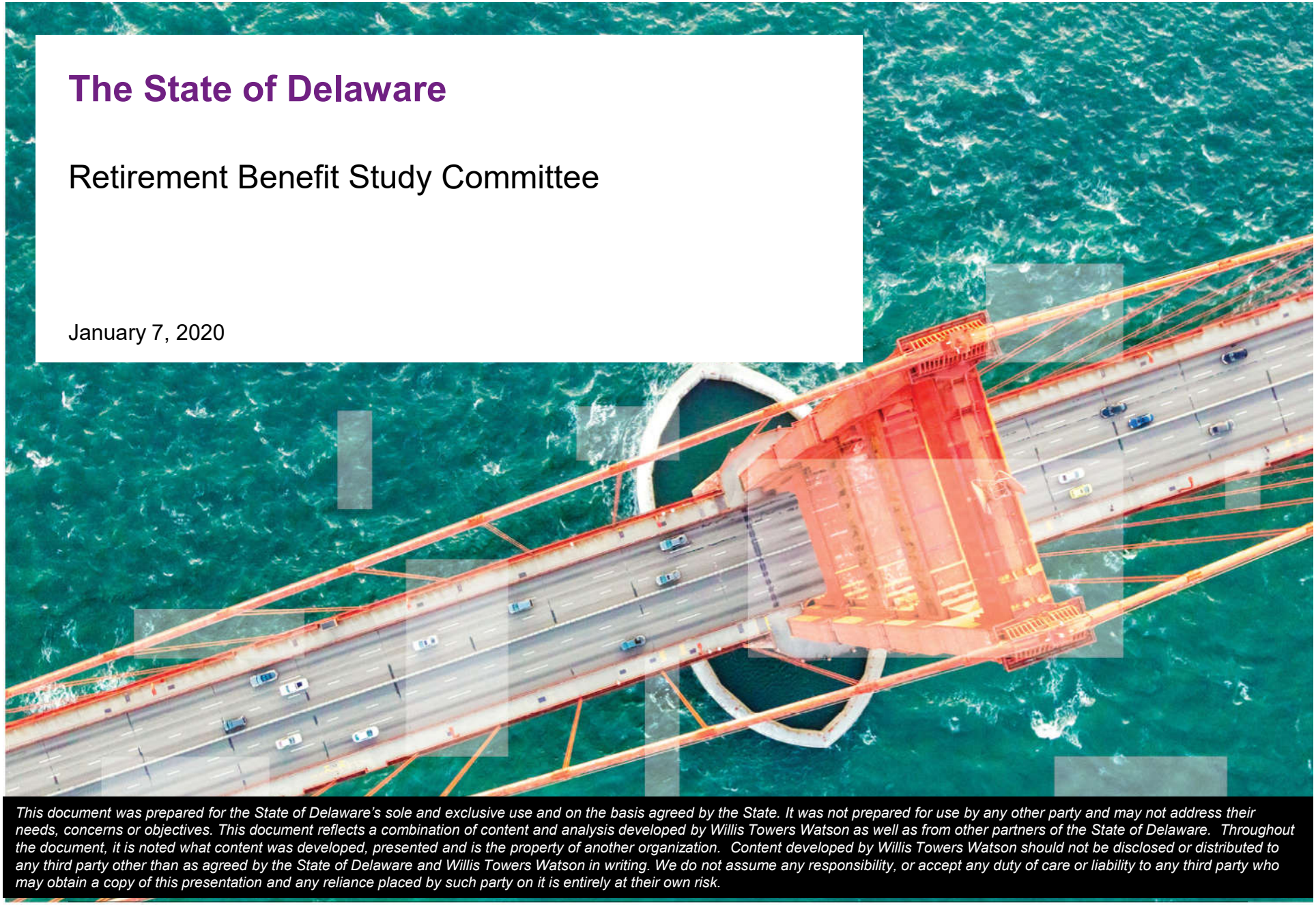
The State of Delaware

Retirement Benefit Study Committee

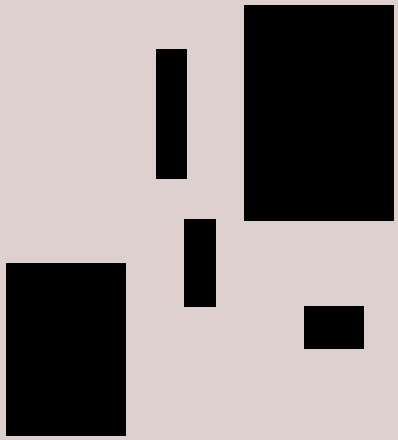
January 7, 2020



Today's discussion

- Review of the Magnitude of the OPEB Liability
- Consideration and Discussion of Goals
- Cost Management
- OPEB Reduction Opportunities
- Additional Modeling: Sample Actuarial Calculations and their Effect on the Liability
- Additional Modeling: Retiree Impact Analysis
- Next steps

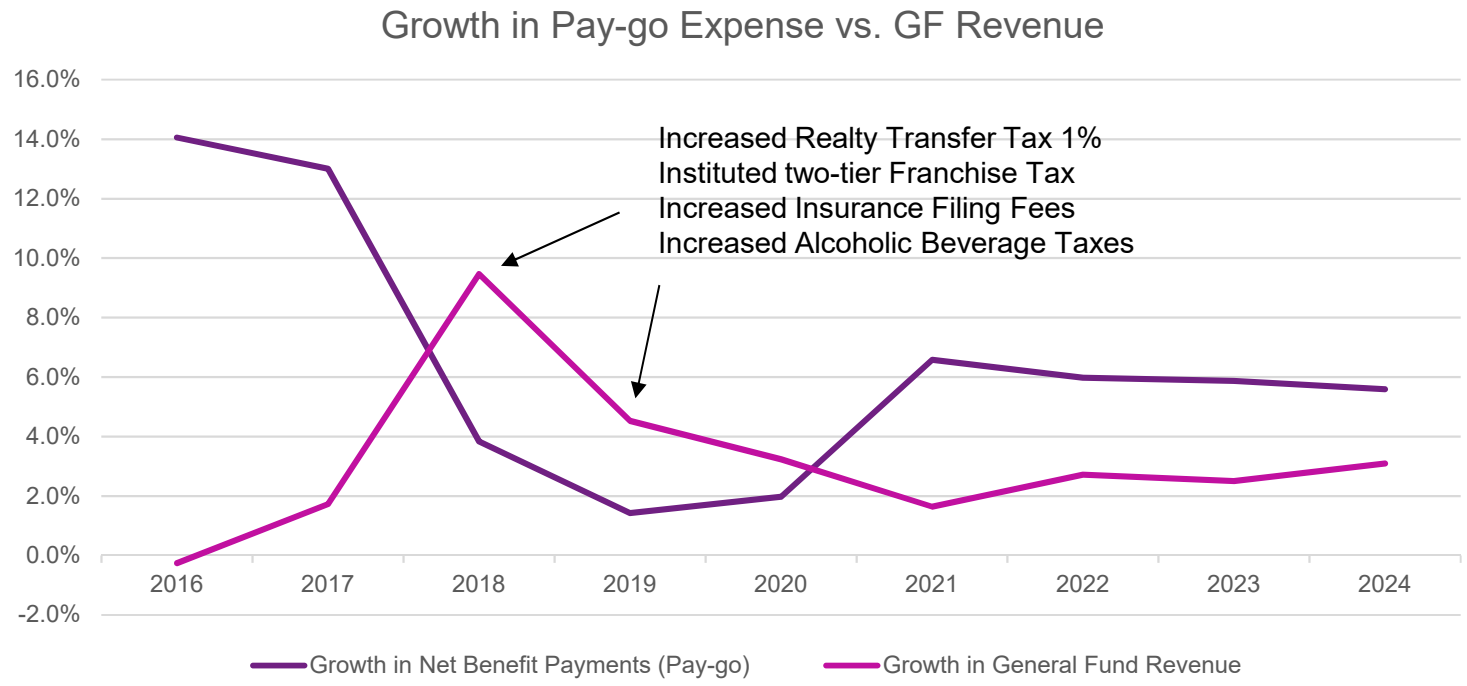
Retirement Benefit Study Committee Overview



