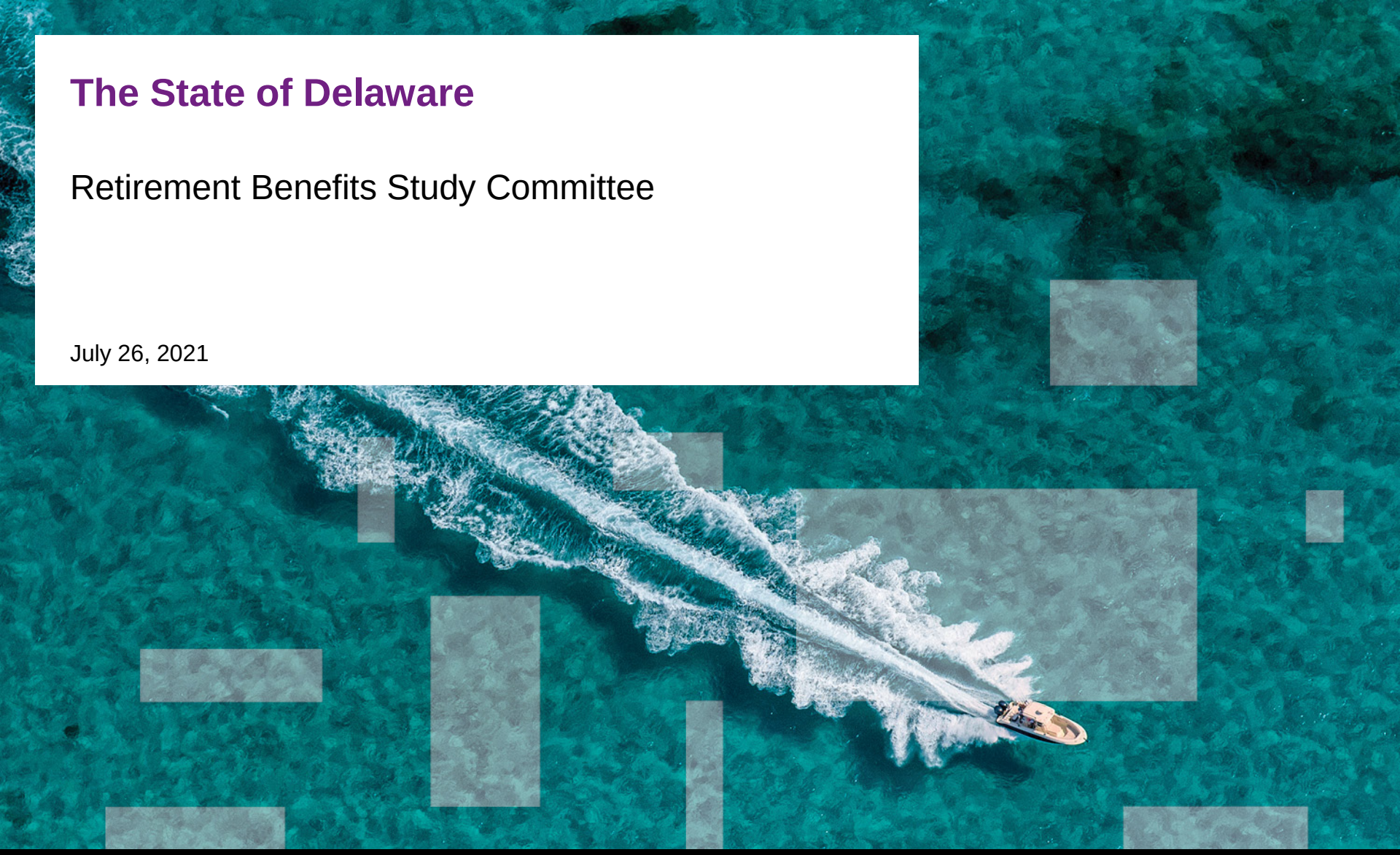
The State of Delaware

Retirement Benefits Study Committee

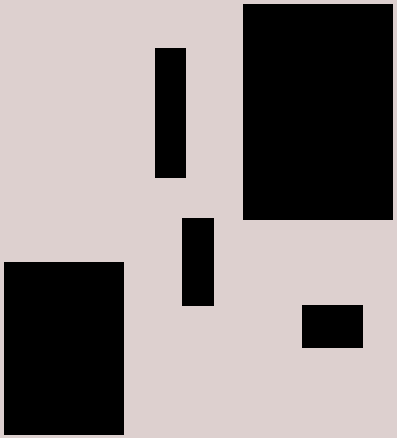
July 26, 2021



Today’s discussion

- Recap from prior meetings
- OPEB liability update
- OPEB reduction opportunities and considerations
- Survey findings from other states
- Additional modeling: retiree impact analysis
- Next steps

Recap



Recap of Work to Date

- **The Governor re-established the Retirement Benefit Study Committee (RBSC) by Executive Order on July 10, 2019**
- **The Committee met four times between September 2019 and March 2020**
  - Reviewed data on the size and relative magnitude of OPEB liabilities and projected costs
  - Reviewed current plan design
  - Discussed the Committee's goals for the State's OPEB benefit
  - Identified and reviewed options for reducing liability / controlling cost growth with benefits consultant and the plan actuary
  - Estimated potential impacts of OPEB liability reduction options, including annual pay-go costs, liability, and impact to individual plan members
- **Presented summary of findings to DEFAC on March 16, 2020**
- **Onset of Covid emergency prevented discussion of RBSC's work with 150th General Assembly. Staff work continued. RBSC meetings paused.**
- **Executive Order 51 replacing Executive Order 34**
  - Findings and Recommendations due to Governor, General Assembly & DEFAC on Nov 1, 2021
  - Updates due March 31, 2022 and March 31, 2023
  - RBSC dissolves April 2023 unless extended.

Recap of Work to Date

- **Additional work completed by staff and consultants since the March meeting**
  - Conducted detailed benchmarking of state OPEB benefits and plan redesign initiatives, to gain additional context related to the options reviewed by the Committee
  - Survey sent to 48 states with responses completed by 27
  - A Medicare Advantage plan option was reviewed as possible alternative to the options considered by the Committee
  - Cheiron, the Health Plan's actuary, provided the updated actuarial valuation as of July 1, 2020 to DPERS
  - Cheiron also applied the updated valuation data to update the estimated impacts of liability reduction options

Summary of Prior OPEB Presentations / Data

1) OPEB Liability is the Present Value of Future Retiree Healthcare Benefits

- Medicare – 18,361 plus 6,270 spouses
- Pre-Medicare – 4,502 plus 2,728 spouses
- Enrolled Actives – 30,913 plus 19,750 spouses and dependents
- Inflation Assumptions – Medical (4%-5.4%) Pharmacy (4%-6.85%)
- Discount Rate - Bond Buyer 20 Year Index - 3.5% and falling

2) Rating Agencies (esp. S&P) increasingly concerned about DE's unfunded OPEB

- Per capita - 26x higher than median AAA state
- % of Personal Income – 14x higher than median AAA state
- 8 of 14 AAA states have no retiree health care, none for new hires or charge 100% of the blended active premium

3) Current Fiscal Impacts

- Balance Sheet Liability - $8.7 billion
- No Employee Contributions toward liability
- OPEB Trust -- $0.4 billion (Underfunded through 0.36% of payroll)
- Pay-Go -- $196 million (9.33% of payroll) Annual Door Opener - $12-20 million

Recent Ratings Commentary

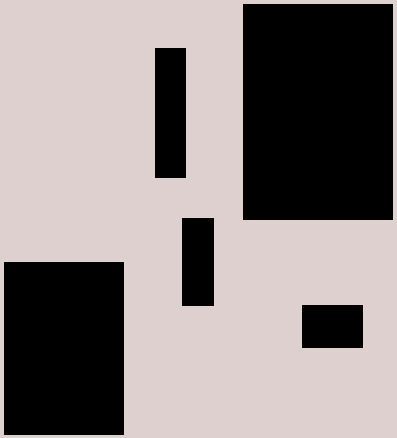
- **Ratings commentary for the State's 2021 bond issuance emphasized the expectation that OPEB liabilities would be addressed**

  - Standard & Poor's: *"We believe the state's history and ability to pass and implement retirement reforms positions Delaware well, compared with many other states without such flexibility…We expect the state's committee to study OPEB will lead to legislative changes to reduce this liability in 2021 and 2022."*

  - Fitch Ratings: *"An inability of the state to address its large unfunded OPEB liability could be considered an asymmetric risk that results in a lower long-term liability assessment… The governor has formed a commission to study OPEB and identify options to address related liabilities, with recommendations expected to be taken up by the Governor and General Assembly in 2021 and 2022."*

Source: Standard & Poor's RatingsDirect State of Delaware, April 5, 2021; Fitch Ratings State of Delaware April 6, 2021

OPEB Liability Update



OPEB Changes Since 2019 Valuation

- 2020 participant data
  - Active counts increased by 2.1%
  - Inactive counts increased by 1.5%

- 2020 claim curves

  Based on actual claims for months (April 2019 to March 2020), trended to 2020
  - Medical at 5.0%
  - Drug at 8.0%

- Claim curves lowered liability compared to the liability calculated under GASB 74/75
  - Mostly due to larger Pharmacy rebates and repeal of the ACA taxes

- Discount rate for determining actuarial liability
  - Down from 3.50% to 2.21%

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Key Results – State OPEB

Eligible Participants are those active employees or terminated vested in the State, Judges, or State Police Retirement Plans. Inactive participants are retirees, disableds, spouses, and surviving spouses with medical coverage.

