiabetic Agents, Insulins	$7,231,401	1,671	$4,328
5	Molecular Targeted Therapy	$6,576,307	65	$101,174
6	Antivirals, NEC	$5,824,100	3,344	$1,742
7	Misc Therapeutic Agents, NEC	$5,296,264	2,087	$2,538
8	Antidiabetic Ag, SGLT Inhibitr	$5,017,326	1,303	$3,851
9	Adrenals & Comb, NEC	$4,889,497	14,208	$344
10	Biological Response Modifiers	$4,473,131	62	$72,147

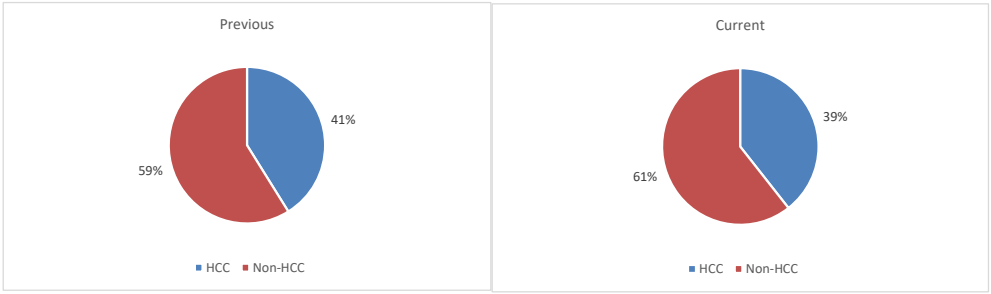


Medical and Prescription Drug Dashboard - Early Retirees
Previous Period: Jan 2020 - Dec 2020 (Paid)
Current Period: Jan 2021 - Dec 2021 (Paid)

1. Quality Metrics



2. High Cost Claimants



	Previous	Current	Trend
Patients	262	260	-0.8%
Patients per 1,000	26.8	26.8	0.2%
Payments (in Millions)	$48 M	$47 M	-1.9%
Payments per Patient	182,802	180,655	-1.2%

3. Well Care and Preventive Visits

	Previous	Current	Trend	Benchmark
Visits per 1000 Well Baby	5700.0	4800.0	-15.8%	5507.4
Visits per 1000 Well Child	808.4	822.9	1.8%	786.6
Visits per 1000 Prevent Adult	435.2	492.6	13.2%	484.2

4. Medical Eligibility

	Previous	Current	Trend
Average Employees	6,128.9	6,073.2	-0.9%
Average Members	9,785.2	9,693.3	-0.9%
Family Size	1.6	1.6	0.0%
Member Age	49.9	50.1	0.3%
Members % Male	41.6%	41.8%	0.4%

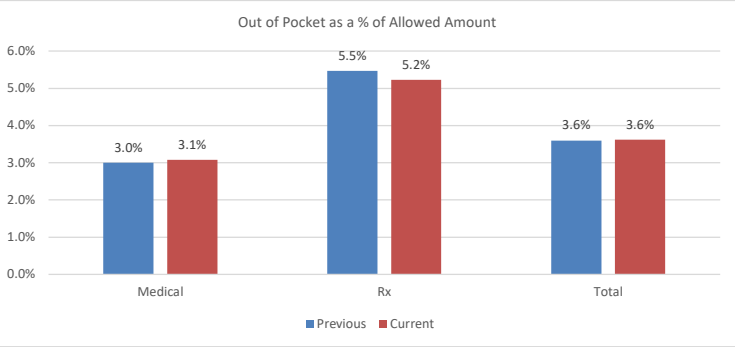
5. Risk Score

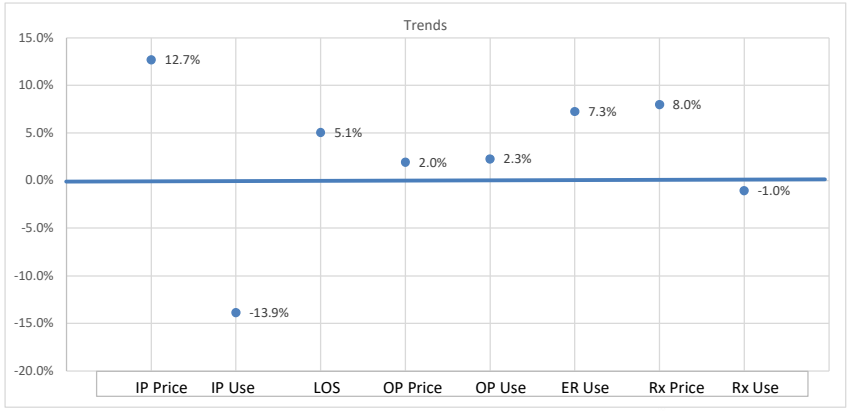
	Previous	Current
Member Risk Score	248.4	246.7

6. Price and Use

		Previous	Current	Trend	Benchmark
Inpatient	Allowed per Admit	$42,578	$47,985	12.7%	$37,947
	Admits per 1000	71.0	61.2	-13.9%	62.4
	Days LOS	6.6	7.0	5.1%	5.4
Outpatient	Allowed per Service	$159	$162	2.0%	$130
	ER Visits per 1000	307.1	314.1	2.3%	238.7
Non-Specialty Rx	Allowed per Days Suppy	$2	$2	7.3%	n/a
	Days Supply PMPY	793	789	-0.5%	n/a
Specialty Rx	Allowed per Days Supply	$82	$117	42.1%	n/a
	Days Supply PMPY	19	14	-24.7%	n/a
All RX	Allowed per Days Supply	$4	$4	8.0%	$4
	Days Supply PMPY	812	803	-1.0%	365

7. Cost Sharing

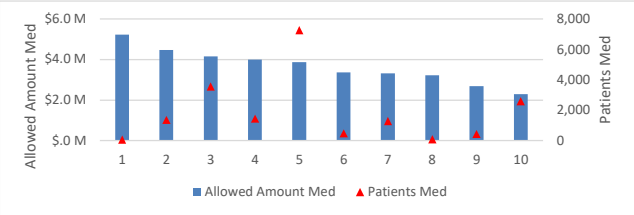




IBM Watson Health

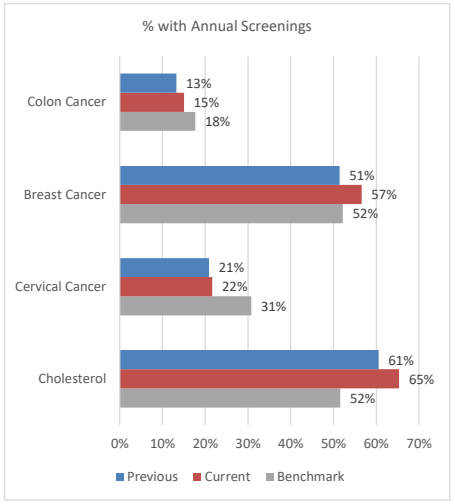
Medical and Prescription Drug Dashboard - Early Retirees
Previous Period: Jan 2020 - Dec 2020 (Paid)
Current Period: Jan 2021 - Dec 2021 (Paid)

8. Top Medical Conditions (by cost)

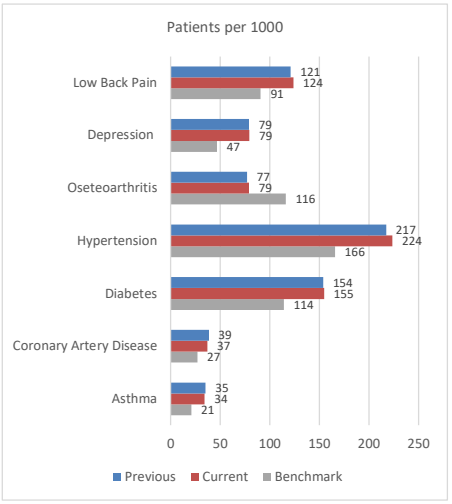


	Condition	Allowed Amount Med	Patients Med	Med Allowed per Patient
1	Chemotherapy Encounters	$5,220,822	68	$76,777
2	Osteoarthritis	$4,471,970	1,367	$3,271
3	Signs/Symptoms/Oth Cond, NE	$4,148,828	3,555	$1,167
4	Spinal/Back Disord, Low Back	$3,998,307	1,458	$2,742
5	Prevent/Admin Hlth Encounters	$3,873,103	7,265	$533
6	Cardiac Arrhythmias	$3,364,640	486	$6,923
7	Infections - Respiratory, NEC	$3,321,310	1,284	$2,587
8	Congestive Heart Failure	$3,225,299	97	$33,251
9	Coronary Artery Disease	$2,687,509	436	$6,164
10	Arthropathies/Joint Disord NEC	$2,298,752	2,598	$885