Retirement Benefit Study Committee overview

Delaware's OPEB liability

- Pay-go expense growth significantly outpacing revenue growth



- Increasing costs of health care create budget pressure crowding out other services

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Retirement Benefit Study Committee overview

Delaware's OPEB liability

- Comparison of State Employee Pension Plan vs. OPEB as of June 30, 2019

	Pension	OPEB
Actuarial Liability	$10.7 billion	$8.7 billion
Unfunded Liability	$ 1.6 billion	$8.3 billion
Actuarial Funding Ratio	85.5%	4.7%
State % of Payroll Rate	13.06%	
Pay-go		9.33%
OPEB Trust		0.36%
Active Employee % Payroll Deduction*	3% - 5%	0%

*Corrections Officers contribute an additional 2% of earnings in excess of $6,000

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Retirement Benefit Study Committee overview

Delaware's OPEB liability

- One of the highest among regional states
- Highest among triple-A states
  - Recent rating agency feedback

Regional States: OPEB Funding Context

State	Moody's Adjusted Net OPEB Liability (ANOL) Per Capita FY2018	Moody's ANOL as a % of Personal Income FY2018	Moody's ANOL as a % of State GDP FY2018	OPEB Trust	Funded % FY2016	Assets (millions) FY2016	OPEB Actual Contribution (millions) FY2016	% ADC Contributed FY2016	Contribute > Pay-Go
NJ	$9,649	14.3%	13.8%	-	0.0%	$0	$2,274	27.9%	-
DE	$7,450	14.5%	9.6%	Y	4.2%	$310	$217	51.0%	Y
PA	$1,961	3.5%	3.2%	Y	2.2%	$526	$1,066	64.6%	Y
MD	$1,774	2.8%	2.6%	Y	2.3%	$291	$506	71.6%	-
WV	$1,743	4.3%	4.1%	Y	20.6%	$705	$187	65.7%	Y
NC	$580	1.3%	1.1%	Y	4.1%	$1,401	$943	36.6%	-
VA	$262	1.2%	1.0%	Y	25.4%	$1,845	$441	66.0%	Y
OH	$247	0.5%	0.4%	Y	60.7%	$15,464	$290	30.3%	-

Sources: The Pew Charitable Trusts' 50-State Survey of Retiree Health Care Liabilities – December 2018; CSLGE/NASRA OPEB Snapshot FY2017 - July 2019; Moody's Investors Service, "Medians – Adjusted net pension liabilities decline; OPEB liabilities vary widely," September 2019. Pay-Go analysis based on FY2017 CAFR review.

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AAA-Rated States: OPEB Funding Context

State	Moody's Adjusted Net OPEB Liability Per Capita FY2018	OPEB Trust	Funded % FY2016	Assets (millions) FY2016	OPEB Actual Contribution (millions) FY2016	% ADC Contributed FY2016	Contribute > Pay-Go
DE	$7,450	Y	4.2%	$310	$217	51.0%	Y
TX	$2,515	Y	0.7%	$641	$1,630	22.8%	
GA	$747	Y	9.1%	$1,643	$1,118	78.3%	Y
MO	$634	Y	4.8%	$154	$122	58.0%	
SC	$529	Y	9.2%	$1,063	$465	60.9%	Y
FL	$352	-	0.0%	$0	$148	20.6%	
TN	$225	Y	0.0%	$0	$74	56.6%	
MN	$109	-	0.0%	$0	$54	44.0%	
IN	$70	Y	28.8%	$137	$42	115.8%	Y
IA	$58	-	0.0%	$0	$25	36.2%	
UT	$31	Y	54.4%	$220	$37	122.2%	Y
SD	$0 (no employer funded OPEB)	N/A	N/A	N/A	N/A	N/A	N/A

Sources: The Pew Charitable Trusts' 50-State Survey of Retiree Health Care Liabilities – December 2018; CSLGE/NASRA OPEB Snapshot FY2017 - July 2019; Moody's Investors Service, "Medians – Adjusted net pension liabilities decline; OPEB liabilities vary widely," September 2019. Pay-Go analysis based on FY2017 CAFR review.

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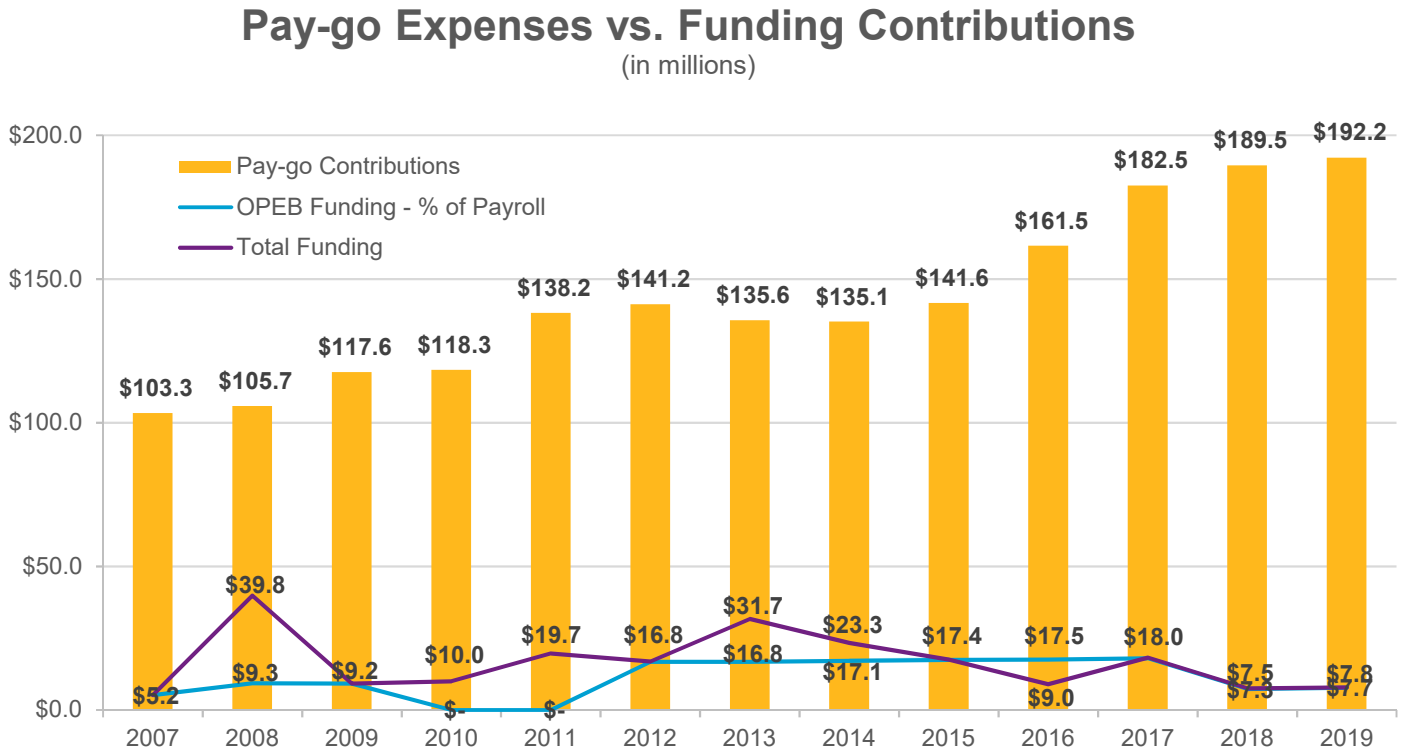
A History of OPEB Funding

Fiscal 2020 Operating Budget:

Trust Contribution 0.36% of Payroll:	+/- $ 8.0 million
Pay-go (Benefit) Contribution 9.33% of Payroll:	+/- $196.1 million
Covered Payroll from all sources GF, ASF, Federal:	$2.2 billion



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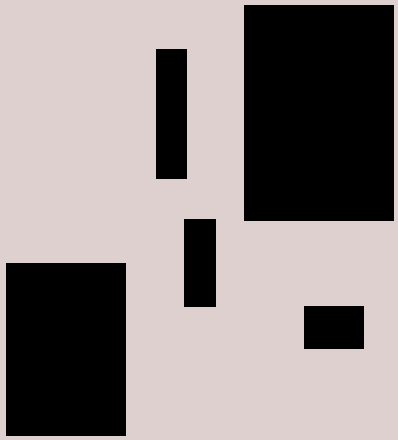
Goal Setting



Goal setting

SMART Goals… Specific, Measurable, Achievable, Relevant, and Time-based

Objective:

Provide an affordable, sustainable, and competitive level of retiree healthcare benefits for career employees that secures retiree health care while balancing state funding priorities.