	2019	2020 Total	2020 Pre-Medicare	2020 Medicare
Actives Actuarial Liability (AL)	$4,475	$ 5,179	$ 2,055	$3,124
Inactive AL	$4,255	$ 4,698	$931	$3,766
Total AL *(in millions)*	$8,730	$ 9,877	$ 2,987	$ 6,890
Market Value of Assets (MVA)	$410	$ 464		
UAL (Total AL – MVA) *(in millions)*	**$ 8,320**	**$ 9,413**		
MVA Funded Ratio (MVA/AL)	**4.7%**	**4.7%**		
Eligible Participant Counts*				
Active	38,497	39,308		
Terminated Vested	3,907	3,959		
Inactive	31,861	32,352		
Total	**74,265**	**75,619**		

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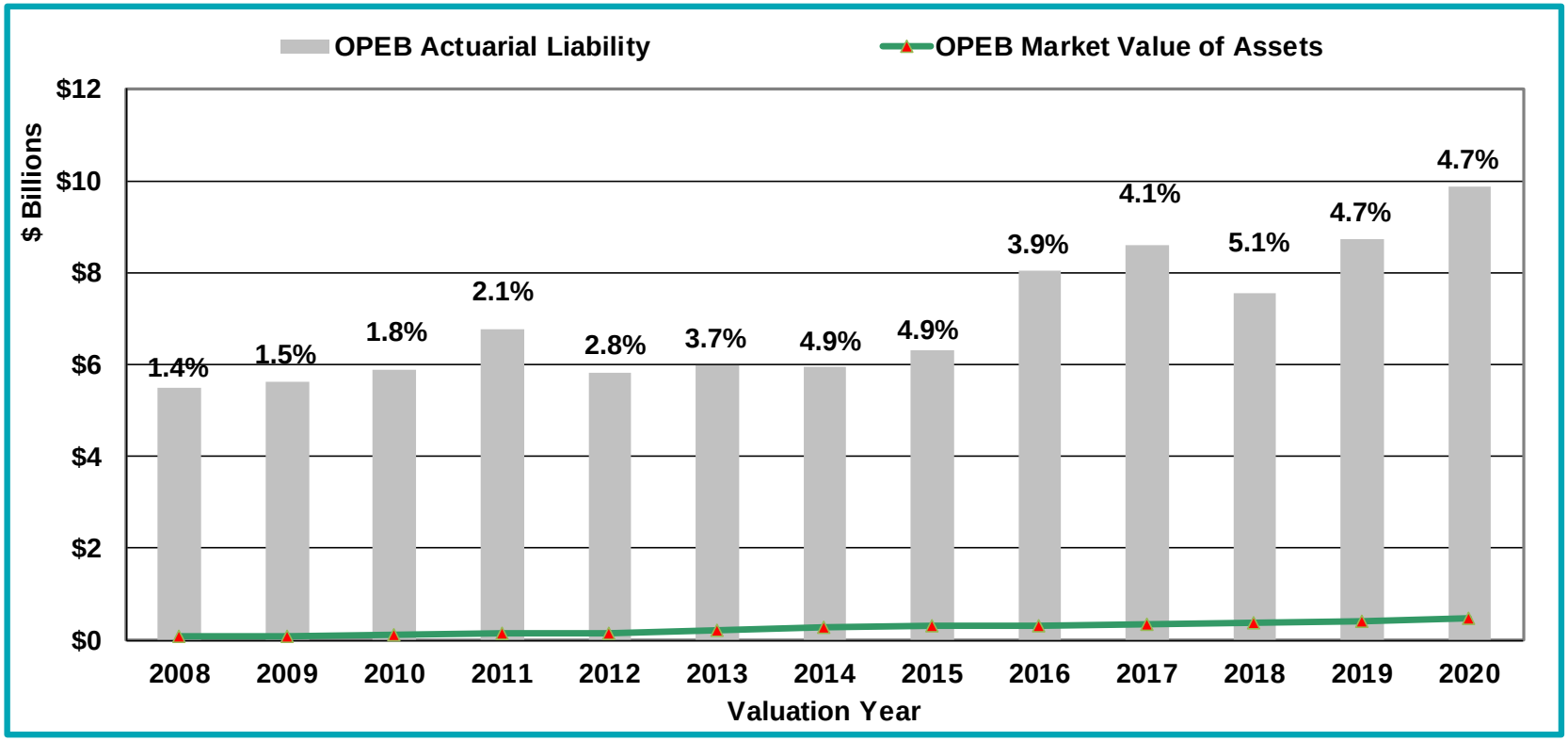
OPEB Historical Review – Liabilities, Assets & Funded Ratios



Discount Rate	5.00%	5.00%	5.00%	4.25%	4.25%	4.25%	4.25%	4.25%	3.75%	3.58%	3.87%	3.50%	2.21%

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OPEB Population Statistics as of July 1, 2020

- Retirees, Disableds and Beneficiaries with coverage
  - Pre-Medicare – 4,449 plus 3,694 spouses
  - Medicare – 18,762 plus 5,134 spouses

- Actives
  - Eligible 39,308
  - Enrolled 31,798 plus 20,140 spouses and dependents

- Inflation Assumptions
  - Pre-Medicare (5.3% trended down to 3.50% over 20 years)
  - Medicare (4.0% trended down to 3.50% over 20 years)
  - Pharmacy (6.70% trended down to 3.50% over 20 years)

- Discount Rate
  - Bond Buyer 20 Year Index – 2.21% and falling

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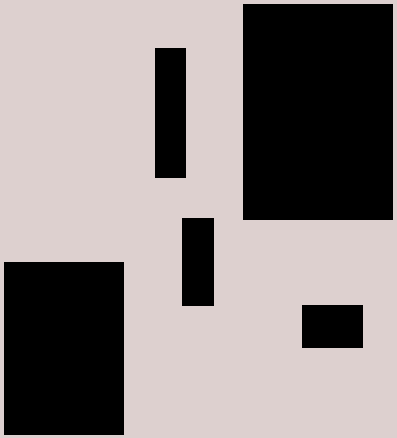
OPEB Reduction Opportunities



Options to Reduce OPEB Liability

Benefit Changes	Benefit Caps and Account-based Health	Marketplaces/ Exchanges	Funding Strategies	Full Exit
▪ Freeze plan to new hires ▪ Reduce benefits offered to retirees (increase deductibles/copays, etc.) ▪ Introduce alternative plan types (Group Medicare Advantage, etc.) ▪ Change retiree eligibility requirements ▪ Change spousal benefit eligibility	▪ Set defined dollar benefits (e.g., subsidy cap) ▪ Adopt account-based benefits (e.g., retiree HRAs)	▪ Eliminate group plans and facilitate access to Medicare marketplace ▪ Provide HRA subsidy	▪ Reduce liability through funding approach	▪ Eliminate benefits for all retirees

Actuarial Value of Options Previously Explored

Presented to RBSC on March 9, 2020

Scenario Label	Description	Immediate OPEB Liability Reduction	OPEB Liability Reduction Over 30 Years	Retiree/Member Impact
HRA (2% Increase)	Delaware eliminates Medicfill coverage and moves to individual marketplace structure – retirees receive annual HRA to purchase individual coverage comparable to the value of subsidy received by State of Delaware currently, *with 2% annual increase* to HRA amount provided in future years	**$2.4b**	**$22.0b**	🟢
Active Spouses	Delaware reduces spousal subsidy by 50% for future retirees; no impact to current spouses of retirees	**$0.9b**	**$5.9b**	🟡
Eligibility of State Share Schedule C	State Share eligibility schedule for those hired since 1/2007 to 20 years = 50%, 25 years = 75% and 30 years = 100%	**$0.5b**	**$9.6b**	🟡
Eliminate Term Deferred Vested Benefits B	Effective 7/1/2020 future terminated vested participants would not have access to any state health benefits, those that are already terminated could still come back and have access to healthcare	**$0.0b**	**$1.4b**	🟢
Set Minimum Age for healthcare	Minimum age to start healthcare would be age 60 for State Employees and Judges but Public Safety would be age 55	**$0.7b**	**$6.8b**	🟡
Combination starting 1/1/2021*	-$5,100 HRA for Medicare retirees with 2% inflation -Vesting schedule C -Future Retiree Spouses would receive 50% of benefit -Eliminate Term Vested Benefits B -Minimum age for healthcare (60 and 55 for public safety) *with 0.5% funding	**$3.75b**	**$28.4b**	🟡🟢

Note: Health Reimbursement Arrangement (HRA) is a tax-free account that can be used to pay premiums for Medicare Parts A, B and D, Medicare Advantage plan and/or supplemental plan, as well as qualified out-of-pocket expenses (deductibles, copays, etc.)

🟢 Minimal negative impact 🟡 Modest negative impact 🔴 Significant negative impact

Revisiting Options with Updated Benchmarking and Market Data

- Since the Retirement Benefits Study Committee last met, SBO conducted additional benchmarking to understand eligibility, coverage and benefit provisions, and subsidization of retiree health care benefits across other state plan sponsors (see separate report for key finding and full results)
- SBO also continues to monitor the retiree medical benefit landscape for solutions and options to address the objectives established by the Retirement Benefits Study Committee
- Options for ongoing discussion may include the following, which can be adopted individually or in combination
  - Changes to eligibility terms
    - Minimum age requirement and/or vesting schedule
    - Term deferred vested coverage
    - Dependent/spouse coverage
  - Changes to the benefits offered via alternative offerings
  - Changes to subsidy structure, e.g., defined dollar subsidy approach with Health Reimbursement Arrangement (HRA)