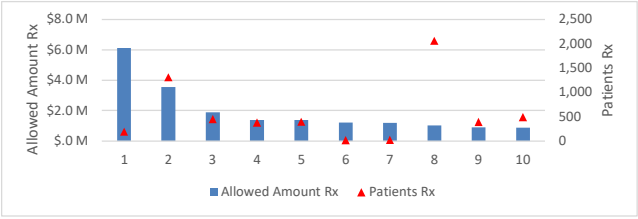
9. Screening Rates



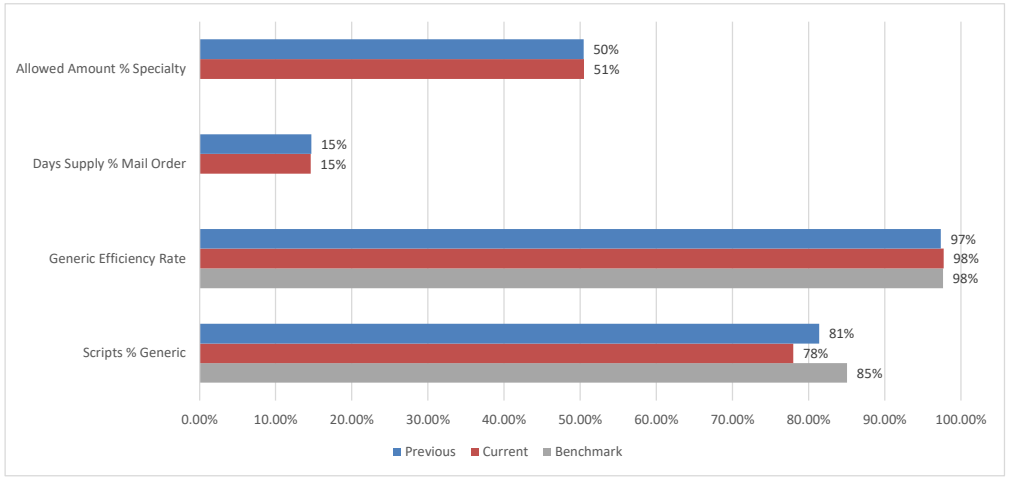
10. Chronic Condition Prevalence



11. Prescription Drug Metrics

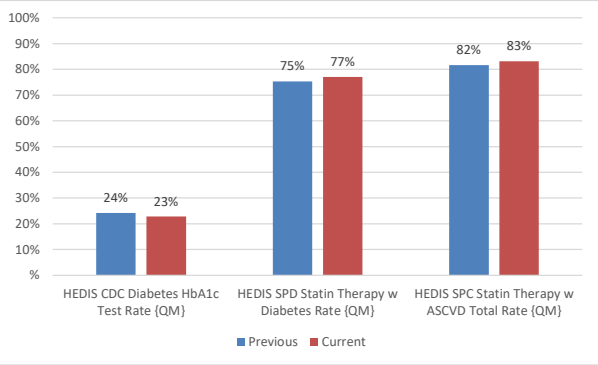


	Therapeutic Class	Allowed Amount Rx	Patients Rx	Rx Allowed per Patient
1	Immunosuppressants, NEC	$6,123,094	187	$32,744
2	Antidiabetic Agents, Misc	$3,549,155	1,308	$2,713
3	Antidiabetic Agents, Insulins	$1,892,914	451	$4,197
4	CNS Agents, Misc.	$1,391,179	377	$3,690
5	Antidiabetic Ag, SGLT Inhibitr	$1,372,334	392	$3,501
6	Molecular Targeted Therapy	$1,222,694	18	$67,927
7	Biological Response Modifiers	$1,194,158	21	$56,865
8	Adrenals & Comb, NEC	$1,017,393	2,060	$494
9	Coag/Anticoag, Anticoagulants	$888,054	390	$2,277
10	Antivirals, NEC	$871,870	489	$1,783



Medical and Prescription Drug Dashboard - Medicare Retirees
Previous Period: Jan 2020 - Dec 2020 (Paid)
Current Period: Jan 2021 - Dec 2021 (Paid)

1. Quality Metrics



2. High Cost Claimants

	Previous	Current	Trend
Patients	215	252	17.2%
Patients per 1,000	8.2	9.4	14.2%
Payments (in Millions)	$32 M	$36 M	11.7%
Payments per Patient	150,729	143,606	-4.7%

3. Well Care and Preventive Visits

	Previous	Current	Trend	Benchmark
Visits per 1000 Prevent Adult	230.8	252.2	9.3%	462.0

4. Medical Eligibility

	Previous	Current	Trend
Average Employees	25,878.3	26,560.8	2.6%
Average Members	26,169.3	26,852.9	2.6%
Family Size	1.0	1.0	0.0%
Member Age	73.0	73.1	0.2%
Members % Male	41.5%	41.3%	-0.4%

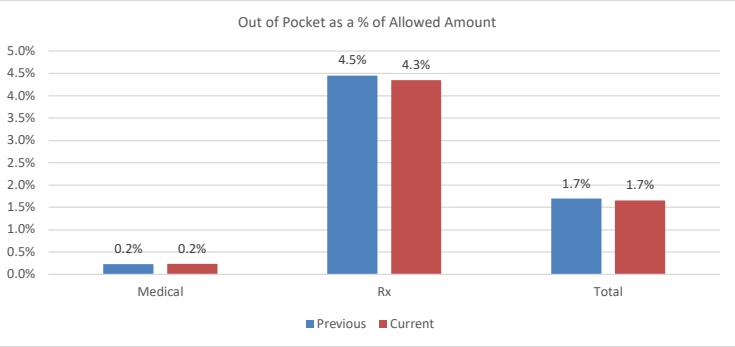
5. Risk Score

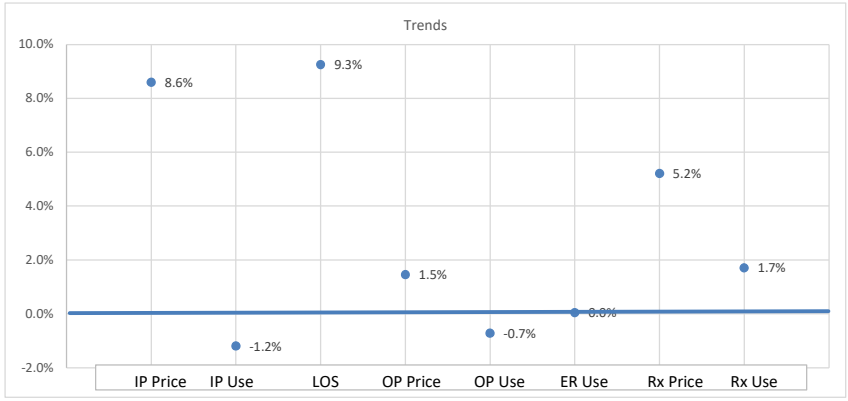
	Previous	Current
Member Risk Score	534.3	537.6