Examples from the City of Oakland

- Maintain a ratio of trust assets to accrued liabilities, with the goal of reaching a 100% funded ratio over a 30 year period. For this purpose, the funded ratio is defined as the actuarial value of trust assets divided by the trust's actuarial accrued liability for explicit subsidy benefits.

- Develop a pattern of stable and regular contribution rates when expressed as a percentage of payroll as measured by valuations prepared in accordance with the generally recognized and accepted actuarial principles and practices which are consistent with the Code of Professional Conduct and applicable Actuarial Standards of Practice set out by the Actuarial Standards Board, ultimately reaching a minimum employer contribution level at least equal to the Actuarially Determined Contribution (ADC) associated with explicit subsidy benefits.

- Manage the cost of benefits to reach and maintain an affordable and sustainable level of coverage.

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Goal setting – Strawman (For discussion purposes only)

Sample Funding Goals:

1. Increase Funded Ratio to 100% over 30 years or Increase Funded Ratio commensurate with the funded ratio of the pension plan over 30 years.
2. Reduce Unfunded Liability per capita to the average of Triple-A states (excl. districts)
3. Have employer funded contributions reach 100% of Actuarial Determined Contribution within 5 Years.
4. Reduce unfunded liability in half over 10 years.

Sample Benefit Goals:

Develop proposed retiree health care benefit solutions that:

1. Are affordable, competitive and portable commensurate with age, years of service, and current retirement status.
2. Include options for Health Reimbursement Arrangements that facilitate easy access to comparable benefits through Marketplace coverages.
3. Eliminate state healthcare plans as the preferred provider of retiree health benefits for non-career employees.

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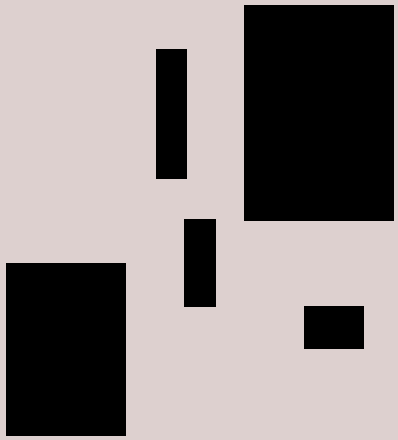
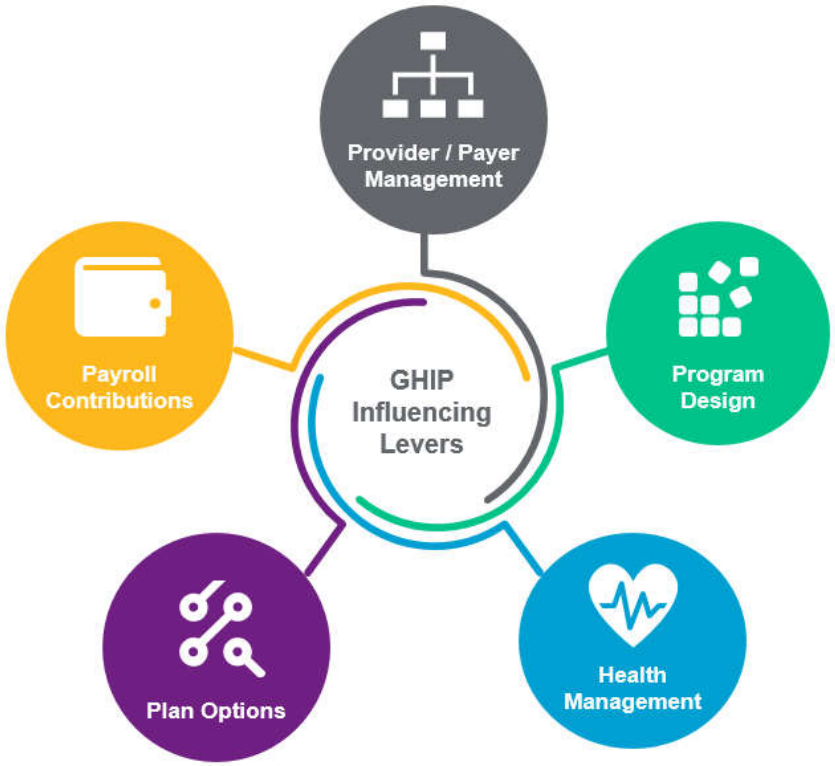
Cost Management



State Employee Benefits Committee

Overview of approach to reviewing health care benefits

Overarching focus on "shrinking the pie" of health care costs



Provider / Payer Management

- Administrative efficiency, value-based contracting and access to providers are all components

Program design

- Includes plan designs that encourage utilization of most appropriate and/or lowest cost site of care
- Must be done thoughtfully to achieve lower total cost of care

Health Management

- Engagement and member education are key components that drive success

Plan Options

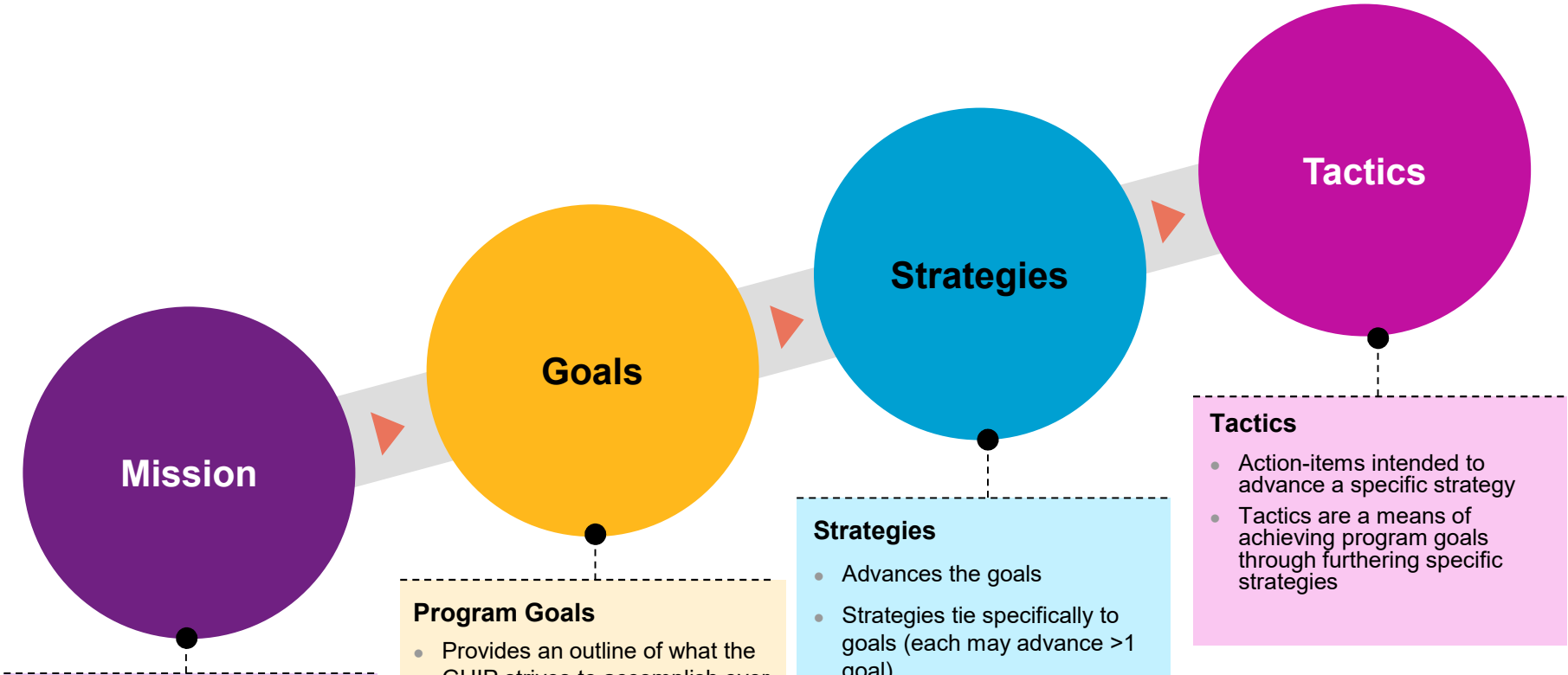
- Current suite of plan options is required by legislation
- May be opportunities to modify networks of existing plans (though may require legal input regarding Delaware Code)