Revisiting Options with Updated Benchmarking and Market Data

	Prior and New Considerations	Benchmarking Results*	Requires legislative change?
Establish minimum age for eligibility	Previously evaluated (age 60 for State Employees and Judges but Public Safety would be age 55)	65% of states have a minimum age requirement (age 55 most common)	Y
State Share vesting schedule	Several options previously evaluated to increase years of service requirements for State Share schedule	74% of states have eligibility and/or subsidy provisions that vary by YOS, but provisions vary widely	Y
Reduce spouse subsidy by 50%	Previously evaluated for current and/or future retirees	Of those states that provide a subsidized benefit to retirees, half provide the same level of subsidy to retiree and spouses	Y
Eliminate Term Deferred Vested Benefits	Previously evaluated eliminating benefits for this group	50% of states allow deferred term-vesting, including most states surrounding Delaware	Y
Health Reimbursement Arrangement (HRA)	Previously evaluated with Individual Marketplace, with and without index; retirees can buy up/down for preferred coverage and accumulate savings for future years HRA could be offered with employer sponsored coverage – but given limited plan choice, administrative burden may outweigh benefits	4 states offer HRA with Individual Marketplace connector as only option, and 1 state offers as a choice No states offer retiree HRA with employer sponsored coverage	Y
Group Medicare Advantage (Group MA)	Last evaluated as part of 2016 Medical TPA RFP and did not yield material cost savings vs. current Medicfill. Since 2016, evolving MA market in Delaware may yield competitive carrier proposals for comparable level of medical coverage; Group MA proposals were solicited as part of 2021 Medical TPA RFP as a potential interim solution	24% of states offer Group MA options only, and 31% offer choice of Group MA and Medicare Supplement options	Y

★ New option for evaluation

* Based on 27 state respondents as of Sept 2020 (see full report for more details)

Revised Actuarial Value of Options

- The following scenarios have been updated based on actuarial valuation results as of November 2020:

Scenario Label	Description	Immediate OPEB Liability Reduction	Savings in Expected Benefits	Retiree/Member Impact
HRA (no index)	Delaware eliminates Medicfill coverage and moves to individual marketplace structure – retirees receive annual HRA to purchase individual coverage comparable to the value of subsidy received by State of Delaware currently, *with no increase* to HRA amount provided in future years	**$3.8b**	**$1.8m**	🟡🟢
HRA (2% Increase)	Delaware eliminates Medicfill coverage and moves to individual marketplace structure – retirees receive annual HRA to purchase individual coverage comparable to the value of subsidy received by State of Delaware currently, *with 2% annual increase* to HRA amount provided in future years	**$2.6b**	**$1.8m**	🟢
Group Medicare Advantage + EGWP	Delaware eliminates Medicfill medical coverage and implements an insured Group Medicare Advantage plan; no change to prescription drug coverage and no change to current subsidy structure ***New option (not previously presented)***	**$1.1b**	**$20.7m**	🟡🟢

- Group Medicare Advantage savings are based on unsolicited bid
  - Liability reduction is dependent upon future carrier procurement outcome; potential for additional liability reduction if the State is able to negotiate more favorable pricing terms including multi-year rate guarantee, etc.
  - The State can also evaluate whether to convert to a MAPD plan that include insured Part D prescription drug coverage

Note: Health Reimbursement Arrangement (HRA) is a tax-free account that can be used to pay premiums for Medicare Parts A, B and D, Medicare Advantage plan and/or supplemental plan, as well as qualified out-of-pocket expenses (deductibles, copays, etc.)

🟢 Minimal negative impact 🟡 Modest negative impact 🔴 Significant negative impact

Recent market dynamics affecting the GHIP

2016 Medical TPA RFP

	Post-2016 RFP
Industry drivers	▪ Consolidation in the health care market through TPA/PBM mergers (e.g., Aetna/CVS Health, Cigna/Express Scripts) ▪ Increasing emphasis on value-based provider contracting ▪ COVID-19 pandemic
Delaware state-level drivers	▪ Consolidation of Delaware providers with hospital systems buying up independent practices ▪ Establishment of Delaware Health Care Spending Benchmark ▪ Establishment of working groups/committees to address statewide health care considerations such as primary care, delivery system transformation, prescription drug purchasing and Delaware's liability for retiree medical expenditures (through OPEB study group)
Key changes to GHIP design and offerings	▪ Adoption of GHIP Strategic Framework (eff. Dec 2016; updated Feb 2020) ▪ Adoption of plan design differentials to encourage site of care steerage for select services (effective Jul 2016 and later) ▪ Addition of SurgeryPlus surgeons of excellence program (effective Jul 2019) ▪ PBM RFP (2020) led to change from Express Scripts to CVS Health

Outcomes of the 2016 Medical TPA RFP (effective July 1, 2017)

- GHIP administration remained with Highmark Delaware and Aetna
- Single administrator for each type of plan resulted in elimination of Highmark HMO and Highmark CDH Gold plans
- Adoption of financial risk-sharing (value-based) agreement with Aetna/Christiana Care for HMO plan
- Adoption of enhanced care management for Aetna HMO ("CareVio") and Highmark PPO and FSB plans ("CCMU")
- No changes to Highmark Special Medicfill Medicare supplement plan

Goals of the 2021 Medical TPA RFP

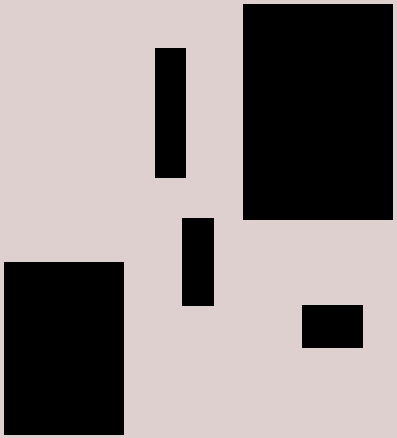
Identify Medical TPA(s) that can:

Support the goals of the GHIP Strategic Framework	Provide competitive financial terms	Support the GHIP's programs and plan offerings	Deliver on core functions of a medical TPA

▪ Increase proportion of spend through advanced alternative payment models
▪ Reduce per-member cost for diabetic members
▪ Limit total cost of care inflation
▪ Offer and increase engagement in decision support tools
	▪ Competitive provider reimbursement rates and administrative fees
	▪ Service level guarantees including accountability for supporting the GHIP Strategic Framework goals
	▪ Offer solutions that uphold and support:
	  ▪ Investments in primary care, and
	  ▪ Affordability Targets of the Delaware Department of Insurance's Office of Value Based Health Care Delivery
		▪ Administer current plans
		▪ Support plan provisions that optimize effectiveness of GHIP benefit offerings
		▪ Integrate with other programs and vendors supporting the GHIP
		▪ Maintain a provider network that meets current and future state goals of the GHIP
		▪ Provide supplemental coverage to Medicare-eligible retirees and their Medicare-eligible dependents
		▪ Support other state-level health care initiatives
			▪ Claims administration
			▪ Provider network
			▪ Care management
			▪ Member services
			▪ Care navigation support
			▪ Online tools/resources
			▪ Communications support
			▪ Account management
			▪ Reporting
			▪ Participation in the DHIN
			▪ Coordination with Delaware community health resources

Retiree Medical Benefits Survey

Survey Results



Executive summary

Key findings

Pre-65 retiree benefits

- All but 2 state offers coverage to pre-65 retirees, and nearly all provide the same plan options as active population
- 7 states offer coverage but do not subsidize, primarily in the Midwest region

Medicare retiree benefits

- All but 4 states provide a benefit to Medicare-eligible retirees
  - 4 states offer coverage through Medicare Marketplace with Health Reimbursement Account (3 of 4 responded to this survey)
  - Of the remaining, offerings are evenly distributed between Group Medicare Advantage, Medicare Supplement, or choice of both types
  - 1 state offers choice between state sponsored plans and Medicare Marketplace
- Subsidization varies significantly, with some states not providing any financial subsidy (primarily Midwest region), some states providing 100% subsidy, and a range in between

Executive summary

Key findings

Eligibility and vesting

- Majority of states have a minimum age and/or years of service component to be eligible
- For a small handful of states, retiree medical benefits are closed to new hires or offerings that vary for grandfathered groups; however, majority of states offer the same coverage to all current and future retirees, and to different employment groups
- 50% of states require individuals to be employed by state at the time of retirement to be eligible for the retiree medical benefit versus allowing term-vesting
  - Years of service required to be term-vested ranges 5-25 years
  - Most of the states surrounding Delaware (Northeast/Mid-Atlantic) do allow term-vested retirees to enroll in health benefits

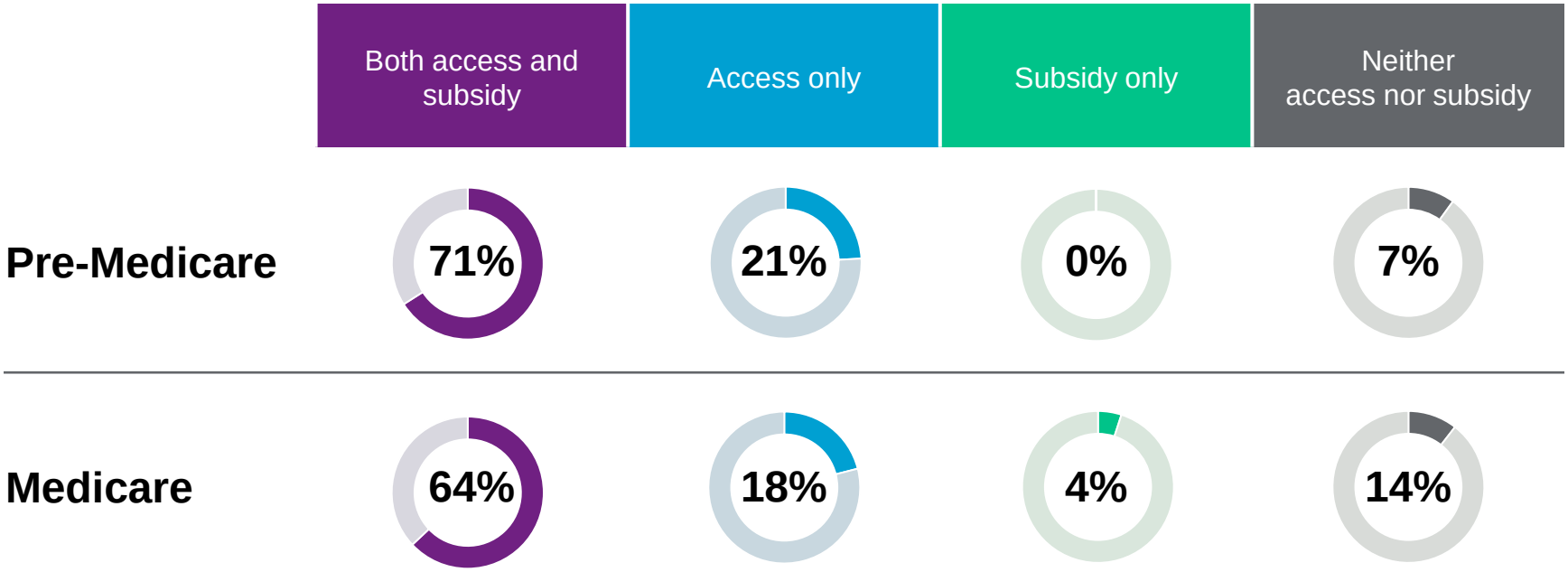
Dependent coverage

- Nearly all states that sponsor coverage for retirees also provide similar access for spouses and dependents, including new additions after retirement
- Of those states that provide a subsidized benefit to retirees, slightly more than half provide the same level of subsidy to both retiree and spouses