6. Price and Use

		Previous	Current	Trend	Benchmark
Inpatient	Allowed per Admit	$18,274	$19,846	8.6%	$35,620
	Admits per 1000	148.0	146.3	-1.2%	55.1
	Days LOS	6.1	6.7	9.3%	4.7
Outpatient	Allowed per Service	$120	$122	1.5%	$130
	ER Visits per 1000	471.0	467.6	-0.7%	229.2
Non-Specialty Rx	Allowed per Days Suppy	$2	$2	0.0%	n/a
	Days Supply PMPY	1,518	1,540	1.4%	n/a
Specialty Rx	Allowed per Days Supply	$93	$90	-3.4%	n/a
	Days Supply PMPY	25	30	18.3%	n/a
All RX	Allowed per Days Supply	$3	$4	5.2%	$4
	Days Supply PMPY	1,543	1,570	1.7%	365

7. Cost Sharing

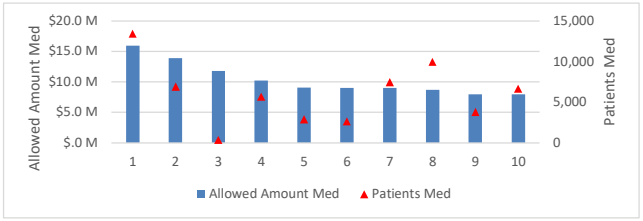




IBM Watson Health

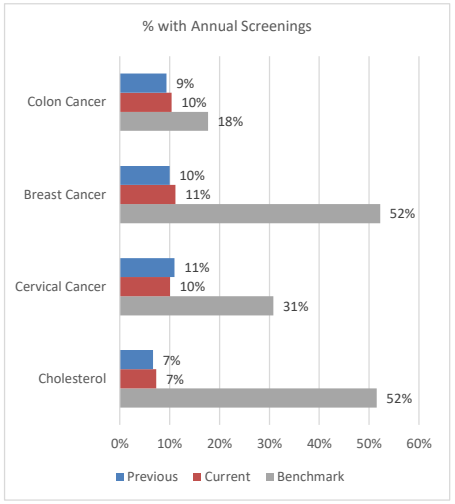
Medical and Prescription Drug Dashboard - Medicare Retirees
Previous Period: Jan 2020 - Dec 2020 (Paid)
Current Period: Jan 2021 - Dec 2021 (Paid)

8. Top Medical Conditions (by cost)

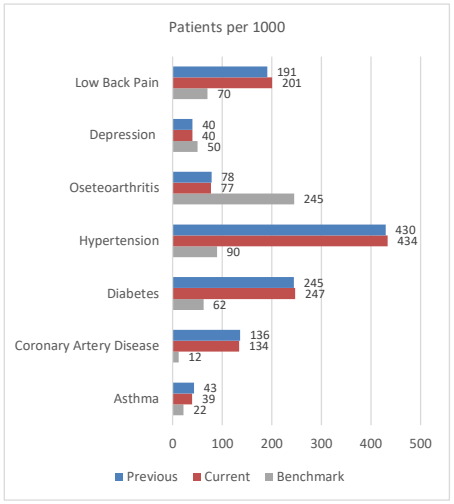


	Condition	Allowed Amount Med	Patients Med	Med Allowed per Patient
1	Signs/Symptoms/Oth Cond, NEC	$15,941,078	13,422	$1,188
2	Osteoarthritis	$13,919,328	6,933	$2,008
3	Chemotherapy Encounters	$11,784,896	367	$32,111
4	Spinal/Back Disord, Low Back	$10,235,462	5,683	$1,801
5	Infections - Respiratory, NEC	$9,065,544	2,911	$3,114
6	Renal Function Failure	$9,042,889	2,657	$3,403
7	Eye Disorders, Degenerative	$9,009,631	7,485	$1,204
8	Arthropathies/Joint Disord NEC	$8,737,155	9,969	$876
9	Coronary Artery Disease	$7,959,520	3,799	$2,095
10	Respiratory Disord, NEC	$7,958,828	6,671	$1,193

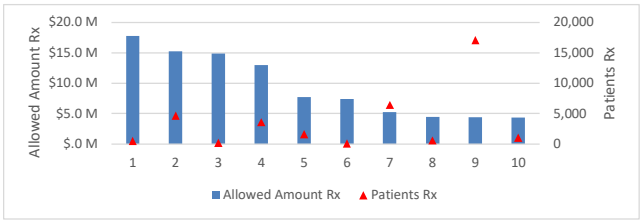
9. Screening Rates



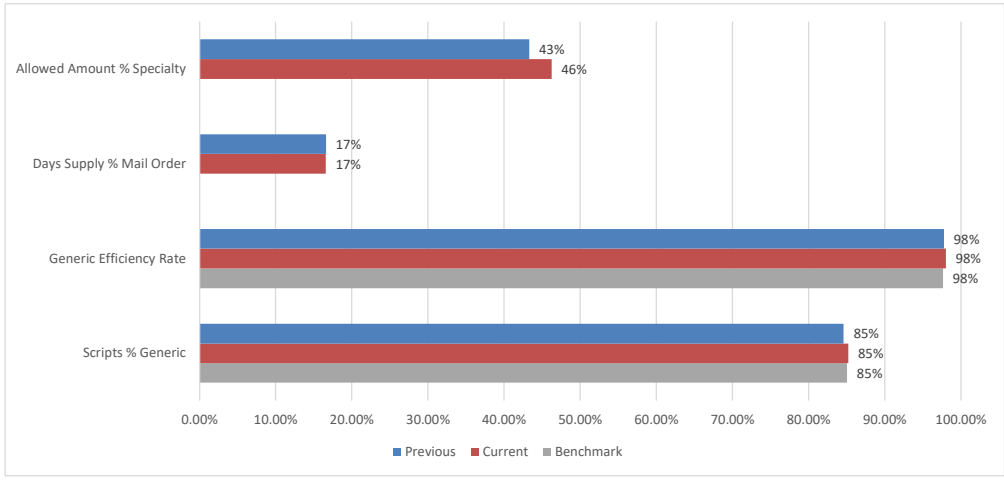
10. Chronic Condition Prevalence



11. Prescription Drug Metrics



	Therapeutic Class	Allowed Amount Rx	Patients Rx	Rx Allowed per Patient
1	Immunosuppressants, NEC	$17,745,784	497	$35,706
2	Antidiabetic Agents, Misc	$15,264,929	4,651	$3,282
3	Molecular Targeted Therapy	$14,861,889	159	$93,471
4	Coag/Anticoag, Anticoagulants	$12,969,738	3,578	$3,625
5	Antidiabetic Agents, Insulins	$7,748,934	1,592	$4,867
6	Biological Response Modifiers	$7,419,318	69	$107,526
7	Adrenals & Comb, NEC	$5,233,154	6,424	$815
8	Hormone-Modifying Therapy	$4,440,340	563	$7,887
9	Antihyperlipidemic Drugs, NEC	$4,398,691	17,097	$257
10	Antidiabetic Ag, SGLT Inhibitr	$4,337,794	1,039	$4,175