Payroll contributions

- Requires legislative changes to reduce State subsidy of healthcare plans

State Employee Benefits Committee

Strategic framework architecture



Mission Statement

- Statement articulating GHIP purpose

Program Goals

- Provides an outline of what the GHIP strives to accomplish over the next 3-5 year time period
- Goals follow SMART principle (Specific, Measureable, Attainable, Relevant and Time-bound)

Strategies

- Advances the goals
- Strategies tie specifically to goals (each may advance >1 goal)

Tactics

- Action-items intended to advance a specific strategy
- Tactics are a means of achieving program goals through furthering specific strategies

State Employee Benefits Committee

Strategic framework goal focus

- The below goals (based on the SEBC's mission statement) were approved and used as a foundation for the approach to the discussions and decision-making.
- The SEBC is going through the process of developing new goals for focus through the next 2-3 fiscal years

Mission Statement:

Offer State of Delaware employees, retirees and their dependents adequate access to high quality healthcare that produces good outcomes…

at an affordable cost…

*promotes **healthy lifestyles,** and helps them be **engaged consumers.***

Goals:

- Addition of at least net 1 value-based care delivery (VBCD) model by end of FY2018
- Reduction of gross GHIP medical and prescription drug trend by 2% by end of FY2020[1]
- GHIP membership enrollment in a consumer-driven or value-based plan exceeding 25% of total population by end of FY2020[2]

[1] Gross trend is inclusive of total increase to GHIP medical plan costs (both "employer" and "employee") and will be measured from a baseline average trend of 6% (based on a blend of the State's actual experience and Willis Towers Watson market data).
[2] Note: To drive enrollment at this level, the State will need to make plan design and employee contribution changes that may require changes to the Delaware Code.

State Employee Benefits Committee

- During the course of the year, the SEBC reviews many potential program modifications that result in improvements in member care quality, access and cost.
- A sampling of recent program improvement/cost savings measures taken by SEBC include:

Recent Modification	Description	FY20 Estimated Annual Claim Savings
ESI Contract Negotiation	2019 renegotiation of ESI pharmacy benefit manager (PBM) contract	$17.1m (2.0%)[1,2]
Site-of-Care Steerage	Program design steerage away form hospital-based to free-standing facilities (i.e. high-cost imaging and lab) – ***Active and Pre-65 Retiree plans only***	$6.9m (0.8%)[1]
Infusion Therapy	Steerage of high-cost infusions to more appropriate/less costly care sites – ***Active and Pre-65 Retiree plans only***	$2.0m (<0.1%)[1]
Diabetes Management Program	Implementation of Livongo through incumbent medical carriers	$0.8m (<0.1%)[1]
Carve-Out Centers of Excellence	Adoption of carve-out centers of excellence program through Surgery Plus (steerage to highest quality facilities, oftentimes non-hospital based) – ***Active and Pre-65 Retirees only***	$0.5 (<0.1%)[1]

[1] As summarized during March 11, 2019 SEBC meeting. Savings shown as a percentage of projected GHIP FY20 medical/pharmacy budget of $838m presented during November 18, 2020 SEBC
[2] Savings reflects reduction in claims cost and increase in rebates

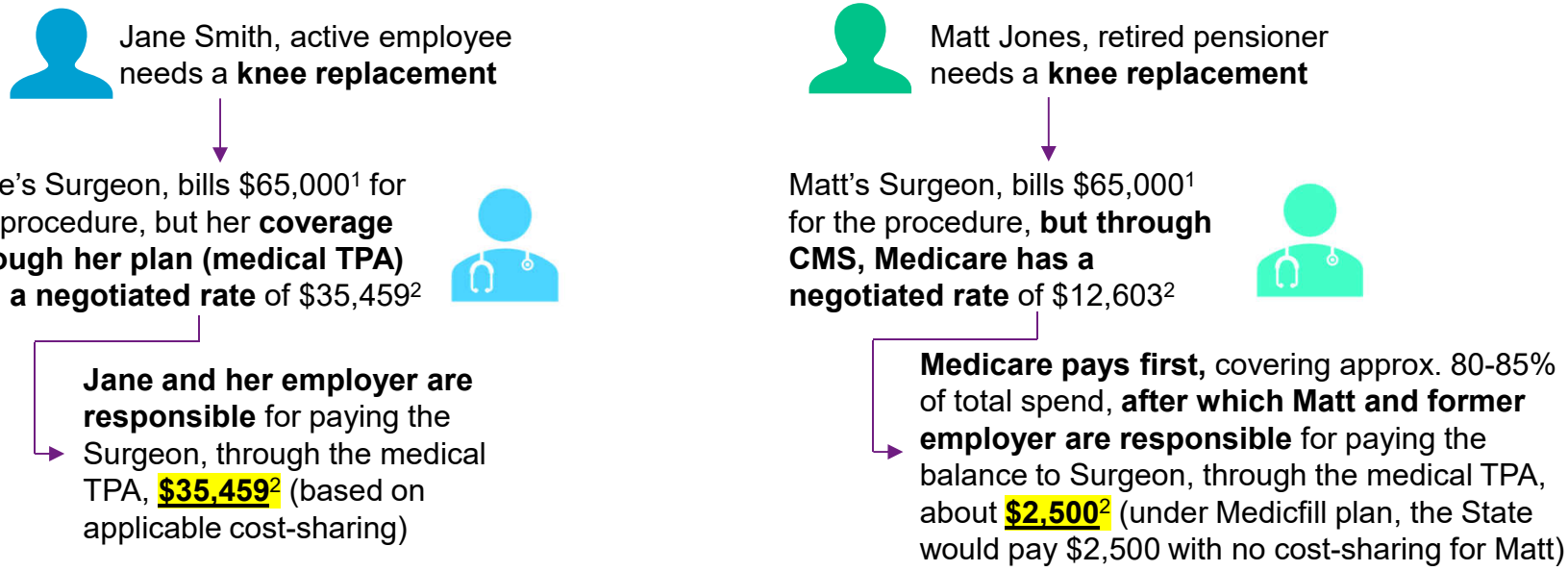
Medicare overview

- Medicare is a federal government program which began in 1966 and provides health coverage to the aged and disabled
  - Most individuals are eligible for Medicare beginning at age 65
  - Disabled individuals may become eligible for Medicare earlier, once approved for Social Security disability income benefits (after a 24-month waiting period)
- Medicare includes the following components
  - Part A pays most of the cost of inpatient hospital stays
  - Part B covers a large portion (typically 80%) of the cost of outpatient services including doctor's office visits, diagnostic tests, x-ray and lab services
  - Part C – Medicare Advantage – combines Parts A, B and (typically) D with integrated hospital, physician and drug coverage in one plan, usually based on a local network (HMO, POS) and not available in all geographies
  - Part D covers prescription drugs (starting in 2006)
- Medicare coverage for retirees and most disabled individuals is primary (it pays first), with employer-sponsored retiree or disabled coverage secondary
- **Since Medicare is the primary payer of medical costs, employer plan costs for a Medicare-eligible individual (i.e. a post-65 retiree) can be lower than an active employee not eligible for Medicare**
- Medicare per capita spending has been growing considerably more slowly than private insurance spending, increasing at an average annual rate of 1.7% since 2010

Source: Kaiser Family Foundation, *The Facts on Medicare Spending and Financing* 8/20/19, https://www.kff.org/medicare/issue-brief/the-facts-on-medicare-spending-and-financing/