Access and/or subsidization of retiree medical programs

All States (including those not offering retiree medical)

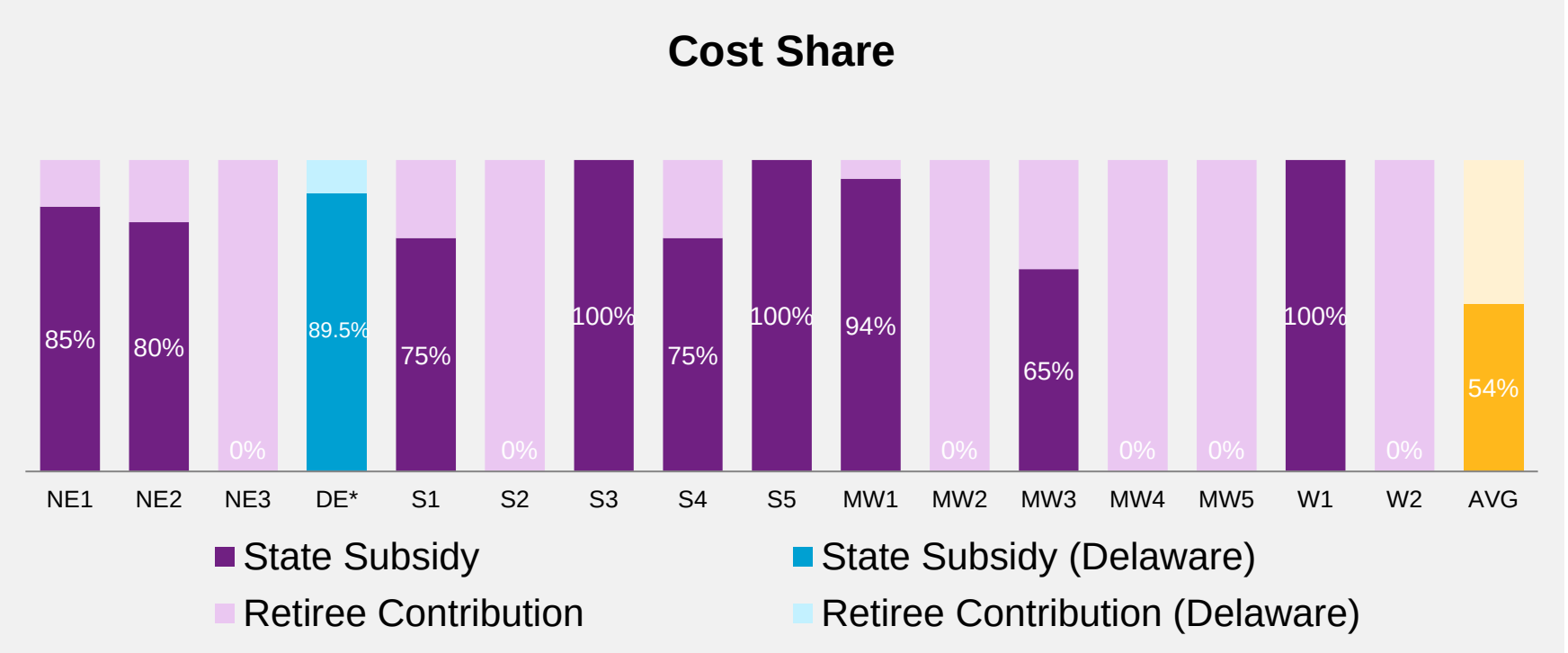
Does your State provide access to coverage and/or financial support through an employer-sponsored plan or an exchange to pre-Medicare and/or Medicare retirees?



Similar to the majority of state respondents, the State of Delaware offers access and subsidy to both Pre-Medicare and Medicare retirees.

Pre-Medicare retiree subsidy

Cost share (retiree only coverage, for fully-vested retirees)



**DE pre-Medicare retiree cost share based on actual plan elections in March 2021*

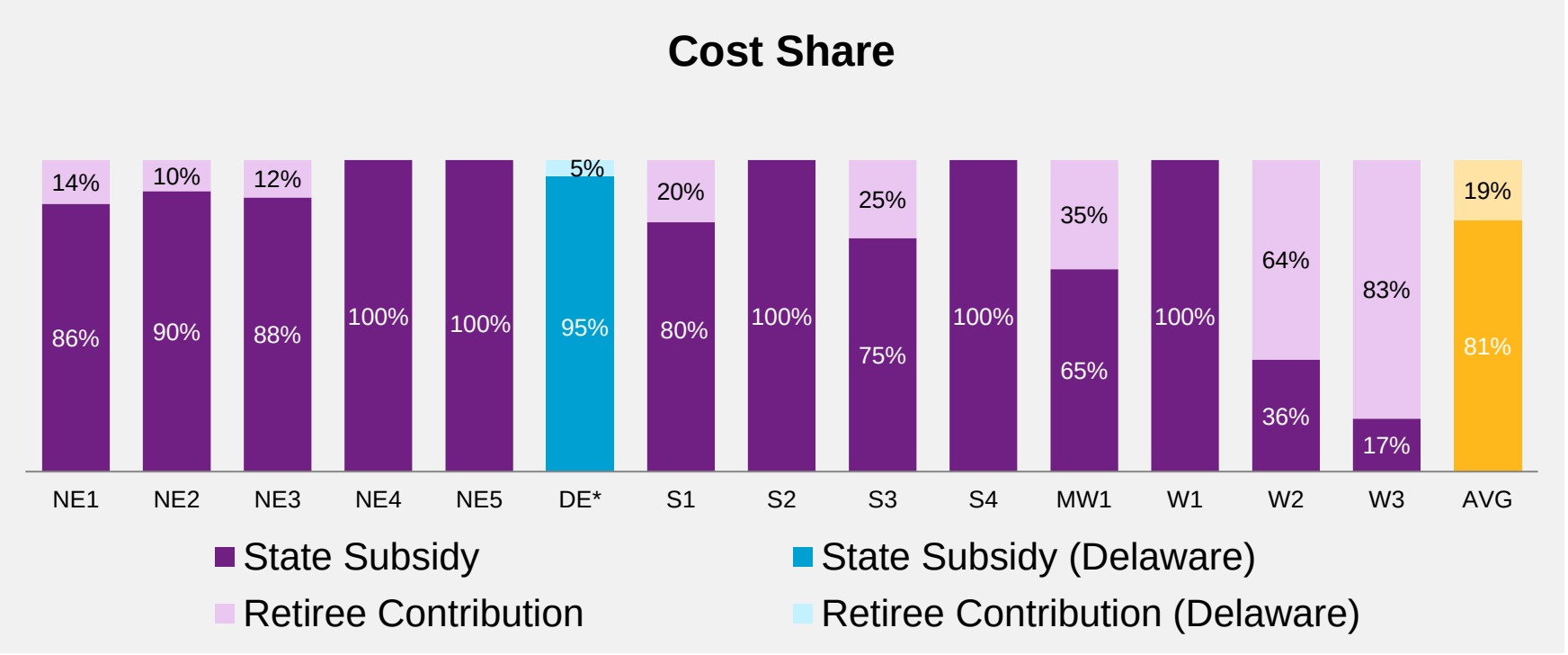
Notes:

- 4 states (NE2, S1, S4, W1) that provide a varying subsidy amount shared a sample amount for the purpose of the survey, based on the fully-vested benefit amount. *These are reflected in the above chart.*
- 5 additional states may provide some subsidy to pre-Medicare retirees, but vary this subsidy based on a variety of factors, including: years of service, cohort, age, etc. (3 from NE, 1 from S, 1 from W) *These states are not reflected in the above chart.*
- S2 provides access to coverage only; however, retirees are permitted to offset the premium by applying accrued leave toward the cost of coverage

State key
NE = Northeast
S = South
MW = Midwest
W = West

Medicare-eligible retiree subsidy

Cost share (retiree only coverage)

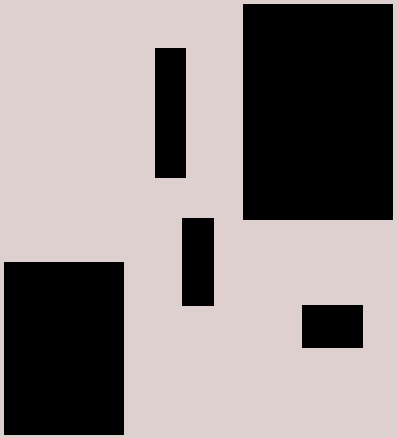


State key
NE = Northeast
S = South
MW = Midwest
W = West

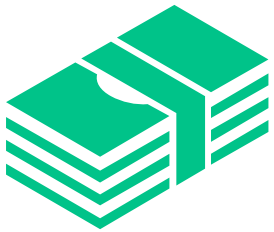
Notes:

- Excludes states that do not offer or do not subsidize retiree coverage, or provide funding through an HRA or other credit
- For states with age/service vesting provisions, rates shown reflect cost sharing for fully vested retiree (maximum subsidy)
- For NE2, subsidy formula is based on pension amount received; the premium cost sharing for a $30,000 pension is included above

Additional Modeling: Retiree Household Impact Analysis

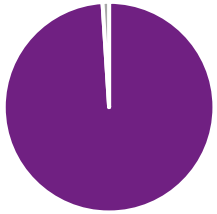


Individual Marketplace with HRA scenario – household impact



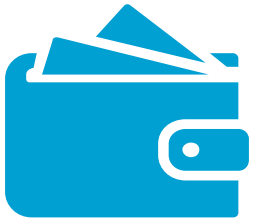
$5,100

is the HRA amount modeled per individual (pensioner or spouse)



>99%

of GHIP retirees would be better off financially in the individual marketplace (compared to current Medicfill plan)



$3,300

is the average annual savings per individual retiree

More choice

Meaningful variety of plan choices and carriers

95% **GHIP retirees would have access to a $0 premium MAPD plan**

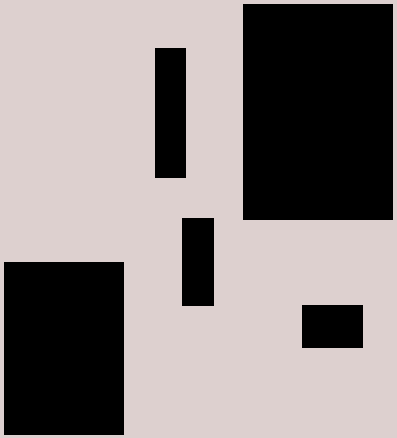
40 million retirees enrolled in individual Medicare supplement and Medicare Advantage plans nationally

* Source: Kaiser Family Foundation, 2018

Retiree household impact analysis

- HRA/Individual Marketplace option was updated to reflect the latest plan offerings and rates available for 2021
- Retiree impact analysis was also updated to include a preliminary estimate of GHIP-sponsored group Medicare Advantage option with current self-funded EGWP coverage
  - Group Medicare Advantage plan assumed to have similar medical plan design features as the current Medicfill plan
  - No change to current retiree premium cost share formula
- The State could offer defined dollar HRA with group Medicare Advantage or other state sponsored plans, but without increasing the choices available, the administrative burden may likely outweigh advantages of providing account
- An analysis of HRA / Individual Marketplace impact on members over time including medical trends is being completed
- This agenda item will be discussed more fully following review of the Medicare Advantage proposals and completion of the HRA / Individual Marketplace impact analysis

Next Steps



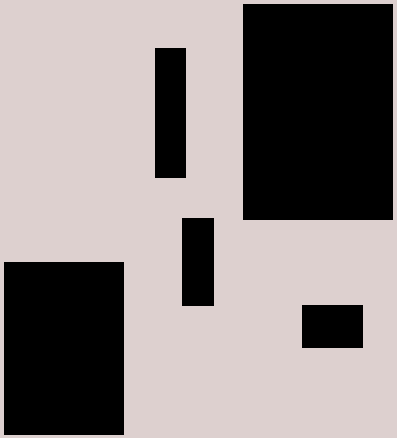
Next steps – Funding Enhancements

- Discuss Section 16 of Bond Bill
- Develop modeling scenarios tied to advisory Benchmark Index (Executive Order 21) and/or % of Payroll
- Review alternatives at upcoming meetings

Next steps – Benefit / Eligibility Revisions

- Review responses to 3rd Party Administrator (TPA) RFP
- Develop additional modeling and data in response to considerations and open questions
- Hold follow-up meeting in August/ September to review options in more detail and rank options

Appendix



Considerations and Open Questions

Scenario: Group Medicare Advantage with EGWP

	Coverage / Cost Impact	
Eliminate current Medicare supplement coverage (Medicfill) and replace with insured Group Medicare Advantage (MA) plan for medical coverage. No change to current EGWP prescription drug coverage. The State can evaluate insuring prescription drug coverage through a MAPD offering. No change to current retiree subsidy formula.	▪ Retiree Coverage / OOP Expenses	**One plan, one carrier**. Comparable coverage to current plan offering
	▪ Retiree Monthly Costs	Average monthly **premium cost of $308**[1]. Includes Group MA medical coverage and no change to current EGWP Rx coverage
	▪ Retiree other Monthly Costs	No change
	▪ Spouse Coverage / OOP Expenses	Same as retiree
	▪ Spouse Monthly Premium Cost	Same as retiree
	▪ Spouse Other Monthly Retiree Costs	No change

Monthly State Costs: Immediate cash reduction in State costs for all retirees and spouses.

1 Based on unsolicited quote for medical coverage under GMA and assumes no change to current EGWP prescription drug coverage.

2 Medicfill population is pooled with GHIP active/pre-65 retiree population for rating purposes – Medicfill projected expenses (claims, fees, rebates, etc.) projected to be $4,800 in calendar year 2020

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Considerations and Open Questions

Scenario: Health Reimbursement Arrangement (HRA)/Individual Marketplace

Eliminate enrollment in retiree coverage and give retirees and spouses an annual HRA of $5,100 (comparable to value of current "State Share" of $5,512[2]). HRA used to purchase health and Rx in individual marketplace. HRA is a tax-free arrangement that can be used to pay for premiums and/or supplemental plan as well as qualified OOP expenses, and can be rolled over each year.

Coverage / Cost Impact	
▪ Retiree Coverage / OOP Expenses	**Wide variety of plan choices**. Comparable plans available including plan option with $0 premium available to 95% of retirees (Medicare Advantage).
▪ Retiree Monthly Costs	Average monthly **premium cost of $225.25[1]**. Varies based on choice of plan monthly HRA amount funded by State
▪ Retiree other Monthly Costs	Potential to **eliminate Part B premium** depending on plan choice
▪ Spouse Coverage / OOP Expenses	Same as retiree
▪ Spouse Monthly Premium Cost	Same as retiree
▪ Spouse Other Monthly Retiree Costs	Same as current for retirees/spouses receiving 100% of state share

Monthly State Costs: Same as current for retirees and spouses receiving 100% of state share. State cost would be capped allowing for reductions in retiree healthcare obligation and liability.

1 Average premium for 75 year-old male choosing Medigap G/PDP Option

2 Medicfill population is pooled with GHIP active/pre-65 retiree population for rating purposes – Medicfill projected expenses (claims, fees, rebates, etc.) projected to be $4,800 in calendar year 2020

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Considerations and Open Questions

Scenario: HRA/Individual Marketplace (cont.)

Considerations, Challenges. Implementation Timeline

- Requires legislative change
- Can allow for increase in HRA funding based upon healthcare trend, pension cost of living increases or other benchmarks, e.g. 1%, 2%, etc.
- Requires an 18-24 months implementation runway – from announcement to effective date – allowing for extensive communications and outreach to existing retirees
- Gives the majority of existing retirees and spouses the ability to purchase coverage comparable to the current coverage with additional funds to invest in other coverage
- Shifts both risk and administration of Medicare retiree health coverage away from the State of Delaware (Office of Pensions and Statewide Benefits/DHR).

Questions and Outstanding Considerations

- How/will implementation of the HRA impact the State dental and vision benefits and premiums for these benefits if they can be purchased by Medicare retirees in the Marketplace?
- Should consideration be given to moving pre-Medicare retirees to the Marketplace and if so, what is the ideal timing transition for this population?
- How does a move the Marketplace impact non State of Delaware retirees and Long Term Disability participants receiving health care through the State Group Health Insurance Program?
- How does an HRA impact the eldest current retiree population? Is a safety net necessary? And, if so, how would it be structured?

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Considerations and Open Questions

Scenario: Group Medicare Advantage with EGWP (cont.)

Considerations, Challenges. Implementation Timeline

- Requires legislative change
- Competitive bidding can be included as part of Spring 2021 Medical TPA RFP
- Group Medicare Advantage can be implemented with our without insured Part D prescription drug benefit
- Communication and change management associated with changing carrier, network, level of managed care etc. (as needed)
- Requires a 12-month implementation runway – from announcement to effective date – with communications and outreach to existing retirees
- State maintains risk and administration of Medicare retiree health coverage

Questions and Outstanding Considerations

- Competitiveness of Medicare Advantage marketplace in Delaware – varies by region; some states have been able to negotiate multi-year rate guarantees
- Evaluate Medicare Advantage option with and without prescription drug coverage?
- Others?