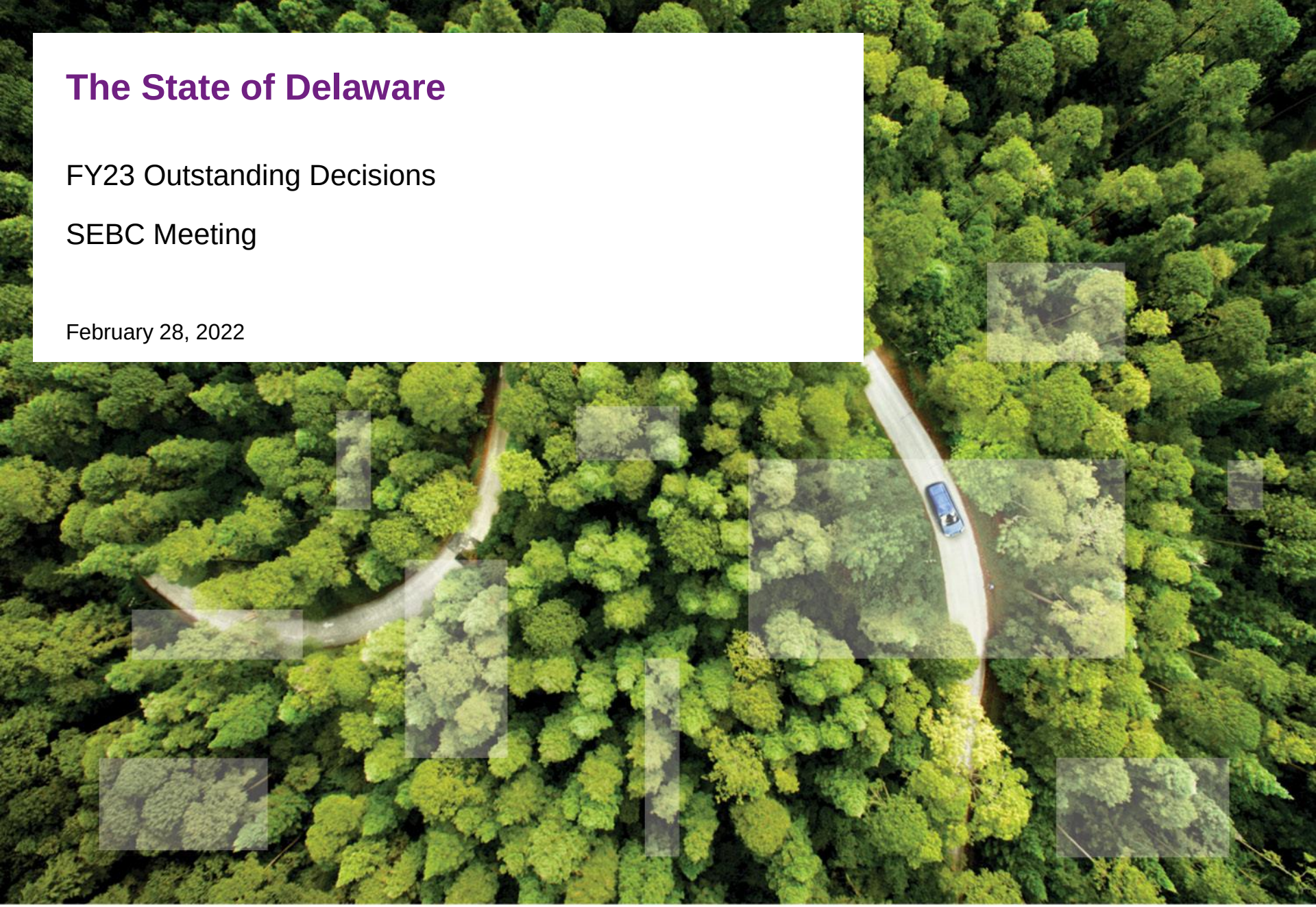


The State of Delaware

FY23 Outstanding Decisions

SEBC Meeting

February 28, 2022



Willis Towers Watson

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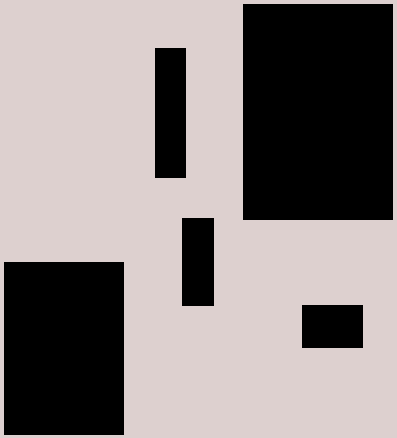
Medicare Plan Options

Overview



Medicare pensioner plan options

Overview of medical TPA RFP scoring decision for Medicare

- On November 2, 2021, the Proposal Review Committee (PRC) voted affirmatively on the following recommendations related to the Medicare plan options:
  - Both Highmark Delaware and Aetna are qualified to administer both a Special Medicfill Medicare Supplement plan as well as a Group Medicare Advantage (Group MA) product to the Medicare pensioner population, with Highmark Delaware's Medicare Advantage product being slightly more favorable than Aetna's product based on the results of the scoring
  - Of a total of 125 points, the scores by plan were as follows:
    - Special Medicfill Medicare Supplement: Highmark Delaware scored 80.4, Aetna scored 78.2
    - Medicare Advantage: Highmark Delaware scored 83.0, Aetna scored 80.2
  - The PRC recommended continued evaluation of these Medicare plan options in accordance with the recommendations from the Retirement Benefits Study Committee (released on November 1, 2021), with no immediate contract award of a Medicare product at that time
  - **The PRC also recommended that the State Employee Benefits Committee (SEBC) should reach a decision on the administration of a Medicare plan for calendar year 2023 no later than March 31, 2022, in order to provide sufficient time for implementation of that plan option before the current Special Medicfill Medicare Supplement plan contract terminates on December 31, 2022**
  - Should the SEBC wish to offer the Special Medicfill Medicare Supplement plan beyond December 31, 2022, then the SEBC could potentially do so through an award to Highmark Delaware based on the scoring results by the PRC
  - Subcommittee members discussed the Medicare plan options for FY23 and formulated recommendations that will be discussed at today's meeting

Medicare pensioner plan options

Industry perspective – Medicare Supplement vs Group Medicare Advantage

Plan type	Description	Current state	Future state
Medicare Supplement* and Coordination of Benefit (COB) plans	▪ Employer-sponsored plans that provide benefits secondary to Medicare ▪ No federal funding for medical claims ▪ Federal funding available for Rx claims (usually not sufficient to fully offset cost) ▪ Generally self insured for larger employers ▪ Employer sets plan design	▪ Shrinking enrollment in recent years due to advent of Medicare marketplace approach driving enrollment in individual coverage	▪ Continued shrinkage as employers continue shift to marketplace plans or convert to group MA plans ▪ Enrollment will decline as older members of closed groups pass away
Group Medicare Advantage (Group MA)	▪ Private group plans that replace Medicare Parts A and B ▪ Always fully insured ▪ Part D Rx coverage can be included or excluded from group MA plan ▪ Significant federal funding covers lion's share of cost ▪ Minimum design standards set by Centers for Medicare and Medicaid (CMS) ▪ Wide latitude for employer custom design	▪ Enrollment over 3m as group MA plans can often match current benefits at lower cost ▪ Many employers offer group MA plans as a full replacement passive Preferred Provider Organization (PPO) that minimizes network disruption ▪ Major group MA insurers: UHC, Humana, Aetna	▪ Good fit for employers with substantial post-65 groups where movement to a Medicare marketplace is not feasible ▪ Stability and growth predicated on continuing favorable federal funding

*GHIP Medicfill plan is a Medicare Supplement plan.

- Per Delaware statute, the State Employee Benefits Committee (SEBC) is tasked with deciding the types of Medicare options available to Delaware retirees

Medicare pensioner plan options

GHIP-specific considerations related to Group MA with Part D Rx coverage

Considerations for including Part D Rx coverage (MAPD)	Considerations for excluding Part D Rx coverage (MA only)
▪ Simplified administration under one carrier ▪ Short term financial predictability with known fixed premiums covering both medical and prescription drug spend ▪ 2020 Pharmacy Benefits Manager (PBM) RFP included flexibility for the State to discontinue Employer Group Waiver Plan (EGWP) for Rx coverage through CVS ▪ More advantageous than MA only to GHIP cash position in year of implementation due to payment timing lag for rebate and EGWP revenues under existing Rx plan	▪ The State is already benefiting from significant federal and PBM subsidies via the EGWP ▪ The State recently concluded negotiation of highly competitive financial terms for the EGWP contract under CVS ▪ Cost volatility is low for the portion of Rx drug spend not covered by Part D ▪ Additional PBM disruption for members including potential change in pharmacy network, formulary, etc. for 1/1/2023, following the change in PBMs from Express Scripts to CVS effective 1/1/2022