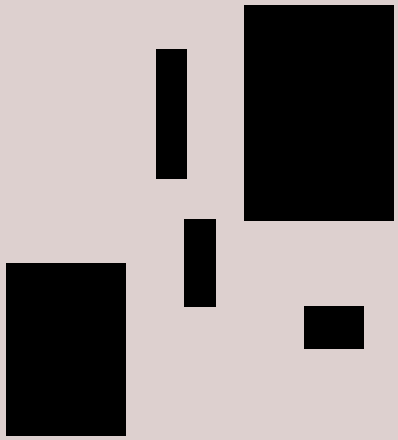
Active vs. Medicare benefit cost

- In December 2018, the Statewide Employee Benefits Committee heard from researchers from the Johns Hopkins Bloomberg School of Health. They reviewed a report titled," Inpatient prices in Delaware: Preliminary analysis of MarketScan and Medicare claims data"
- The report showed that for many procedures within Delaware, commercial health care costs were more than double that of Medicare. For certain procedures (like knee replacements), the cost ratio was 2.81 compared to Medicare. Using this data to directionally illustrate the comparison between commercial and Medicare payments, below highlights an example procedure (knee-replacement) and the associated responsibility for an employer who covers both active and post-65 retiree populations:



[1] Total health care cost shown is illustrative
[2]Medicare cost data source: https://dhr.delaware.gov/benefits/sebc/documents/2018/1210-healthcare-cost-landscape.pdf
Figures shown here represent 2016 data as shown in above report

OPEB Reduction Opportunities



Illustrative scenarios to reduce OPEB liability

- On December 10, the RBSC met to discuss several illustrative scenarios to reduce the OPEB liability. Summarized below are the scenarios that were reviewed:

Scenario Label	Description	OPEB Liability Reduction *(Presented 12/10/19)*	Retiree/Member Impact
Benchmark	Delaware adopts a Medicare Supplement plan design aligned with Virginia's medical design, which includes a $100 deductible, and similarly increases the deductible by $100 for all pre-65 retiree plans	**<$0.1b**	🟡
Active Spouses	Delaware reduces spousal subsidy by 50% for future retirees; no impact to current spouses of retirees	**$0.9b**	🟡
All Spouses	Delaware reduces spousal subsidy by 50% for all current and future retirees	**$1.6b**	🔴
HRA (No 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 no increase* to HRA amount provided in future years	**$3.5b**	🟡🟢
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**	🟢

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

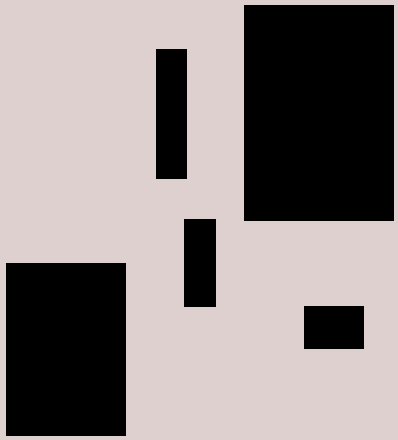
Note: Health Reimbursement Arrangement (HRA) is a tax-free account that can be used to pay premiums for Medicare Parts A, B and D, Medicare Advantage plan and/or supplemental plan, as well as qualified out-of-pocket expenses (deductibles, copays, etc.)

Presented to RBSC on November 12

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.) ▪ 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

Additional Modeling: Sample Actuarial Calculations and their Effect on the Liability



Additional scenarios to reduce OPEB liability

- Additional scenarios that were modeled after December 10:

Scenario Label	Description	OPEB Liability Reduction	Retiree/Member Impact
Vesting Schedule A	State Share vesting schedule for hired since 1991 to 15 years = 50%, 20 years = 75% and 25 years = 100%	**$0.2b**	🟡
Vesting Schedule B	State Share vesting schedule for hired since 1991 to 20 years = 50%, 25 years = 75% and 30 years = 100%	**$0.8b**	🟡
Vesting Schedule C	State Share vesting schedule for hired since 1/2007 to 20 years = 50%, 25 years = 75% and 30 years = 100%	**$0.5b**	🟡
Eliminate Term Vested Benefits A	Effective 7/1/2019 all current and future terminated vested participants would not have access to any state health benefits	**$0.4b**	🟡
Eliminate Term 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**	🟢
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**	🟡
Combination starting 1/1/2021	-$5,100 HRA for Medicare retirees with 2% inflation -Future Spouses would receive 50% of benefit -Eliminate Term Vested Benefits B -Minimum age for healthcare (60 and 55 for public safety) -Vesting schedule C	**$3.75b**	🟡 🟢

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

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Compare additional scenarios to reduce OPEB liability

	2019 Results			2049 Results			
Pay as you Go Funding	Initial Liability	Delta Baseline	ARC as % of Pay	Projected Liability	Delta Projected	Percent Funded	ARC as % of Pay
Baseline	$ 8,729.80			$ 35,994.33			
Eliminate TV	$ 8,383.64	$ (346.15)	28.37%	$ 34,630.88	$ (1,363.45)	9.01%	42.46%
Change Vesting Schedule 15, 20 and 25	$ 8,562.48	$ (167.32)	28.22%	$ 33,493.73	$ (2,500.60)	9.32%	40.84%
Change Vesting Schedule 20, 25 and 30	$ 7,956.20	$ (773.60)	24.93%	$ 26,350.10	$ (9,644.22)	11.85%	31.41%
Minimum Age to Collect	$ 8,045.49	$ (684.31)	25.41%	$ 29,161.78	$ (6,832.55)	10.71%	33.87%
HRA $5,100 Medicare	$ 6,368.84	$ (2,360.96)	19.56%	$ 13,978.44	$ (22,015.89)	22.33%	16.33%
Spouse 50% future retirees	$ 7,787.33	$ (942.47)	26.07%	$ 30,101.61	$ (5,892.71)	10.37%	36.75%
Combined - HRA, Sp50%, Def Age, No TV, Vest Sch 20, 25, 30	$ 4,974.45	$ (3,755.35)	13.44%	$ 11,068.21	$ (24,926.11)	28.21%	11.93%

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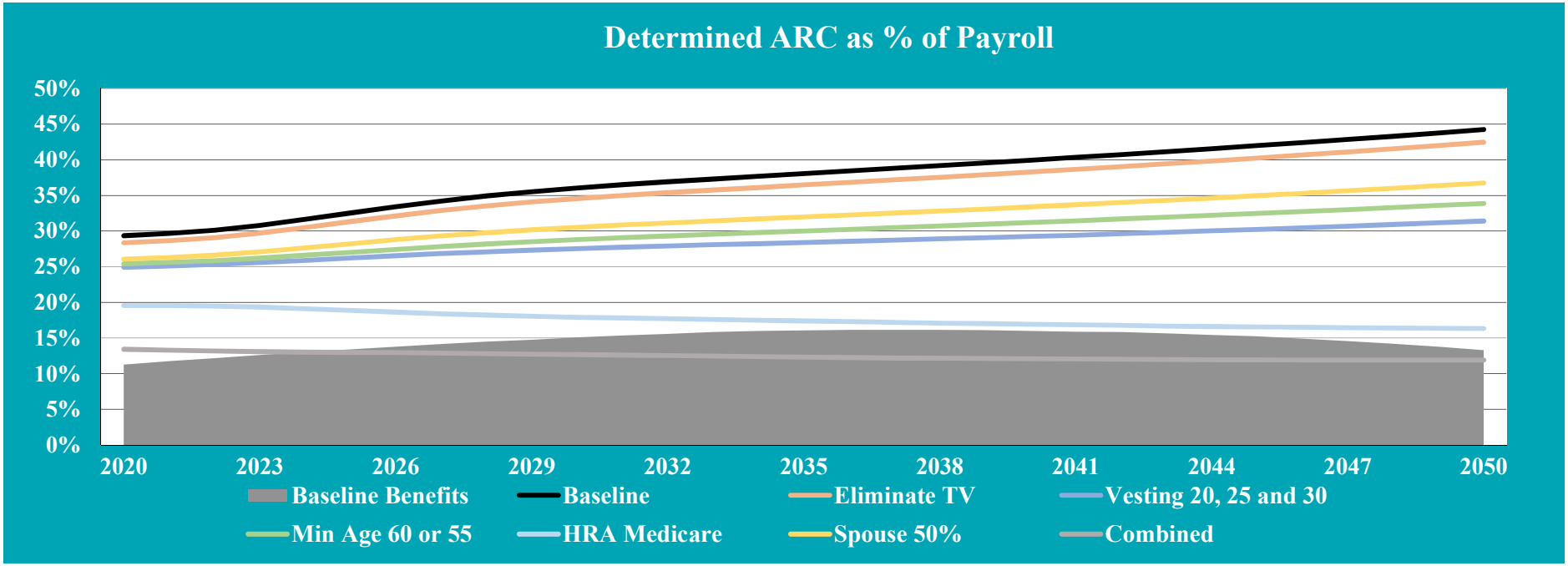
Compare additional scenarios to reduce OPEB liability

ARC as a % of Payroll

Baseline benefits are shown in grey below. The ARC for each additional run are shown below. As you see below, the ARC will continue to grow as a result of not funding. Reducing benefits will not completely solve the problem. The combined scenario will be about 28% funded after 30 years.