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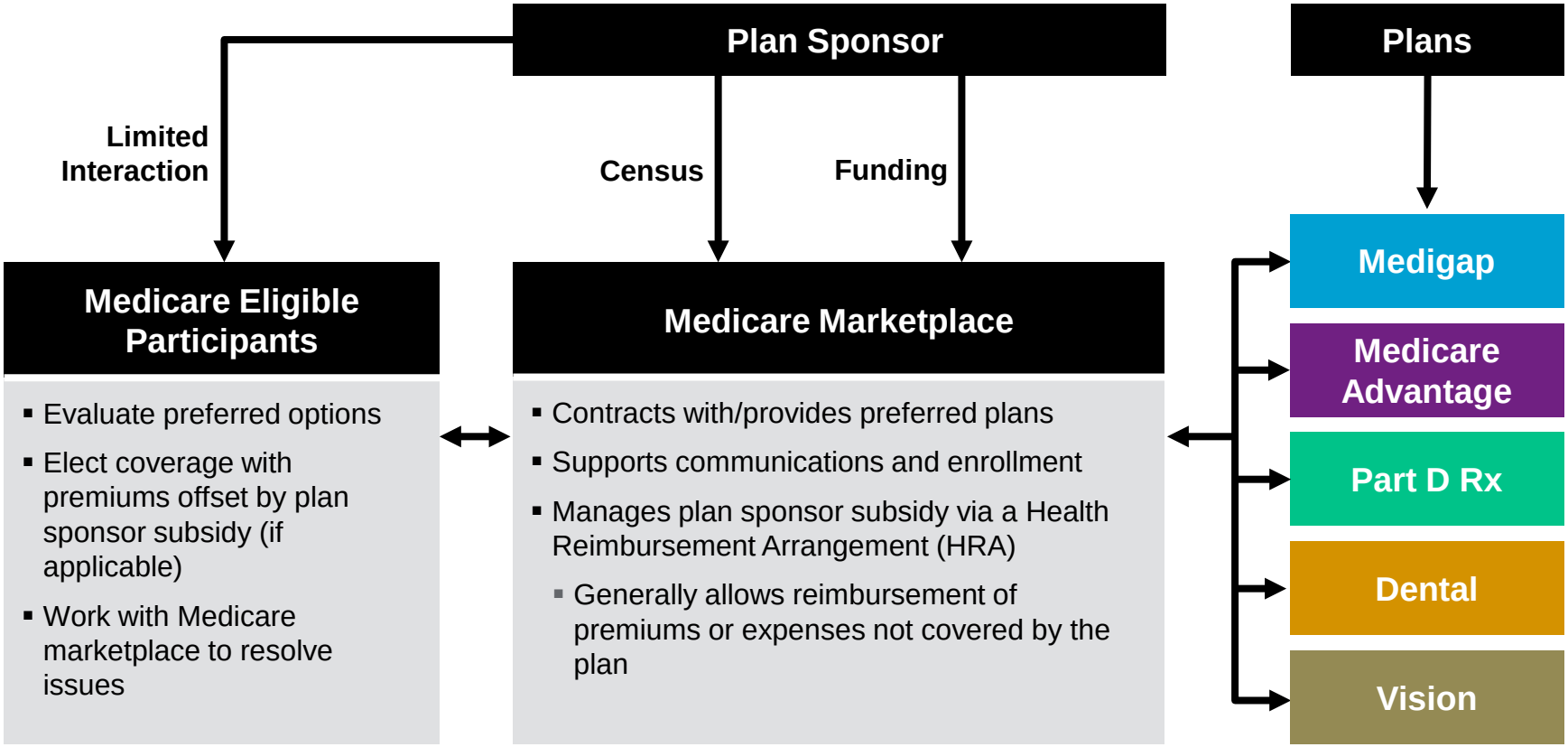
Medicare marketplace overview

Why Medicare is ideal for an individual marketplace

- **Very large risk pools, and growing**: 58 million retirees are enrolled in Medicare
- **Best-in-market plans with choice**: retiree picks the best performing plan from best performing carrier
- **Carriers compete on price**: rates filed every year and standardized plans
- **Guaranteed issue**: no adverse selection issue
  - Virtually everyone can join at 65: Healthy, episodic, chronic and catastrophic
- CMS subsidies for Medicare Advantage and Part D Rx plans

Delaware retirees: wide range of individual options available, and average Plan G + PDP premium is significantly less than Medicfill annual premium rate ($5,512)

Medicare marketplace: how it works



- HRA: "Health Reimbursement Arrangement" under which employer subsidy is provided on a tax free basis to reimburse retirees for premium and OOP expenses eligible under the plan
- Individual coverage purchased through the marketplace costs exactly the same as identical coverage purchased directly from the insurer
- Unlike a Flexible Spending Account, unused HRA amounts can be rolled over to use in a future year (no "use it or lose it" provision)
- Individual plan rates may vary by geography, age, gender and benefits

Retiree household impact analysis – Methodology

Individual Marketplace with HRA scenario

Analysis examined total retiree costs:

Total retiree costs = **Out-of-pocket costs**
- Deductibles
- Co-pays
- Coinsurance

\+ **Fixed premiums**
- Medicfill plan
- Medicare Part D
- Medigap/MAPD

Retiree costs reflect the following variables:

Utilization	Choice	Geography	Age
Amount of services a retiree uses	Costs will depend on level of benefit chosen by retiree	Individual insurance rates vary by location	Individual Medicare Supplement rates vary by age

Retiree household impact analysis – Methodology

Individual Marketplace with HRA scenario

- State of Delaware retirees have access to a meaningful variety of plan choices in the individual marketplace
- 95% of State of Delaware retirees have access to a $0 premium MAPD plan
- Average Medigap Plan G plus PDP premium is significantly less than Medicfill annual cost

MSA	Eligibles	# of plan options available			Maximum annual premium		
		MAPD	Medigap	PDP	Min MAPD	Medigap [1]	PDP [2]
DE New Castle	9,216	15	24	19	$0	$1,951	$338
DE Kent	5,339	13	24	19	$0	$1,951	$338
DE Sussex	3,965	13	24	19	$0	$1,951	$338
PA Chester	721	49	25	21	$0	$2,431	$395
MD Cecil	487	0	17	19	n/a	$2,526	$338
Rates for Average Retiree Modeling[3]	19,728				$0	$2,183	$350

1. Medigap premium(s) displayed show the maximum premium available to a 75-year old male for Plan G, or G equivalent. (richest Medigap plan)
2. Part D plan rates reflect the SilverScript Choice Plan PDP
3. Rates to be used in modeling that reflect actual age band distribution for top 5 areas (age 74 for supplement plans)

Retiree household impact analysis – Methodology

Individual Marketplace with HRA scenario

Medigap (Medicare Supplement) plans evaluated:

Rates modeled reflect the avg. of lowest rates available in the top retiree locations, weighted by age distribution of population.

High Deductible F (HiF)

(Low)

Provides 100% coverage but requires the participant to fulfill a $2,300 annual deductible first

Plan N

(Med)

Benefits include office visit copay of $20, ER copay of $50 and Part B deductible ($185 in 2019). All other Medicare covered services covered at 100%

Plan G

(High)

Benefits offer 100% coverage for all Medicare covered Services after the Part B deductible

Medicare Part D: PDP plan rates are based on the SilverScript Choice PDP plan and modeled benefits (for PDP and MAPD) are based on Standard Part D Parameters.

Medicare Advantage Prescription Drug Plan (MAPD) plans evaluated:

Philadelphia, PA-NJ-DE-MD MSA (High Area):

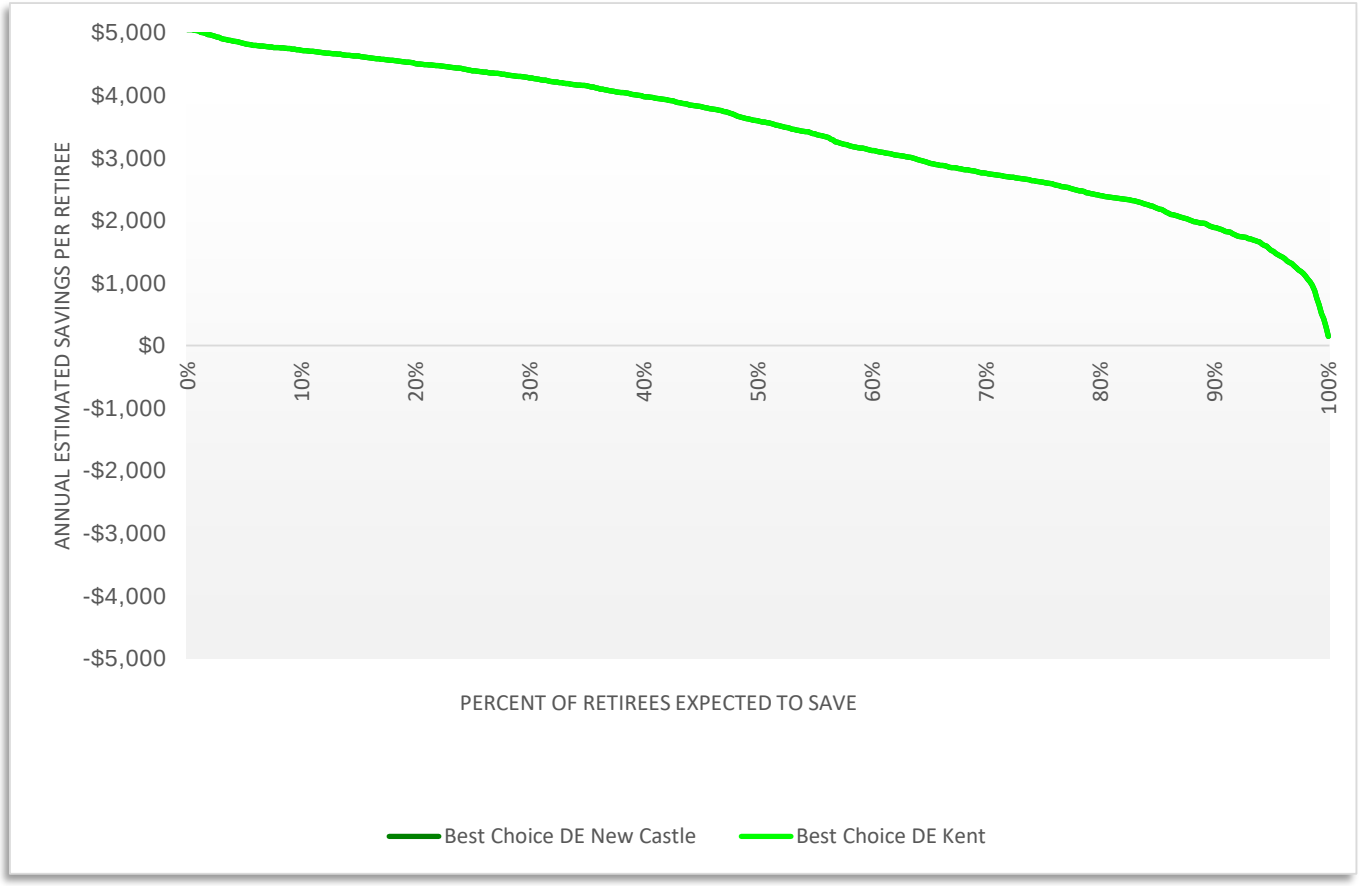
Aetna Medicare Value (PPO) H5521-262 4 1/2 Stars