Medicare pensioner plan options

Overview of proposed options – Medicfill vs Group MA

Plan feature	Medicfill (current)	Proposed Group MA (Aetna)	Proposed Group MA (Highmark)
Plan type	▪ Self-funded medical/EGWP	▪ Fully-insured MA (medical only) or MAPD	▪ Fully-insured MA (medical only) or MAPD
Federal funding	▪ Retained by GHIP (EGWP only)	▪ Retained by Aetna	▪ Retained by Highmark
Medical plan design[1]	▪ Member responsible for Part B premium only ($170.10/month for 2022)	▪ Same as Medicfill	▪ Same as Medicfill
Rx plan design[2]	▪ Generic copay: $8 / $16 retail/mail ▪ Brand formulary: $28 / $56 ▪ Brand non-formulary: $50 / $100 ▪ Out-of-pocket max: None[3]	▪ Same as Medicfill	▪ Same as Medicfill
Provider network	▪ Passive PPO (members may seek care from any medical provider that accepts Medicare assignment) ▪ See appendix for more details	▪ Same as Medicfill ▪ Mirrors access to providers available today	▪ Same as Medicfill ▪ Mirrors access to providers available today
CY 2023 premium rate (per retiree per month)[4]	▪ $459.38 total ▪ $260.44 medical ▪ $198.94 Rx	▪ Redacted	▪ $162 total (MAPD) ▪ $0 medical (MA medical only) ▪ $162 Rx
Group MA transition credit	▪ N/A	▪ $	▪ $$$

1. Plan fully covers medical out-of-pocket costs not covered by Medicare Part B, other than the Part B premium
2. Prescription drug copays and 5% premium cost share applies for pensioners retiring on or after 7/1/2012; State share is 100% for pensioners retiring before 7/1/2012; State pays 100% of State Share for pensioners with 20+ years of service
3. Catastrophic Coverage: After yearly out-of-pocket drug costs reach $7,050, retirees pay the greater of 5% coinsurance or from $3.95 to $9.85 copayment per script based on drug tier
4. Assumes no change in rates effective 7/1/2022; Medicfill rates represent funding revenue only; actual cost of Medicfill program differs from the current funding rates

Considerations for Medicare plan options

- Balance short term financial impact to the GHIP of Medicare Supplement vs. Medicare Advantage plan options with the longer-term impact of change in terms of OPEB liability
- Another option discussed by the Retirement Benefits Study Committee (RBSC) – the Medicare marketplace – is outside the scope of this RFP and was not considered in this analysis
- Changes in Medicfill program design that reduce the State's unfunded OPEB liability can be recognized once the changes have been announced, regardless of effective date
- Important for SEBC to thoroughly evaluate all options and make the best decision for the GHIP, for pensioners and for the State’s retiree liability obligations
- Any change from the current Medicfill plan will require extensive outreach and communication in advance of the plan effective date
- If moving from Medicfill to Group MA, Medicare rates will reset to the fully-insured rate (with or without Rx), and will reduce overall subsidy for active and pre-65 rates

SEBC Decision Points:

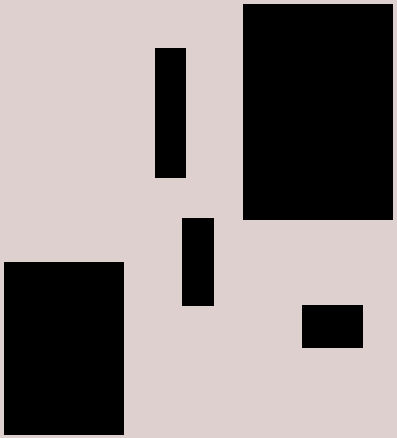
- **Maintain Medicfill plan or move to Group MA product, effective 1/1/23 (or later)**
- **Aetna or Highmark**
- **Including/Excluding Part D drug coverage as part of Group MA product**

Medicare pensioner plan options

Decisions requiring vote by SEBC

- The joint Subcommittees provide recommendations for the following with regards to a Medicare plan:
  - Effective January 1, 2023, move to Group Medicare Advantage Plan
  - Award administration of the Group MA plan to Highmark
  - Maintain existing self-funded EGWP coverage

Active/Non-Medicare Plan Considerations



Active Non-Medicare Plan Considerations

Overview of outstanding decisions for 2/28 SEBC vote

- Subcommittee members discussed the following programs for FY23 and formulated recommendations that will be discussed at today's meeting:
  - Care management program option for each medical vendor
  - Aetna HMO plan's PCP election/referral requirement
  - Other FY23 opportunities for consideration
- At the conclusion of today's discussion, the SEBC will be asked to take a vote on Subcommittee recommendations

Outstanding decisions from the Medical RFP

Care management programs – Aetna

Outstanding decision	Effective date of decision	Estimated FY23 Admin Cost / (Savings)
Aetna HMO and CDH Gold plans: Choose which care management program to implement: ▪ Option 1 (“One Advisor”): Targets more people, engages with them earlier, uses more advanced technology, is more integrated with other Aetna services ▪ Option 2 (“One Flex”): Targets fewer people, uses less advanced technology/integration, is lower cost than Option 1 Both programs are new to the State Group Health plan and both offer performance guarantees.	7/1/2022 (SEBC must vote by 2/28)	**($0.6M)** – Option 1 **($1.7M)** – Option 2 Savings are based on administrative costs only and do not factor in any potential savings from the performance guarantee.

- Aetna appeared before the Combined Subcommittees in January to present on key differences between these programs, using several member scenarios to illustrate how the member’s experience would be different under each option, and answered questions from Subcommittee members, who were briefed on both options prior to this meeting
  - This briefing focused on information Aetna submitted in its response to the 2021 Medical RFP including descriptions of each program, fees, performance guarantees, outcomes achieved and case studies

- At the February Subcommittee meeting, follow-ups from Aetna’s presentation were discussed; this included clarification of the engagement rates produced by each option, further description of how both care management programs address components of the member experience such as members’ social determinants of health, early identification of members with pre-diabetes, and care coordination with members’ PCPs and other community providers

Outstanding decisions from the Medical RFP

Care management programs – Aetna (continued)

- The Subcommittees saw value in a program that identifies more plan participants for engagement, at earlier points in their health care journey, and how doing so could lead to a better member experience, improved health outcomes and reduced cost
- Subcommittee members also felt that Aetna's presentation in January effectively outlined key differences in the degree of care advocacy and navigation support available to members through each option
- The availability of performance guarantees addressing member engagement and clinical outcomes, in addition to financial outcomes, was viewed favorably by Subcommittee members
- Based on the above, Subcommittee members agreed that the **Aetna One Advisor program ("Option 1")** would be better suited to identify, engage and support the health care needs of plan participants

Outstanding decisions from the Medical RFP (continued)

Care management programs – Highmark

Outstanding decision	Effective date of decision	Estimated FY23 Admin Cost / (Savings)
Highmark PPO and First State Basic plans: Choose which care management program to implement: ▪ Option 1 ("Well360 Clarity"): New program, targets more people, delivered in conjunction with partner, more steerage to high quality providers ▪ Option 2 ("CCMU"): In place today, targets fewer people, Highmark alone delivers program, WTW* provides clinical oversight on behalf of all mutual customers served by the CCMU Both programs offer performance guarantees.	7/1/2022 (SEBC must vote by 2/28)	**($0.6M)** – Option 1 **$0.1M** – Option 2 Savings are based on administrative costs only and do not factor in any potential savings from the performance guarantee.

- Highmark appeared before the Combined Subcommittees in January to present on key differences between these programs, using several member scenarios to illustrate how the member's experience would be different under each option, and answered questions from Subcommittee members, who were briefed on both options prior to this meeting
  - This briefing focused on information Highmark submitted in its response to the 2021 Medical RFP including descriptions of each program, fees, performance guarantees, outcomes achieved and case studies

- At the February Subcommittee meeting, follow-ups from Highmark's presentation were discussed; this included clarification of which functions of the Option 1 "Well360 Clarity" program would be managed by Highmark vs. its care management partner and further description of how both care management programs address components of the member experience such as members' social determinants of health, early identification of members with pre-diabetes, and care coordination with members' PCPs and other community providers

* WTW oversight consists of clinical audits, ongoing calls to discuss CCMU operations and review of outcomes reports and is provided by WTW's CCMU operations team, which includes WTW clinicians and is separate from the WTW team supporting the State of Delaware.