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Compare additional scenarios to reduce OPEB liability with Funding

Projections with funding savings

Eliminate TV and fund 0.5% of payroll does not reach 7.0% funding target over the next 30 years and neither does the change vesting schedule.

However, both minimum age and HRA will reach 7.0% funding targeted discount rate before 30 years, reducing the liability significantly.

	2019 Results			2049 Results			
Fund Plan with Savings	Initial Liability	Delta Baseline	ARC as % of Pay	Projected Liability	Delta Projected	Percent Funded	ARC as % of Pay
Eliminate TV Fund 0.5% of Payroll	$ 8,383.64	$ (346.15)	28.37%	$ 33,710.24	$ (2,284.09)	12.84%	40.49%
Change Vesting Schedule 20, 25 and 30 Fund 1.3% of Payroll	$ 7,956.20	$ (773.60)	24.93%	$ 24,106.50	$ (11,887.83)	25.76%	26.47%
Minimum Age to Collect Fund 2.5% of Payroll	$ 8,045.49	$ (684.31)	25.41%	$ 17,690.66	$ (18,303.67)	52.89%	14.90%
Combined and Fund 0.5% of Payroll	$ 4,974.45	$ (3,755.35)	13.44%	$ 7,649.44	$ (28,344.88)	60.75%	5.95%

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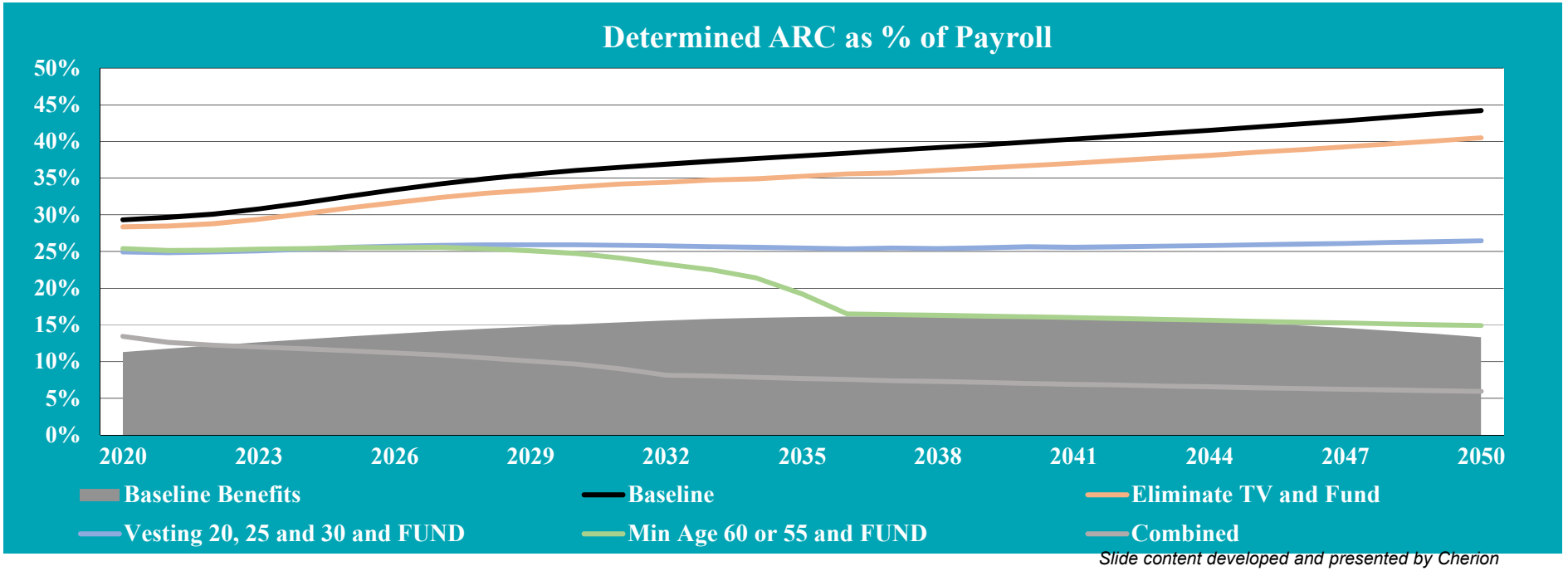
Compare additional scenarios to reduce OPEB liability with Funding

ARC as a % of Payroll with Funding

Baseline benefits are shown in grey below. The ARC for each additional run are shown below. As you can see below, the ARC as a percentage of payroll for each scenario does not grow as fast as above, due to funding of the plan. With as little as 0.5% of payroll ($11 million, growing to $30 million over 30 years), funds the combined scenario to 60% over the next 30 years, reducing the ARC to about 5% of payroll.



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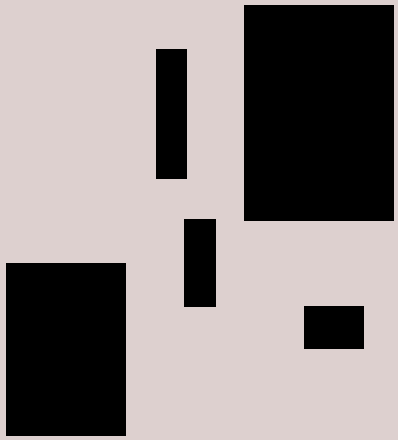
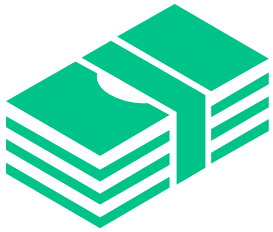
Additional Modeling: Retiree Household Impact Analysis



Individual Marketplace with HRA scenario – household impact

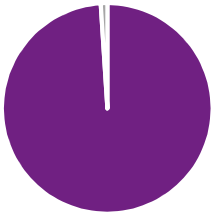
Scenario: Retirees receive annual HRA to purchase individual coverage comparable to the value of subsidy received by State of Delaware currently, used to purchase individual coverage through Medicare Marketplace.

OPEB Liability Reduction
- 2% index: $2.4b
- No index: $3.5b



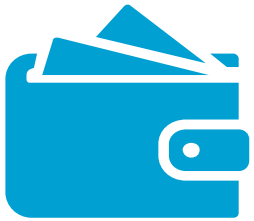
$5,100

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)



