Statewide Benefits Office Strategic Plan FY2023 Results

Executive Summary

Based upon the actions completed by the Statewide Benefits Office (SBO) towards achieving the goals set forth by the State Employee Benefits Committee (SEBC) and the projections of meeting those goals, the SBO had devised a Fiscal Year (FY) 2023 strategic plan that included the following actions as well as other initiatives:

Goal: Using the Alternative Payment Model (APM) Framework and FY2021 medical spend as a baseline, increase Group Health Insurance Plan (GHIP) spend through advanced APMs to be at least the following by the end of FY2023 (as % of total spend): Category 3 – 40% and Category 4 – 10%

- Implemented training courses to educate GHIP members about high-quality, high-value providers
- Notified GHIP membership of the release of Leapfrog's new hospital safety grades
- Distributed various communications regarding Centers of Excellence and SurgeryPlus
- Monitored disease management program participation, utilization, and costs through quarterly reporting
- Added machine readable files to the SBO website as required by the Transparency Rule, as well as implement the January 1, 2023 requirement that health plans add shoppable tool for 500 covered healthcare services
- Worked with health plan Third Party Administrators (TPAs) to develop a communications strategy that educates members about safety and quality
- Continued participation in the RAND study and utilized the data in the Delaware Health Care Claims database to compare our cost situation to other states
- Annual request of the health plan TPAs to complete the Delaware Office of Value Based Health Care Delivery (OVBHCD) affordability template specifically for the GHIP to support reporting to the SEBC on the GHIP's progress towards achieving this goal

Goal: In light of the GHIP's changing demographic profile, strive for an incremental increase in unique users utilizing a specific point-of-enrollment and/or point-of-care engagement platform/consumerism tool by at least 5% annually

- Distributed various communications to increase awareness and promote the myBenefitsMentor® Consumer Decision Tool
- Included information about the myBenefitsMentor® Consumer Decision Tool in new hire communications and forms
- Supported the SEBC and its Subcommittees in evaluating opportunities for changes to GHIP options that encourage meaningful differences in member cost sharing to prompt a greater need for members to utilize decision support tools

Goal: Reduction of GHIP diabetic cost per-member-per-month (PMPM) by 8% by the end of FY2023 using FY2021 spend as a baseline

- Provided SEBC and its Subcommittees with information on the primary care landscape in Delaware
- Distributed various communications to increase awareness and encourage participation in covered services, including Diabetes Prevention Programs (DPPs) (Livongo® DPP, Solera DPP, and YMCA DPP) and diabetes management programs (Livongo® Diabetes Monitoring Program and Transform Diabetes Care Program)
- Promoted Division of Public Health (DPH) diabetes self-management program, as well as health-related classes/events offered by local hospitals
- Provided GHIP data for the HB203 "Impact of Diabetes in Delaware" report that was sent to the Delaware Legislature in June 2023

Goal: Limit total cost of care inflation for GHIP participants at a level commensurate with the Health Care Spending Benchmark by the end of FY2023 by focusing on specific components, which are inclusive of, but not limited to: Outpatient facility costs, Inpatient facility costs, and Pharmaceutical costs

- Distributed various communications regarding health plan features, appropriate sites of care, member testimonials, wellness and condition care management programs, the value of the benefits, and resources available to GHIP members
- Implemented training courses to educate GHIP members about their benefits
- Created scorecards specific to organizations that outline how each organization ranked in key metrics
- Developed communications, educated GHIP members, and implemented Hinge Health (a virtual exercise therapy program) effective January 1, 2023
- Developed communications and began to educate GHIP members about the bariatric surgery carve-out through SurgeryPlus effective July 1, 2023
- Worked with SEBC's consulting partner, Willis Towers Watson (WTW), to bring forth options for evaluation by the SEBC to help solve for the FY2024 projected deficit
- Continued monitoring SurgeryPlus utilization and member engagement strategy
- Worked with Aetna to implement its Gene-Based, Cellular and other Innovative Therapies (GCIT) Network effective July 1, 2023, as directed by the SEBC
- Worked with CVS to implement PrudentRx effective July 1, 2023, as directed by the SEBC