Outstanding decisions from the Medical RFP

Care management programs – Highmark (continued)

- Subcommittee members discussed key differences between each program's operations, mechanisms for engaging members and ability to influence members' site-of-care choices
- There was hesitation from Subcommittee members around adopting a program for which Highmark is using a new care management provider to deliver services to members
- Subcommittee members expressed concerns about an insufficient level of transparency into Highmark's broader relationship with its care management provider, despite multiple inquiries requesting further details
- There was deliberation about the fact that, in general, care management programs are not "locked in" throughout the life of a TPA contract and can be changed, unlike most core administrative components of the State's contracts with the TPAs
- Based on the above, Subcommittee members agreed that the **Highmark CCMU ("Option 2")** would be better suited to continue supporting plan participants for FY23. There was a willingness to consider reevaluating this decision throughout the subsequent years of the State's contract with Highmark

Outstanding decisions from the Medical RFP (continued)

Outstanding decision	Effective date of decision	Estimated FY23 Admin Cost / (Savings)
Aetna HMO plan: Maintain or waive current requirement for participants to select a primary care physician and obtain referrals	7/1/2022 (SEBC must vote by 2/28)	**$2.0M** if waived (though within margin of error of estimated discounts)

- Today, the State's HMO requires members to select a PCP upon enrollment and also requires referrals for members seeking specialty care
- Prompted by feedback from plan participants about the difficulty of finding a PCP or accessing primary care, the medical RFP included a request for alternative HMO designs that would remove this PCP selection/referral requirement
- The Subcommittees discussed the possible implications of removing this requirement on plan costs and on GHIP revenue through enrollment migration from the PPO to the HMO (i.e., lost contribution revenue for similar plan design, potential impact on Highmark performance guarantees and other elements of Highmark's financial proposal)
- Based on the above, Subcommittee members agreed that **maintaining the requirement for PCP selection and referrals** is preferable to waiting this requirement

Other FY23 opportunities for consideration

Recommended by Subcommittees for SEBC

- Combined Subcommittees revisited the FY23 opportunities that were previously recommended to the SEBC by Subcommittee members in December 2021, since no vote was taken at the 12/13 SEBC meeting
- There was a discussion several updates on these potential opportunities since December, with the exception of the CVS Drug Savings Review program, did not make them feasible for vote in February or March and in time to apply as savings against the FY23 deficit
  - There was agreement that telemedicine utilization would continue to be monitored with the feasibility of plan design changes reevaluated in the future
  - Further discussion of the CVS Transform Diabetes Care program will coincide with additional discussion of other condition-specific program opportunities available through the Medical RFP at the March Subcommittee meetings

FY23 Opportunity	Description	Est. # Members Impacted*	Est. FY23 Net Savings / Cost Avoided
Telemedicine copay changes	WTW modeled reinstatement of member cost sharing for telehealth visits with community providers	102,100 *(Commercial plans only)*	**$4.0M**, assuming future utilization mirrors pre-pandemic utilization
CVS Drug Savings Review	Program reviews Rx utilization to ensure that prescriptions follow evidence-based medical guidelines	102,100 *(Commercial plans only)*	**$1.0M** – **$2.8M,** assuming 7/1/22 effective date
CVS Transform Diabetes Care	Engages members with diabetes on actionable steps to address gaps in care, evaluate medical needs and facilitate overall wellness	Approximately 6,400 Commercial plan members who are currently participating in the Livongo diabetes management program	**$1.9M** *(impact on Medicfill plans addressed separately)*

*Based on enrollment as of August 2021.

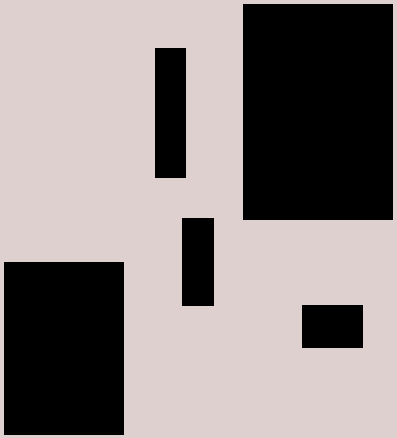
CVS Drug Savings Review

- There was discussion to gauge Subcommittee members' interest maintaining their earlier recommendation for the Drug Savings Review program to the SEBC
- Key elements of the program were discussed (see sidebar)
- Some Subcommittee members were concerned about whether this program was truly voluntary for providers and recalled requirements to change prescriptions with earlier PBM transition to CVS; clarification was provided about the differences between those situations and this program
- Discussed the State's ability to turn this program "On" / "Off" throughout the duration of the CVS contract
- Notwithstanding the above, the Subcommittees remain in support of the SEBC considering this program for FY23, but with continued monitoring of the member experience, physician engagement and program results throughout the first year of the program for reconsideration of continuing the program past FY23

CVS Drug Savings Review

- Identifies opportunities for improved prescribing and utilization based on evidence-based medical guidelines
- Program savings highly dependent on responsiveness and engagement of the medical provider community
  - CVS outreach to physicians with patient safety and savings opportunities; would request physician considers changing member's prescription therapy
  - Provider retains discretion over making any changes; if provider declines to change member's prescription, CVS will honor provider's clinical opinion
- Minimal impact to member outside of possible change in prescription(s)
- Program has a 3:1 minimum Return on Investment (ROI) guarantee
  - Monthly administrative fee applies
  - Est. annual net savings range (after member cost sharing): $1.0M – $2.8M

Updated long-term projections



GHIP long term health care cost projections (updated through Jan' 22)

Overview

- GHIP long-term projections have been updated to reflect all legislation signed into law and initiatives voted on by the SEBC as of February 24th, 2022 (see slide 21)
- Projections include assumed $24m in COVID-19 reimbursement funds based on COVID claims incurred in 2021; payment expected to be received during FY23
  - No additional COVID-19 funding relief reflected in projections as funding relief would offset COVID-19 related expenses
- EGWP revenue projections (direct subsidy, coverage gap discount payment and federal reinsurance) for CY23 based on estimates previously provided by ESI; CVS will provide revised projections by 2/25 and any material deviation from current projections will be updated for 2/28 SEBC meeting
- Rate action required to solve for FY23 deficit, and annual rate action in FY23, FY24 and FY25 required to target $0 deficit by end of FY25 are also provided
  - Member impact slides for various rate actions included beginning on slide 24
- On February 28th, 2022, the SEBC will vote on a Medicare plan option for 1/1/23
- On February 28th, 2022, the SEBC will also vote on a premium rate increase for FY23, based on a recommendation to be provided by the Financial Subcommittee

Financial Subcommittee recommendations to SEBC must consider:

- **Recommended Medicare plan option for 1/1/23**
- **Signed/pending legislation impacting future GHIP costs**
- **Impact of any proposed rate action on FY23 and beyond (i.e., one-time rate action for FY23, or target 3-year smoothed rate increase)**

GHIP long term health care cost projections (updated through Jan' 22)

FY23 legislation impacting the GHIP

- The following bills have either been signed or are anticipated to be signed with an effective date on or before the end of FY23; future cost estimates are not reflected in the updated long-term projections but are included below:

Bill	Effective Date	Description	Fiscal Year Cost (Savings)
Bills signed and/or enacted without signature from the Governor:			
SB 25	January 1, 2022	Chiropractor reimbursement not less than Medicare	**$0.5M-$1.0M***
SS 1 for SB 120	January 1, 2023; or as early as March/April 2022	Sustaining primary care through increased reimbursements	**$4.6M – $29.9M;** reflects cost estimate for Highmark population only
HB 219	Immediately	Provides enhanced oversight and transparency as it relates to PBMs	**$1.8M**
Bills anticipated to be passed during the 151st General Assembly:			
150th General Assembly HB 307	As early as January 1, 2023	Requires coverage of annual behavioral health well visits with a non-physician behavioral health provider	**$2.0M-$3.1M**
TBD	As early as January 1, 2023	Sponsored bill will require all insurers, including the GHIP, to provide supportive/maintenance chiropractic care	**>$1M**

- Potential FY23 Cost / (Savings): $9.9m - $36.8m

*Reflected in updated long-term projections due to 1/1/2022 effective date.