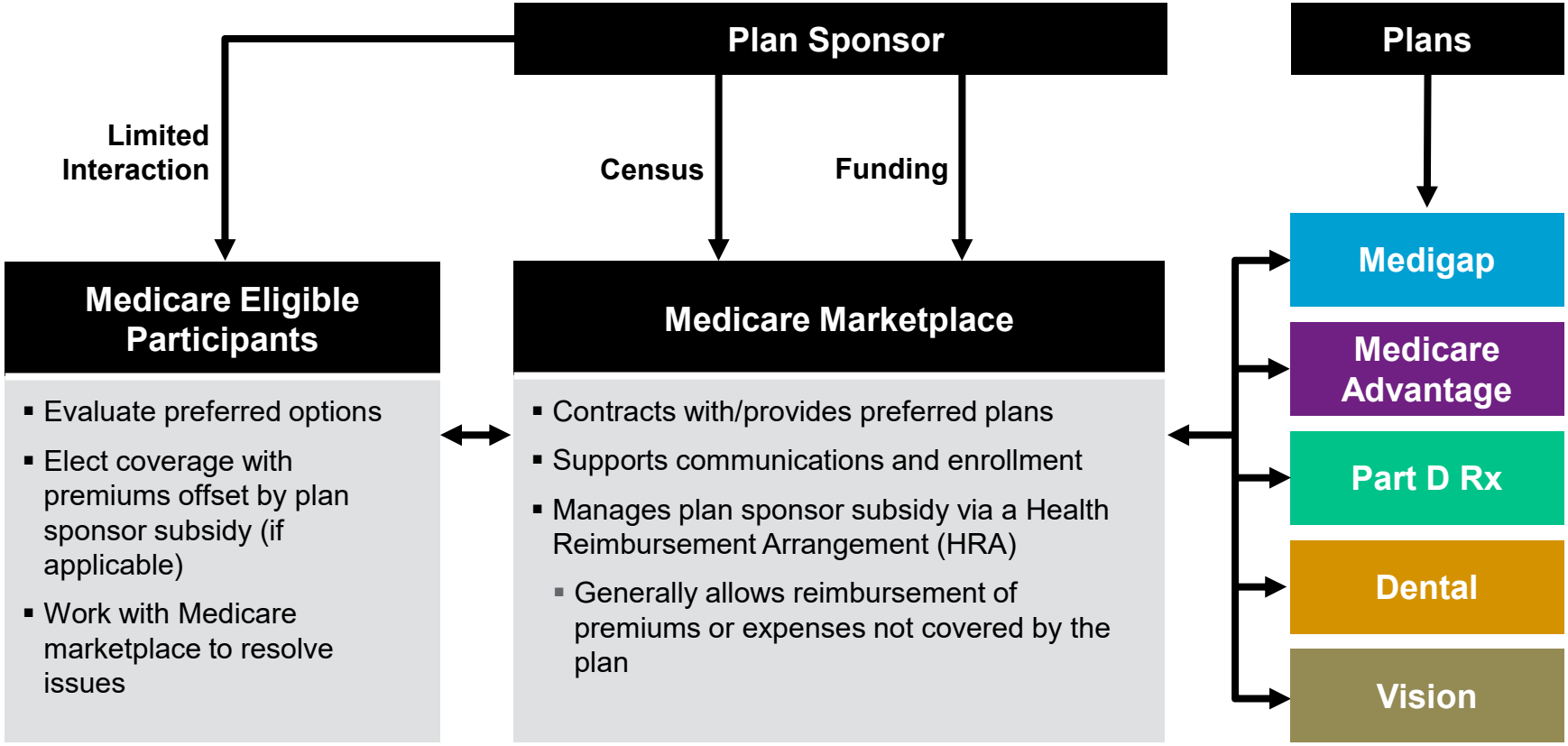
$3,310

is the average annual savings per individual retiree

- Current single rate for Medicfill plan is **$5,512** per year
- 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
- For modeling purposes on December 10 and again for today's discussion, first year HRA amount assumed to be **$5,100** for retirees with 100% state share (prorated for other cohorts)
- Other HRA amounts can be modeled that may yield significant savings for the majority of retirees

Note: State cost includes $5,050 HRA allotment plus estimated $50 per retiree per year reimbursement for catastrophic Rx claims, covering the 5% coinsurance for retirees once TrOOP reached under Part D plan.

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]
Philadelphia-Camden-Wilmington, PA-NJ-DE-MD MSA	10,717	0-56	17-35	18-21	$0	$2,631	$323
Dover, DE MSA	4,681	8-10	29	18	$0	$2,106	$323
DE NONMETROPOLITAN AREA	4,623	0-8	17-29	18	$0	$2,403	$323
MD NONMETROPOLITAN AREA	195	0-2	17	18	$0	$2,403	$323
Salisbury, MD MSA	147	0	17	18	n/a	$2,403	$323
Rates for Average Retiree Modeling[3]	20,363				$0	$2,380	$323

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 – Average utilizer (first year)

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

Cost Comparisons Retiree Costs	Current Medical Plan	Medicare Supplement + Part D Plan HiF	Plan N	Plan G	MAPD
Premium Cost Comparison					
Plan Premium	$ 4,800	$ 1,144	$ 2,342	$ 2,703	$ -
Employer subsidy/suggested HRA	$ (4,800)	$ (5,050)	$ (5,050)	$ (5,050)	$ (5,050)
Cost to retiree	$ -	$ (3,906)	$ (2,708)	$ (2,347)	$ (5,050)
Annual Retiree point-of-care costs					
Projected Medical	$ 24	$ 1,326	$ 480	$ 176	$ 2,017
Projection Rx	$ 454	$ 858	$ 858	$ 858	$ 858
Total	$ 478	$ 2,184	$ 1,338	$ 1,034	$ 2,875
Average total retiree cost	$ 478	$ (1,722)	$ (1,370)	$ (1,313)	$ (2,175)
Average retiree savings		$ 2,200	$ 1,847	$ 1,791	$ 2,653

- Illustrative retiree with average utilization would save $1,791 to $2,653 for the four individual marketplace plan options modeled
- If retiree covers a spouse, the spouse would also receive $5,100 HRA

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

Retiree household impact analysis – Low, average, high utilizer

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

Low Utilizer

Retiree Costs	Current Medical Plan	Medicare Supplement + Part D								MAPD
		Plan HiF		Plan N		Plan G				
Net Retiree Premium	$ -	$ (3,906)		$ (2,708)		$ (2,347)				$ (5,050)
Projected Medical	$ 1	$ 203		$ 190		$ 136				$ 52
Projected Rx	$ 73	$ 107		$ 107		$ 107				$ 107
Total Retiree Cost	$ 74	$ (3,596)		$ (2,411)		$ (2,104)				$ (4,892)
Retiree Savings		$ 3,671		$ 2,486		$ 2,179				$ 4,966

Average Utilizer

Retiree Costs	Current Medical Plan	Medicare Supplement + Part D								MAPD
		Plan HiF		Plan N		Plan G				
Net Retiree Premium	$ -	$ (3,906)		$ (2,708)		$ (2,347)				$ (5,050)
Projected Medical	$ 24	$ 1,326		$ 480		$ 176				$ 2,017
Projected Rx	$ 454	$ 858		$ 858		$ 858				$ 858
Total Retiree Cost	$ 478	$ (1,722)		$ (1,370)		$ (1,313)				$ (2,175)
Retiree Savings		$ 2,200		$ 1,847		$ 1,791				$ 2,653

High Utilizer

Retiree Costs	Current Medical Plan	Medicare Supplement + Part D								MAPD
		Plan HiF		Plan N		Plan G				
Net Retiree Premium	$ -	$ (3,906)		$ (2,708)		$ (2,347)				$ (5,050)
Projected Medical	$ 71	$ 2,371		$ 787		$ 187				$ 6,291
Projected Rx	$ 1,022	$ 1,762		$ 1,762		$ 1,762				$ 1,762
Total Retiree Cost	$ 1,093	$ 228		$ (158)		$ (398)				$ 3,003
Retiree Savings		$ 865		$ 1,251		$ 1,491				$ (1,910)