Dover, DE MSA (Low Area):

Aetna Medicare Value (PPO) H5521-262 4 1/2 Stars

Retiree household impact analysis – Summary

100% State Share Group: Highmark/Express Scripts with $5,100 HRA



BEST CHOICE

Lowest Cost Plan of:

- MAPD
- Plan G + PDP
- Plan N + PDP
- Hi Plan F + PDP

High Area

DE New Castle

	Best
Avg. Loss	$0
Avg. Win	$3,427
% Loss	1%
% Win	**99%**

Low Area

DE Kent

	Best
Avg. Loss	$0
Avg. Win	$3,427
% Loss	1%
% Win	**99%**

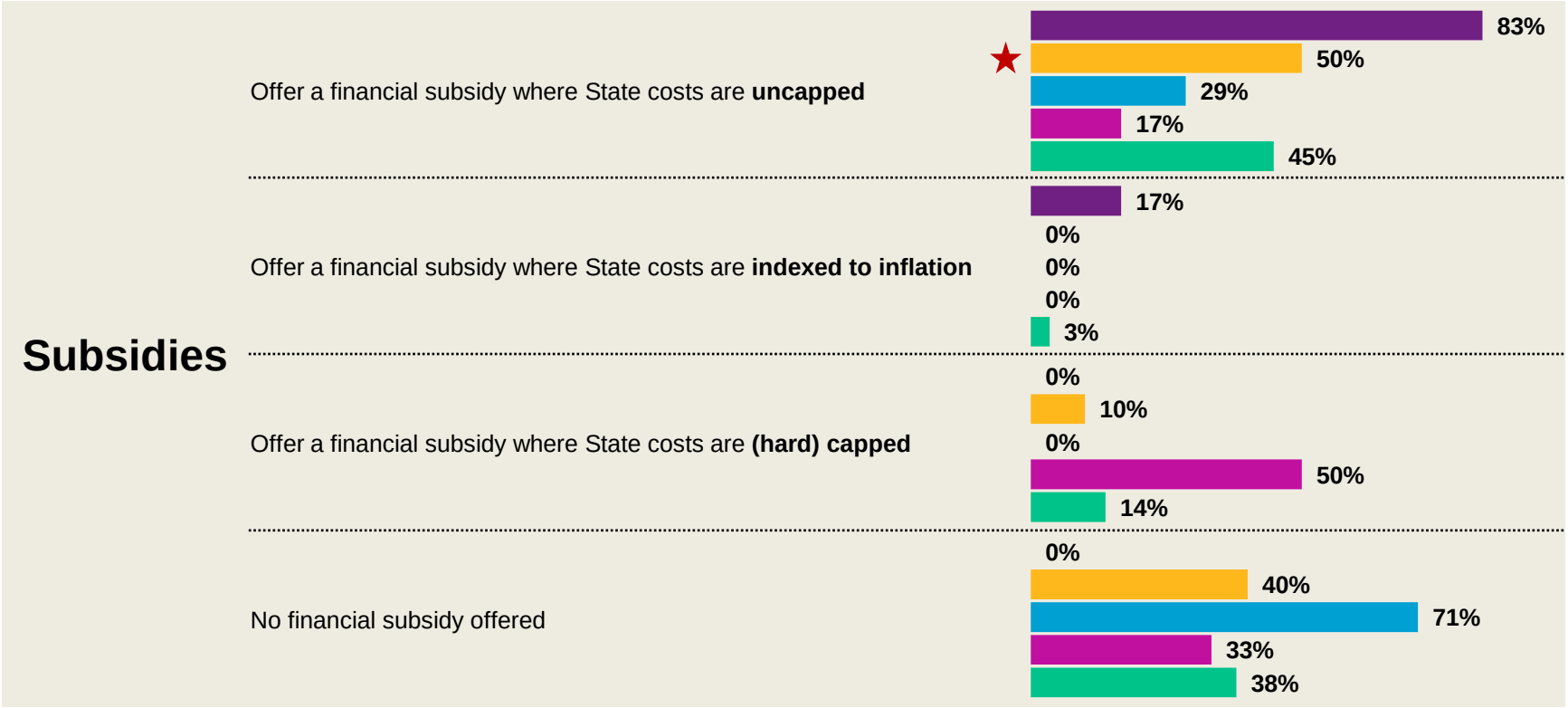
Over 99% of GHIP retirees and their spouses would be better off financially in the individual marketplace, with average first year savings to the retiree of $3,300 per individual

Note: $5,100 HRA assumes $5,050 HRA with $50 average reimbursement for drugs exceeding the true out-of-pocket maximum

Medicare-eligible retiree health benefits by region

All employers (including those not offering retiree medical)

Which of the following best describes the type of health coverage that you offer to **Medicare-eligible** retirees, and whether you provide a financial subsidy?

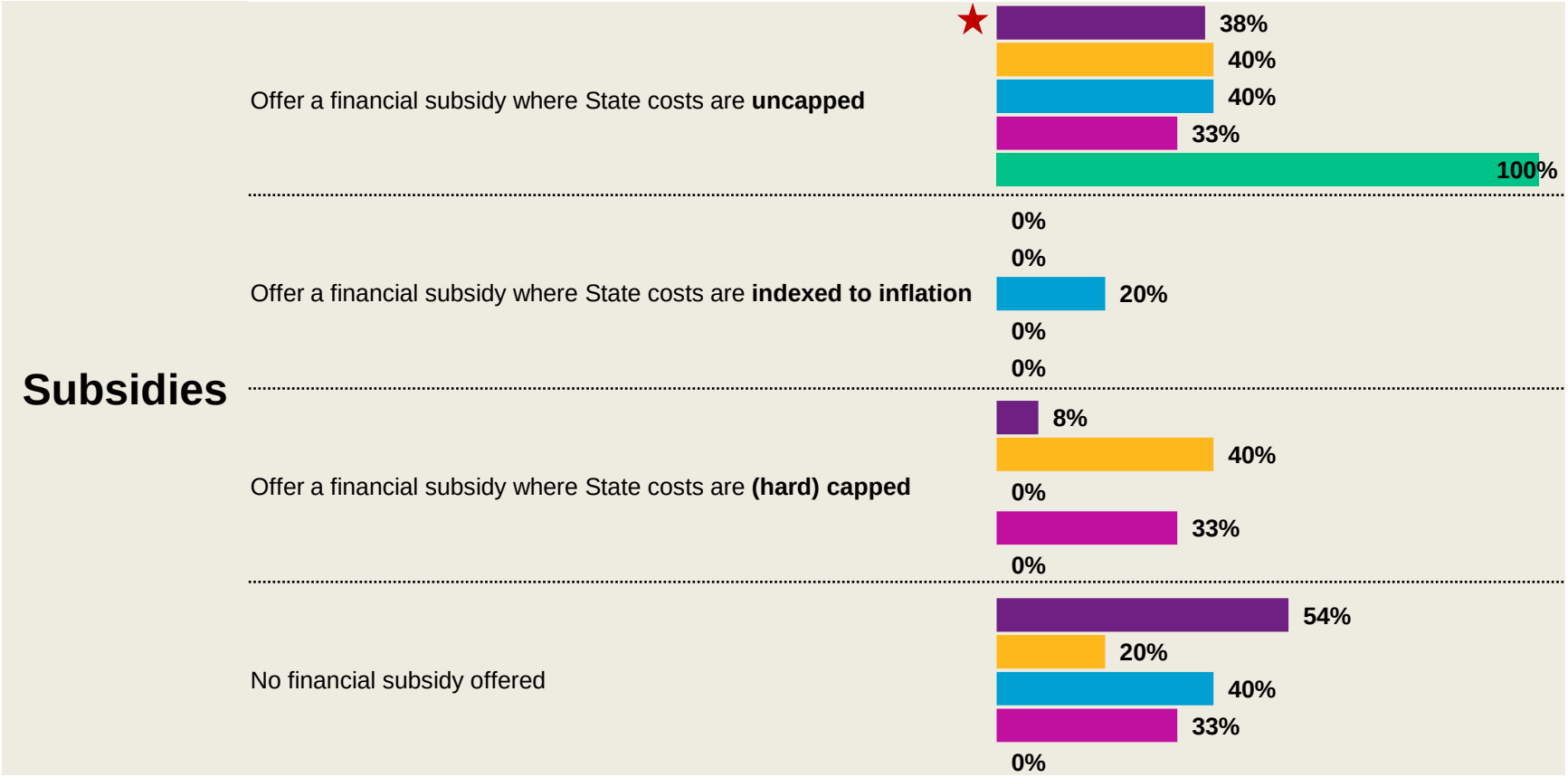


Regions based on United States Census Bureau

Medicare-eligible retiree medical benefits by credit rating

All employers (including those not offering retiree medical)

Which of the following best describes the type of health coverage that you offer to **Medicare-eligible** retirees, and whether you provide a financial subsidy?