GHIP long term health care cost projections (updated through Jan' 22)

No premium increases FY22-FY26 (***move to Group MA, medical only, eff. 1/1/23***)

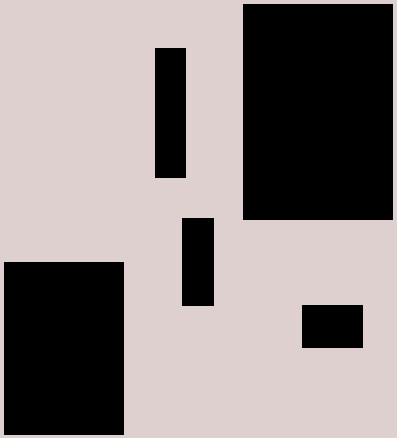
GHIP Costs ($ millions)	FY20 Actual	FY21 Actual	FY22 Projected[1]	FY23 Projected[1]	FY24 Projected[1]	FY25 Projected[1]	FY26 Projected[1]
Average Enrolled Members	128,531	129,768	130,158	131,460	132,775	134,103	135,444
GHIP Revenue							
Premium Contributions (Increasing with Enrollment)[2]	$830.8	$839.4	$839.4	$802.5	$764.8	$772.4	$781.1
Hold premium rates flat FY23 and beyond	-	-	$0.0	$0.0	$0.0	$0.0	$0.0
Other Revenues[3]	$122.8	$128.9	$188.3	$186.1	$219.7	$238.2	$258.2
Total Operating Revenues	**$953.7**	**$968.3**	**$1,027.7**	**$988.6**	**$984.5**	**$1,010.6**	**$1,039.3**
GHIP Expenses (Claims/Fees)							
Operating Expenses[4]	$927.7	$1,005.7	$1,064.6	$1,080.2	$1,136.7	$1,214.1	$1,299.1
% Change Per Member	*0.9%*	*7.4%*	*5.5%*	*0.5%*	*4.2%*	*5.8%*	*5.9%*
Adjusted Net Income (Revenue less Expense)	**$26.0**	**($37.4)**	**($36.9)**	**($91.6)**	**($152.2)**	**($203.5)**	**($259.8)**
Balance Forward	$163.8	$189.8	$152.3	$115.5	$23.9	($128.2)	($331.7)
Ending Balance	$189.8	$152.3	$115.5	$23.9	($128.2)	($331.7)	($591.5)
- Less Claims Liability[5]	*$57.5*	*$57.5*	*$61.0*	*$61.9*	*$65.1*	*$69.5*	*$74.4*
- Less Minimum Reserve[5]	*$24.3*	*$24.3*	*$24.3*	*$24.7*	*$26.0*	*$27.8*	*$29.7*
- Less COVID-19 Reserve[6]	-	-	-	-	-	-	-
GHIP Surplus (After Reserves/Deposits)	**$108.0**	**$70.5**	**$30.2**	**($62.7)**	**($219.3)**	**($429.0)**	**($695.6)**

- 8.67% rate increase needed to solve for FY23 deficit
- 8.98% annual increase in FY23, FY24, FY25 needed to target $0 deficit by end of FY25

It is evident that the COVID-19 pandemic will have an impact on health care costs. We have used available information and reasonable estimation techniques to develop health care cost estimates for the GHIP that reflect the impact of COVID-19. However due to the high degree of uncertainty associated with this pandemic, results may vary from the estimates provided.

Please refer to Appendix for FY17, FY18, and FY19 actual results (slide 30) and detailed projection footnotes (slide 31)

Member Impact Scenarios



FY23 monthly rates and employee/retiree contributions

Illustrative: 8.67% increase effective 7/1/2022

FY23 reflects employee contribution increases of $2.41 - $23.66 per employee per month ($28.92 - $283.92 per year) and State subsidy increases of $57.88 - $156.14 per employee per month ($694.56 - $1,873.68 per year) effective 7/1/2022

	Current Rates			FY 2023 with 8.67% Increase (effective 7/1/2022)			$ Change Employee/ Pensioner Contribution		$ Change State Subsidy	
	Rate	Employee Contribution	State Subsidy	Rate	Employee Contribution	State Subsidy	Monthly	Annual	Monthly	Annual
First State Basic										
Employee	$695.36	$27.84	$667.52	$755.65	$30.25	$725.40	$2.41	$28.92	$57.88	$694.56
Employee + Spouse	$1,438.68	$57.52	$1,381.16	$1,563.41	$62.51	$1,500.90	$4.99	$59.88	$119.74	$1,436.88
Employee + Child	$1,057.02	$42.26	$1,014.76	$1,148.66	$45.92	$1,102.74	$3.66	$43.92	$87.98	$1,055.76
Family	$1,798.42	$71.92	$1,726.50	$1,954.34	$78.16	$1,876.18	$6.24	$74.88	$149.68	$1,796.16
CDH Gold										
Employee	$719.68	$35.98	$683.70	$782.08	$39.10	$742.98	$3.12	$37.44	$59.28	$711.36
Employee + Spouse	$1,492.22	$74.58	$1,417.64	$1,621.60	$81.05	$1,540.55	$6.47	$77.64	$122.91	$1,474.92
Employee + Child	$1,099.56	$54.96	$1,044.60	$1,194.89	$59.73	$1,135.16	$4.77	$57.24	$90.56	$1,086.72
Family	$1,895.74	$94.78	$1,800.96	$2,060.10	$103.00	$1,957.10	$8.22	$98.64	$156.14	$1,873.68
Aetna HMO										
Employee	$725.94	$47.16	$678.78	$788.88	$51.25	$737.63	$4.09	$49.08	$58.85	$706.20
Employee + Spouse	$1,530.58	$99.50	$1,431.08	$1,663.28	$108.13	$1,555.15	$8.63	$103.56	$124.07	$1,488.84
Employee + Child	$1,110.52	$72.18	$1,038.34	$1,206.80	$78.44	$1,128.36	$6.26	$75.12	$90.02	$1,080.24
Family	$1,909.82	$124.12	$1,785.70	$2,075.40	$134.88	$1,940.52	$10.76	$129.12	$154.82	$1,857.84
Comprehensive PPO										
Employee	$793.86	$105.18	$688.68	$862.69	$114.30	$748.39	$9.12	$109.44	$59.71	$716.52
Employee + Spouse	$1,647.34	$218.26	$1,429.08	$1,790.16	$237.18	$1,552.98	$18.92	$227.04	$123.90	$1,486.80
Employee + Child	$1,223.46	$162.08	$1,061.38	$1,329.53	$176.13	$1,153.40	$14.05	$168.60	$92.02	$1,104.24
Family	$2,059.40	$272.86	$1,786.54	$2,237.95	$296.52	$1,941.43	$23.66	$283.92	$154.89	$1,858.68

Medicare Supplement – Special Medicfill

Rates effective January 1, 2022 – December 31, 2022

	Total Monthly Rate	State Share	Pensioner Pays
Highmark Delaware Medicare Supplement for Pensioners Retired On or Prior to July 1, 2012			
Special Medicfill with Prescription	$459.38	$459.38	$0.00
Special Medicfill without Prescription	$260.44	$260.44	$0.00
Highmark Delaware Medicare Supplement for Pensioners Retired After July 1, 2012			
Special Medicfill with Prescription	$459.38	$436.42	$22.96
Special Medicfill without Prescription	$260.44	$247.44	$13.00

- If you have less than 20 years of service and were first hired on or after July 1, 1991, the State does not pay the full state share but will pay a percentage of the state share of the cost of your coverage as explained in the charts below.