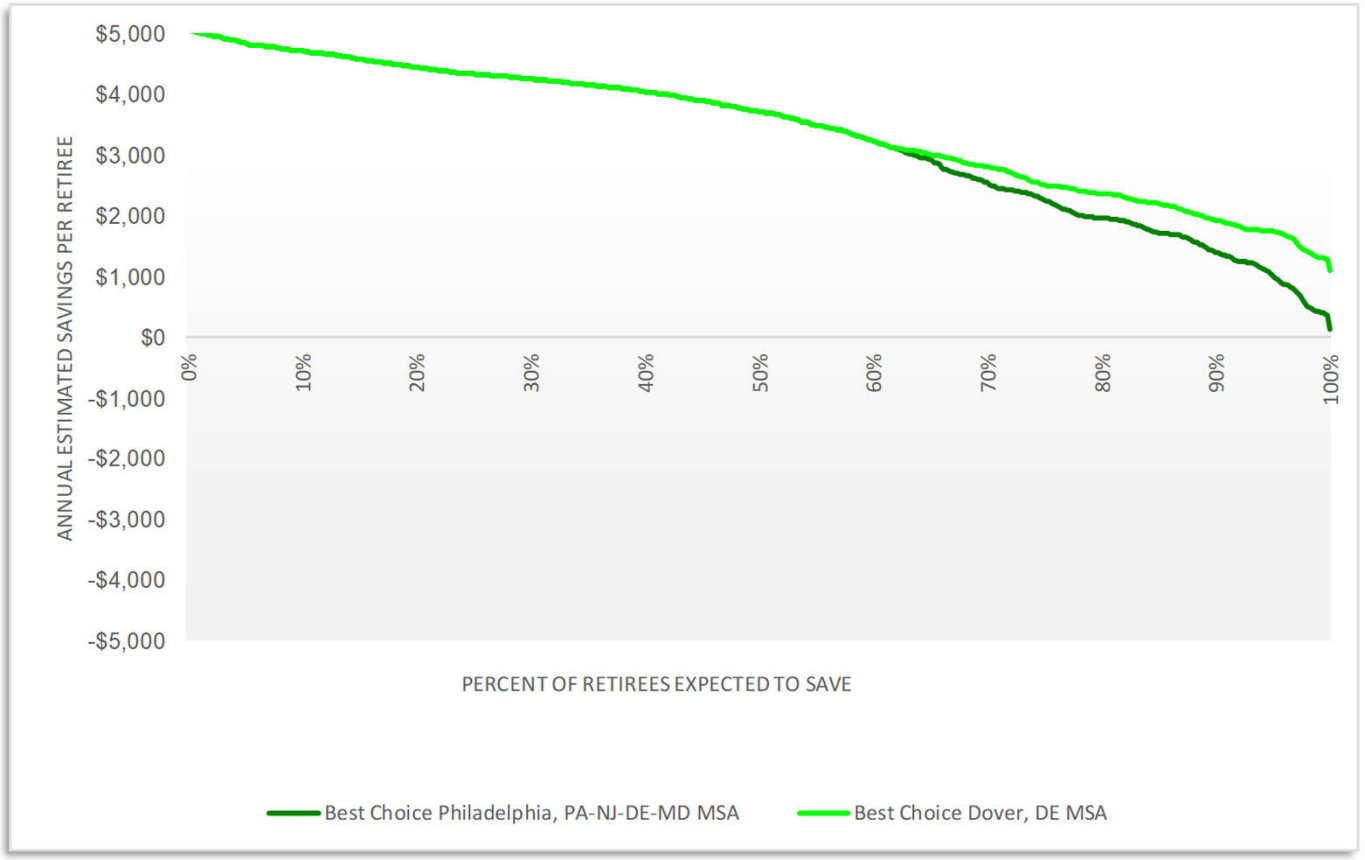
Illustration of plans chosen for selected utilization levels.

Extrapolated across every utilization level for retiree savings analysis modeled on next slide

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

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

Philadelphia, PA-NJ-DE-MD MSA

	Best
Avg. Loss	$0
Avg. Win	$3,310
% Loss	1%
% Win	**99%**

Low Area

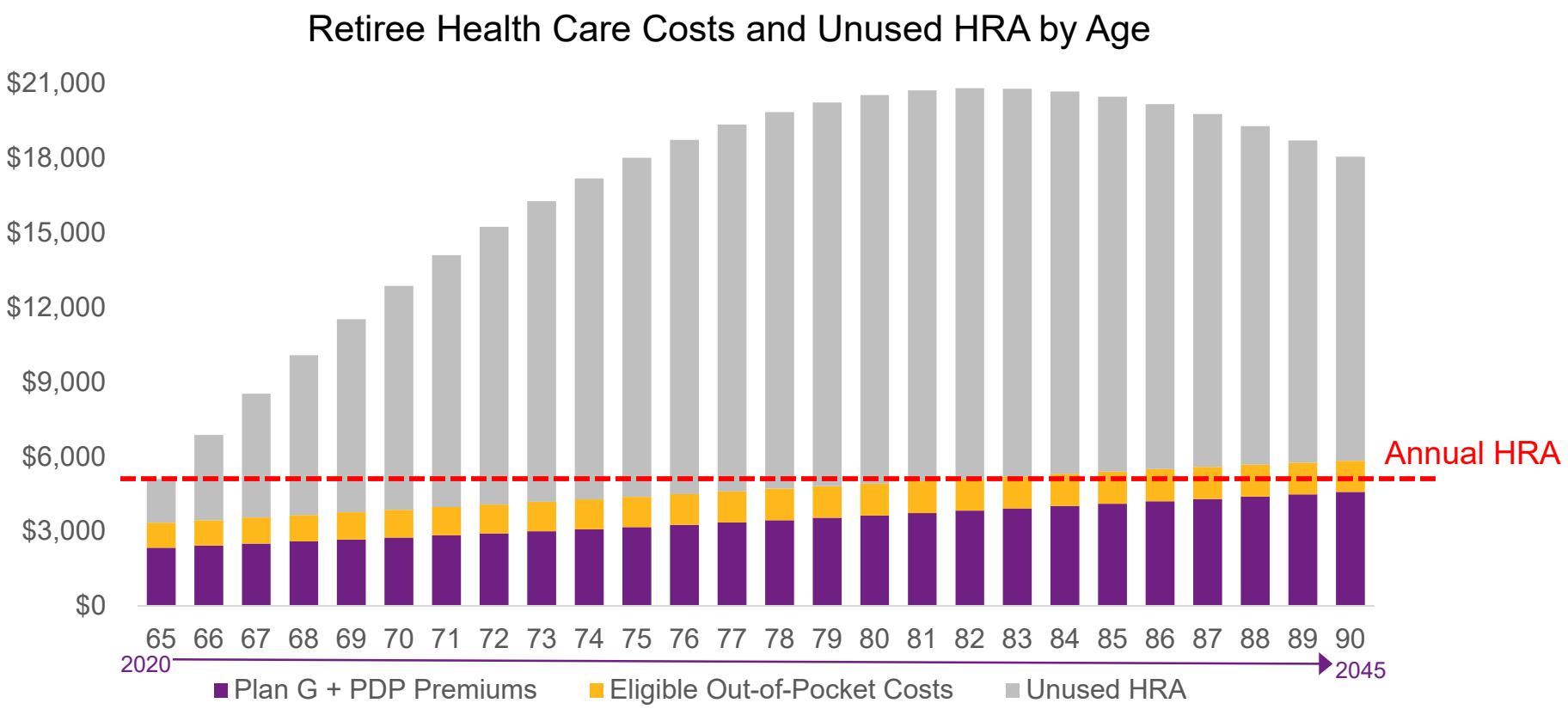
Dover, DE MSA

	Best
Avg. Loss	$0
Avg. Win	$3,469
% 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

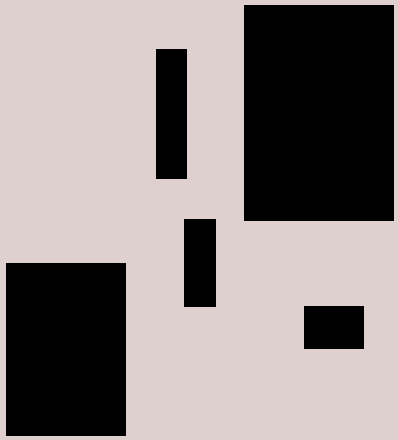
Retiree impact analysis – Long term view (illustrative)



- Medigap premiums and average out-of-pocket expenses increase with age
- Retiree may not use full HRA allotment in certain years; unused HRA amount rolls over and accumulated HRA balance can be used to pay for qualified premiums and out-of-pocket expenses in future years

Note: long term illustration assumes retiree is age 65 in 2020, located in Philadelphia/Wilmington MSA and elects Medigap Plan G with PDP; $5,100 HRA per individual provided annually; $1,000 in qualified out-of-pocket expenses at age 65; HRA not indexed and analysis excludes impact of health care trend.

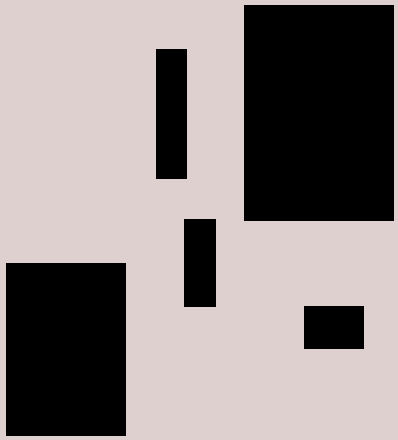
Next Steps



Next steps

- Next meeting scheduled on March 9, 2020
- Preliminary report to DEFAC
- Final report to Governor and General Assembly by March 31, 2020

Appendix



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)