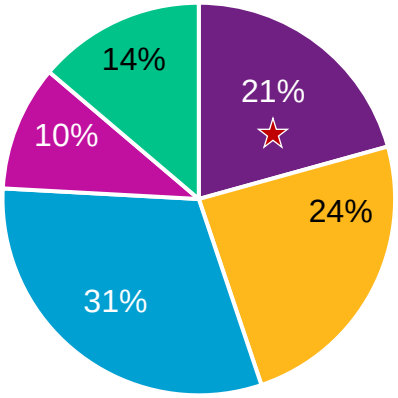
State credit ratings as of *U.S. State Rating and Outlooks, S&P Global,* 9/1/2020

Medicare-eligible retiree medical plan sponsorship

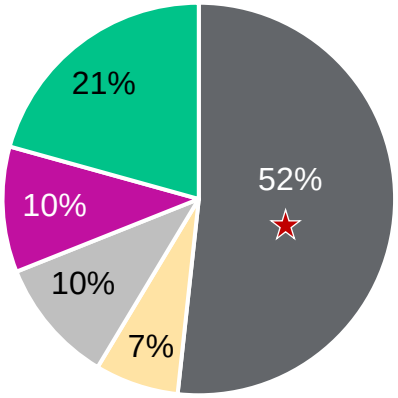
All States (including those not offering retiree medical)

Which of the following best describes the type of medical and prescription drug plans that you offer to **Medicare-eligible** retirees?

Medical Plan



Prescription Drug



★ Delaware GHIP

- Traditional Medicare Supplement (Med Supp)
- Group Medicare Advantage (GMA)
- Both Med Supp and GMA options
- No group coverage, but access to a Marketplace/Exchange
- Do not offer coverage

- EGWP
- Non EGWP
- Offer Rx coverage, did not specify EGWP
- No group coverage, but access to a Marketplace/Exchange
- Do not offer coverage

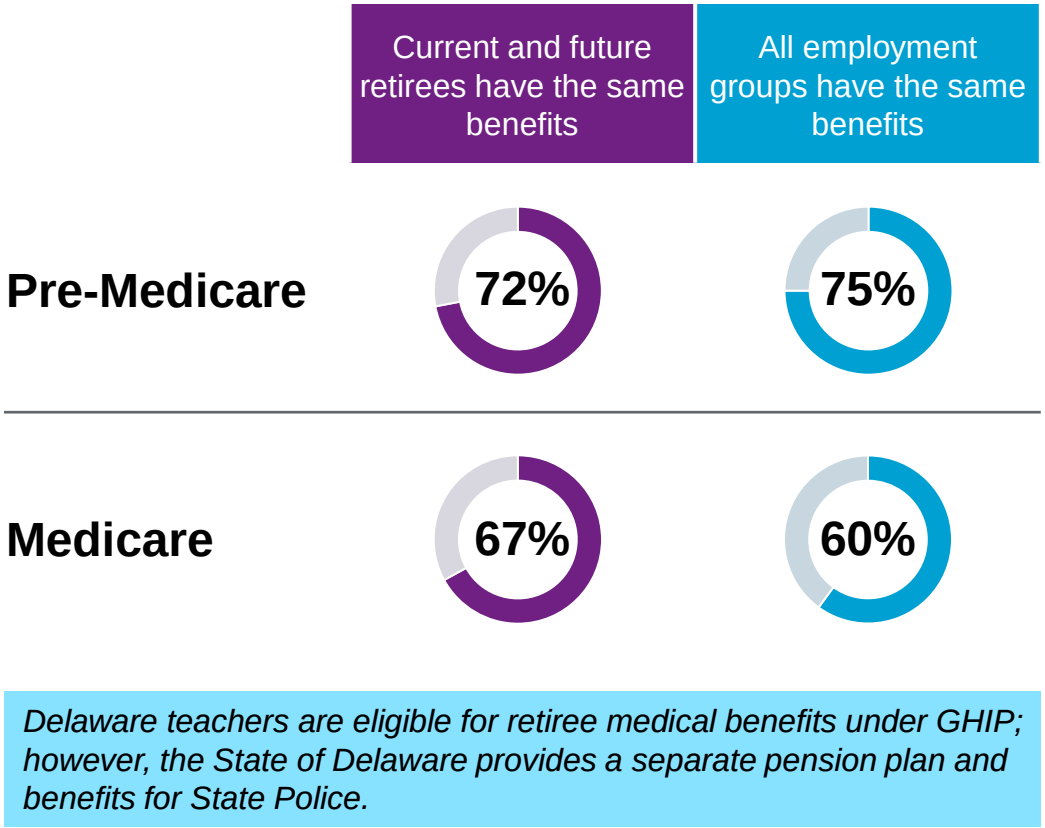
Group Medicare Advantage can be offered as medical-only coverage paired with EGWP prescription drug benefit, or combined medical and prescription drug coverage (MAPD plan).

Note: one state offers choice of employer-sponsored coverage and access to Medicare marketplace, and is captured in the “Both Med Supp and GMA options” category

Eligibility by cohort

States providing retiree medical benefits

Do you vary benefits for current vs. future retirees, or by employment cohorts (state employees, education, public safety)?



Delaware teachers are eligible for retiree medical benefits under GHIP; however, the State of Delaware provides a separate pension plan and benefits for State Police.

*15% of states have **reduced or eliminated benefits** for new hires (or will in near future)*

- 2 states closed all plans to new hires and 1 state closed select plans to new hires
- 1 state will be closing plan to those that have no service credit in 2021

***Teachers** and **law enforcement** are the most common cohorts receiving separate[1] benefits:*

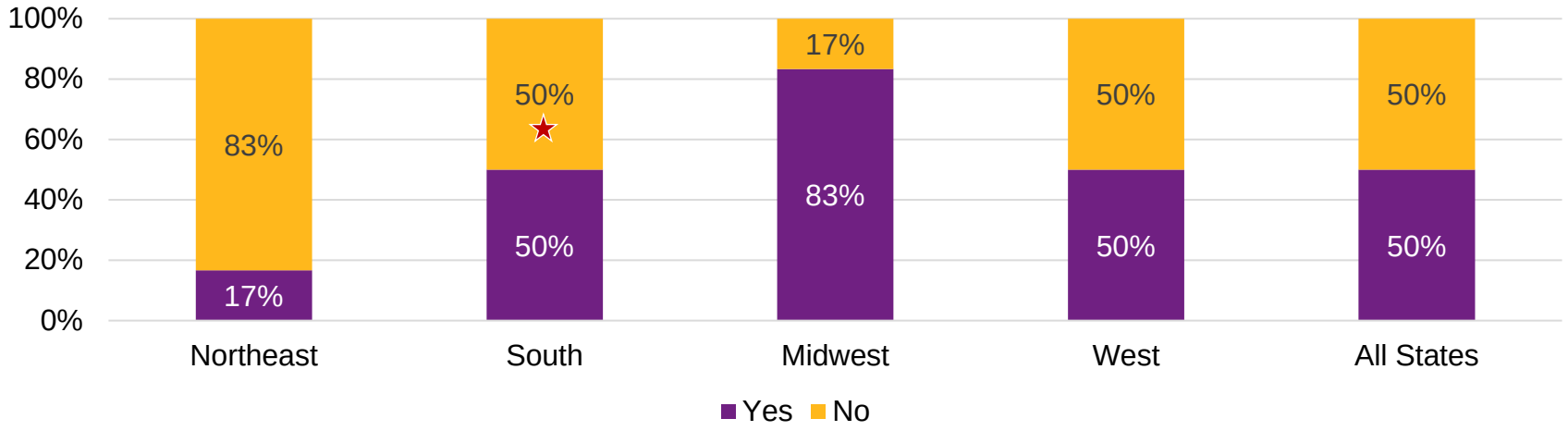
- **37%** of States have a separate program for teachers (higher ed only, public school only, or both)
- **22%** of States have a separate program for law enforcement

[1] Covered under a different program, trust, or other agency and therefore eligibility, coverage, and/or subsidy may vary from other state employees.

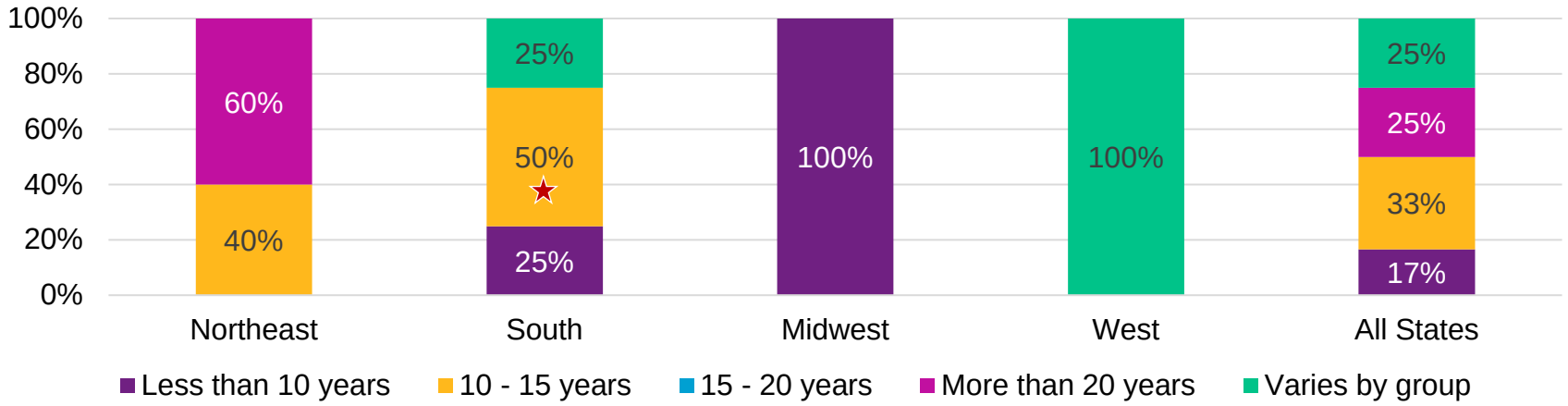
Term vested eligibility

States that offer retiree medical coverage

Are individuals required to be employed by the state at the time of retirement to be eligible for the medical benefit?



If not, how many of years of service are required until employees become term vested?



Note: Some states have differing eligibility rules if the retiree is directly transitioning to retirement versus retiring from another employer; minimum service requirement may be higher when retiring from other employers.

Regions based on United States Census Bureau

★ Delaware GHIP