Eligible Pensioners Hired By The State On Or After July 1, 1991 Through December 31, 2006 *(The following portion of the State Share will be paid by the State)* **(Except those receiving a disability pension or receiving an LTD benefit)**		
Less than 10 years service	0%	state share paid by state
10 years - less than 15 years service	50%	state share paid by state
15 years - less than 20 years service	75%	state share paid by state
20 years or more service	100%	state share paid by state
Eligible Pensioners Hired By The State On Or After January 1, 2007 *(The following portion of the State Share will be paid by the State)* **(Except those receiving a disability pension or receiving an LTD benefit)**		
Less than 15 years service	0%	state share paid by state
15 years - less than 17.5 years service	50%	state share paid by state
17.5 years - less than 20 years service	75%	state share paid by state
20 years or more service	100%	state share paid by state

Medicare Advantage

Rates effective January 1, 2023 – December 31, 2023

	Total Monthly Rate	State Share	Pensioner Pays
Highmark Delaware Medicare Supplement for Pensioners Retired On or Prior to July 1, 2012			
Special Medicfill with Prescription*	$216.19	$216.19	$0.00
Special Medicfill without Prescription*	$0.00	$0.00	$0.00
Highmark Delaware Medicare Supplement for Pensioners Retired After July 1, 2012			
Special Medicfill with Prescription**	$216.19	$205.38	$10.81
Special Medicfill without Prescription	$0.00	$0.00	$0.00

*Rates reflect Medicare Advantage plan recommended by Combined Subcommittee on 2/24/2022, which are pending SEBC vote on 2/28/2022

- If you have less than 20 years of service and were first hired on or after July 1, 1991, the State does not pay the full state share but will pay a percentage of the state share of the cost of your coverage as explained in the charts below.

Eligible Pensioners Hired By The State On Or After July 1, 1991 Through December 31, 2006 *(The following portion of the State Share will be paid by the State)* **(Except those receiving a disability pension or receiving an LTD benefit)**		
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Eligible Pensioners Hired By The State On Or After January 1, 2007 *(The following portion of the State Share will be paid by the State)* **(Except those receiving a disability pension or receiving an LTD benefit)**		
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15 years - less than 17.5 years service	50%	state share paid by state
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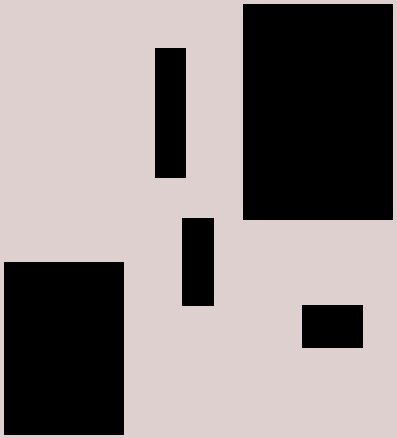
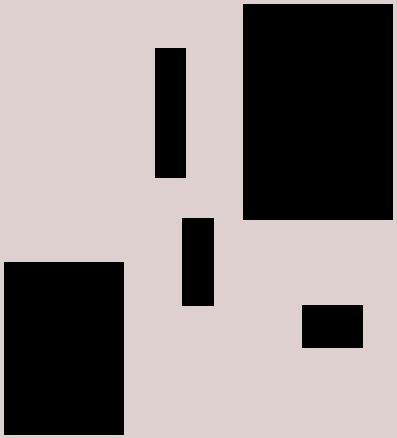
Next Steps



Outstanding decisions for 2/28 SEBC vote

- The SEBC must vote on the Subcommittee recommendations from the February 24th, 2022 Combined and Financial Subcommittee meetings; Subcommittee recommendations are summarized below:
  - Medicare plan option:
    - Subcommittees recommend moving to Group Medicare Advantage plan (medical only), effective 1/1/2023, administered by Highmark, and to continue offering drug coverage through CVS EGWP
  - Care Management program decisions:
    - HMO and CDH Gold plans: Subcommittees recommend Aetna One Advisor
    - PPO and First State Basic plans: Subcommittees recommend Highmark CCMU
  - Aetna HMO:
    - Subcommittees recommend retaining requirement for PCP selection and referrals
  - CVS Drug Savings Review Program:
    - Subcommittees remain in support of the SEBC considering this program for FY23, but with continued monitoring of the member experience, physician engagement and program results throughout the first year of the program for reconsideration of continuing the program past FY23
  - FY23 rate action:
    - Financial Subcommittee recommends an 8.67% rate increase effective 7/1/2022 to solve for the projected FY23 deficit of $62.7M

Appendix



GHIP historical health care fund information

FY17-FY19

GHIP Costs ($ millions)	FY17 Actual	FY18 Actual	FY19 Actual
Average Enrolled Members	123,132	125,488	126,360
GHIP Revenue			
Premium Contributions (Increasing with Enrollment)[2]	$799.0	$810.9	$817.4
Hold premium rates flat FY21+)	-	-	-
Other Revenues[3]	$81.6	$92.1	$98.5
Total Operating Revenues	**$880.6**	**$903.0**	**$915.9**
GHIP Expenses (Claims/Fees)			
Operating Expenses[4]	$816.8	$853.9	$904.0
% Change Per Member		*2.6%*	*5.1%*
Excise Tax Liability[5]			
Adjusted Net Income (Revenue less Expense)	**$63.8**	**$49.1**	**$11.9**
Balance Forward	$38.9	$102.7	$151.8
Ending Balance	$102.7	$151.8	$163.8
- Less Claims Liability[6]	*$54.0*	*$58.9*	*$58.8*
- Less Minimum Reserve[6]	*$24.0*	*$24.0*	*$24.3*
GHIP Surplus (After Reserves/Deposits)	**$24.7**	**$68.9**	**$80.7**

GHIP long term health care cost projection footnotes

Note: FY17-FY21 actuals based on final June Fund Equity reports for respective fiscal year; FY22+ projected operating expenses and enrollment based on experience through October 2021 with adjustments due to COVID-19 financial impact; assumed 1% annual enrollment growth; numbers in table may not add up due to rounding

1. Includes approved design changes effective 7/1/2019 including implementation of SurgeryPlus COE ($0.5m annual savings), site-of-care steerage ($6.9m), Highmark infusion therapy program ($2.0m) and implementation of Livongo ($0.7m); FY21 reflects implementation of Highmark radiation therapy authorization program ($633k annual savings per Highmark); FY22-FY26 projections based on 5% medical, 8% pharmacy baseline trend; assumes 1% annual growth in GHIP membership; FY22 projection reflects impact of COVID-19; assumes no other program changes in FY22 and beyond.
2. Includes State and employee/pensioner premium contributions; assumes 1% annual enrollment growth for FY22-FY26
3. Includes Rx rebates, EGWP payments, other revenues based on when revenues will be received; FY22 and beyond includes estimated improvements in Rx rebates based on result of PBM award to CVS Health; rebates assumed to be paid 60 days after the quarter adjudicated; includes fees for participating non-State groups (assumed to increase proportionally with membership and premium growth); FY22 includes projected $8.4m CY2020 CMS financial reconciliation payment to be received Jan. 2022.
4. FY22 and beyond includes estimated reduction in pharmacy claims as a result of PBM award to CVS Health
5. FY20 Minimum Reserve levels updated with data through June 2019; FY20 Claim Liability updated with lag factors as of Dec 2019 and claims data through December 2019; FY21 reserves assumed to remain at FY20 levels; FY22 claim liability and future years assumed to increase with overall GHIP claims growth; FY22 minimum reserve assumed to remain at FY21 level.
6. One-time COVID-19 reserve as approved by SEBC on July 27th, 2020; released at the end of FY21

It is evident that the COVID-19 pandemic will have an impact on health care costs. We have used available information and reasonable estimation techniques to develop health care cost estimates for the GHIP that reflect the impact of COVID-19. However due to the high degree of uncertainty associated with this pandemic, results may vary from the estimates provided.