Other SBO Initiatives

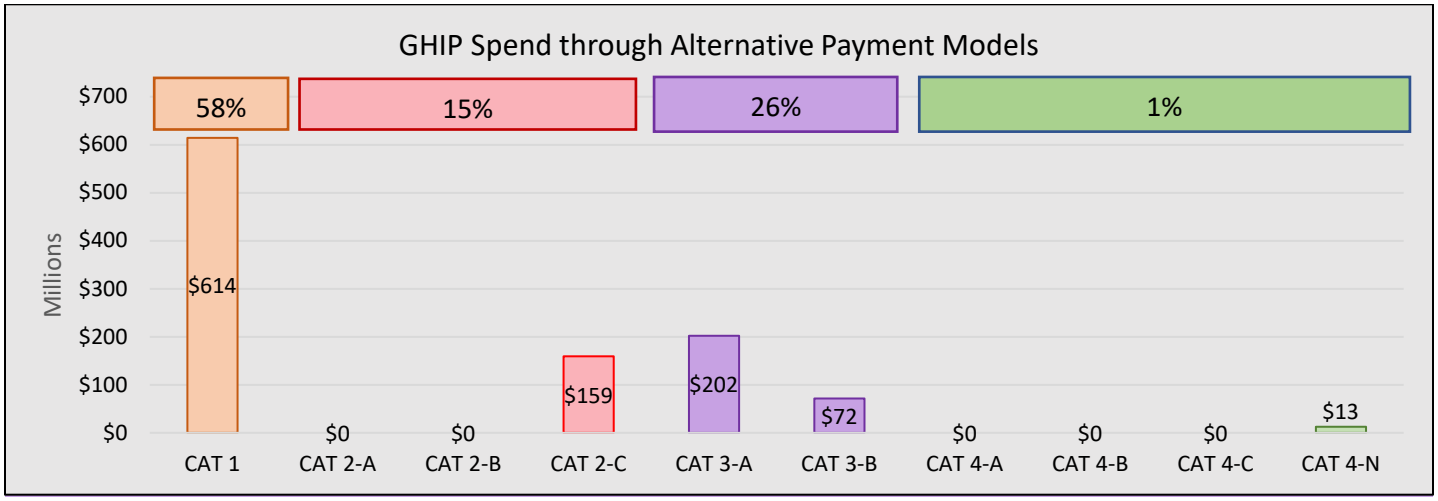
- Retiree Healthcare Benefits Advisory Subcommittee
- The Impact of Diabetes in Delaware 2023 Report
- Represented Department of Human Resources (DHR) on the Delaware Primary Care Reform Collaborative
- Diversity, Equity and Inclusion Benefits Review
- Updated SBO portion of DHR New Employee Orientation
- Disability Insurance Program (DIP) Assessment
- Mental Health Parity Assessment of the GHIP medical plans
- Implemented the Bariatric Surgery carve-out through SurgeryPlus to non-Medicare members effective 7/1/23
- Implemented Transform Diabetes Care for Medicare members under CVS effective 1/1/23
- Enhanced communications and trainings on health plan decisions and benefits
- Availability of myBenefitsMentor® tool for new State employees
- HIPAA Risk Assessment
- Revised Spousal Coordination of Benefits (SCOB) Policy and Chart effective 1/1/23
- Launched an employee modernization survey for benefit eligible employees in February 2023
- CVS Caremark and SurgeryPlus added as Single Sign-On (SSO) options in Employee Self-Service
- Implemented Hinge Health effective 1/1/23
- Implemented Transform Diabetes Care and Aetna One Advisor for Aetna non-Medicare members effective 7/1/22

The FY2023 strategic plan reflects the desire of the SBO and the SEBC to continue enhancing the mission of offering 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. The following pages detail the tactics and actions taken by the SBO in FY2023 to support these goals and an evaluation of the results that followed.

Goal: Using the Alternative Payment Model (APM) Framework and FY2021 medical spend as a baseline, increase GHIP spend through advanced APMs to be at least the following by the end of FY2023 (as % of total spend):

- **Category 3: 40%**
- **Category 4: 10%**

The following chart reflects total GHIP medical spend (i.e., allowed amount, including both member cost share and plan payments) under Highmark, Aetna and SurgeryPlus, incurred in FY2023 (July 1, 2022 – June 30, 2023) under each category of the Alternative Payment Model Framework:



The Alternative Payment Model categories ("CAT") noted in the chart above correspond to the Health Care Payment and Learning Action Network's Alternative Payment Model Framework:

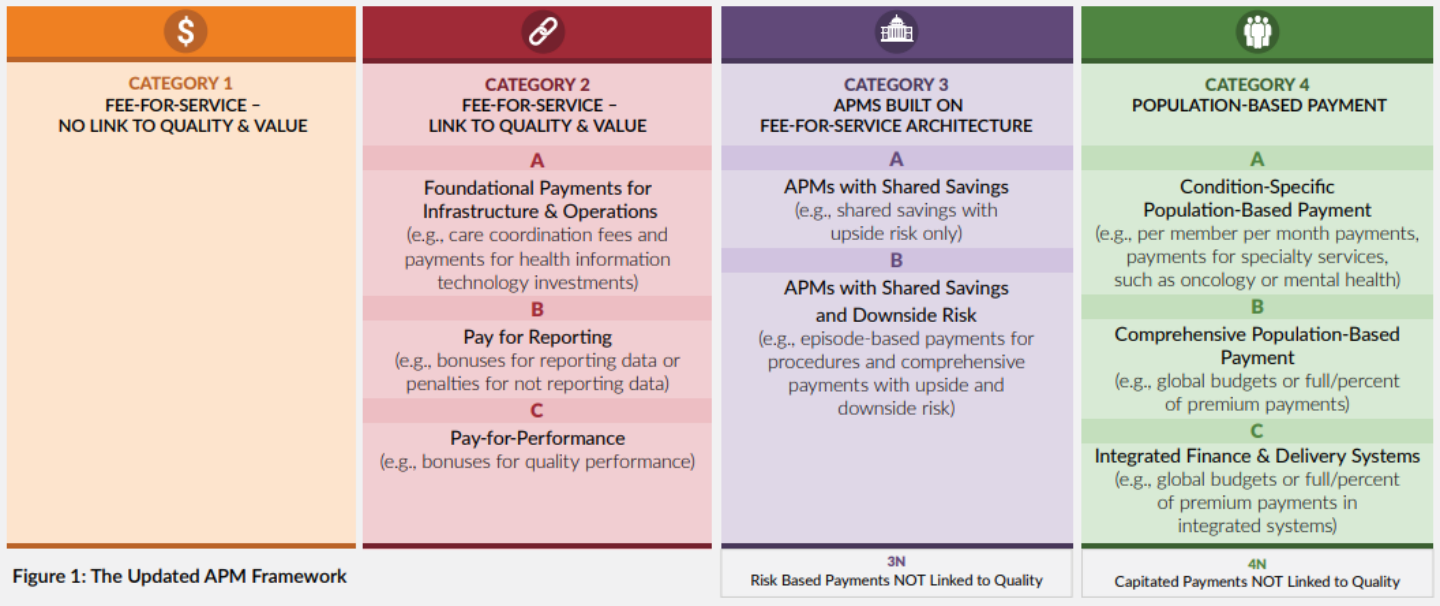


Figure 1: The Updated APM Framework

Source: https://hcp-lan.org/

Why is this goal important?

Traditionally, employer-sponsored health benefits have often cycled between strategies that hold healthcare providers accountable for managing cost and quality of care ("supply" strategies) and strategies that hold plan participants accountable for managing cost and quality of care ("demand" strategies). Interventions that operate in a silo by addressing only supply or only demand do not work well. To simultaneously control cost in a sustainable way, the provider must be more accountable and member healthcare shopping habits must change. Alternative payment models (also known as "value-based payment models") are grounded in supply-based strategies that leverage higher quality care to drive changes in demand, reduce the total cost of care for the GHIP and plan participants, and align with the GHIP's Mission Statement to '*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'.*

Prompted by an uptick in interest and contracting activity, the US Department of Health and Human Services (HHS) launched the Health Care Payment Learning & Action Network (HCP-LAN) in March 2015, which is a public-private partnership established to accelerate transition in the healthcare system from a fee-for-service payment model to ones that pay providers for quality care, improved health, and lower costs. The HCP-LAN established the Alternative Payment Model (APM) Framework to track progress toward payment reform and provide a "common language" for describing various types of value-based payment models with the goal of providing patient-centered care. Patient-centered care allows patients and their care teams to form partnerships around high-quality, accessible care, which is both evidence-based and delivered in an efficient matter whereby a patients' and caregivers' individual preferences, needs and values are paramount. Since that time, several Delaware state agencies responsible for various statewide initiatives adopted the APM Framework as the codex for describing, tracking and reporting on the Delaware provider community's adoption of alternative payment models. The SEBC saw an opportunity to align this goal within the GHIP Strategic Framework with the same definitions of alternative payment models in use by other healthcare policy makers throughout the state.

Tactics to meet the goal:

- Continued to hold medical TPAs accountable for expanding their pay-for-value contracts with providers
- Continued to promote tools and resources that help members identify high-quality, high-value providers
- Continued to require medical TPAs to submit GHIP claim data to the DHIN and to support value-based provider contracts (e.g., ACOs) where applicable
- Evaluated the readiness of the provider marketplace in Delaware to assume additional financial risk
- Leveraged the Delaware Health Care Claims database to compare cost across other state populations
- Worked with providers and TPAs to ensure non-claims payments were collected and reported to the DHIN

Actions SBO has taken to achieve the goal:

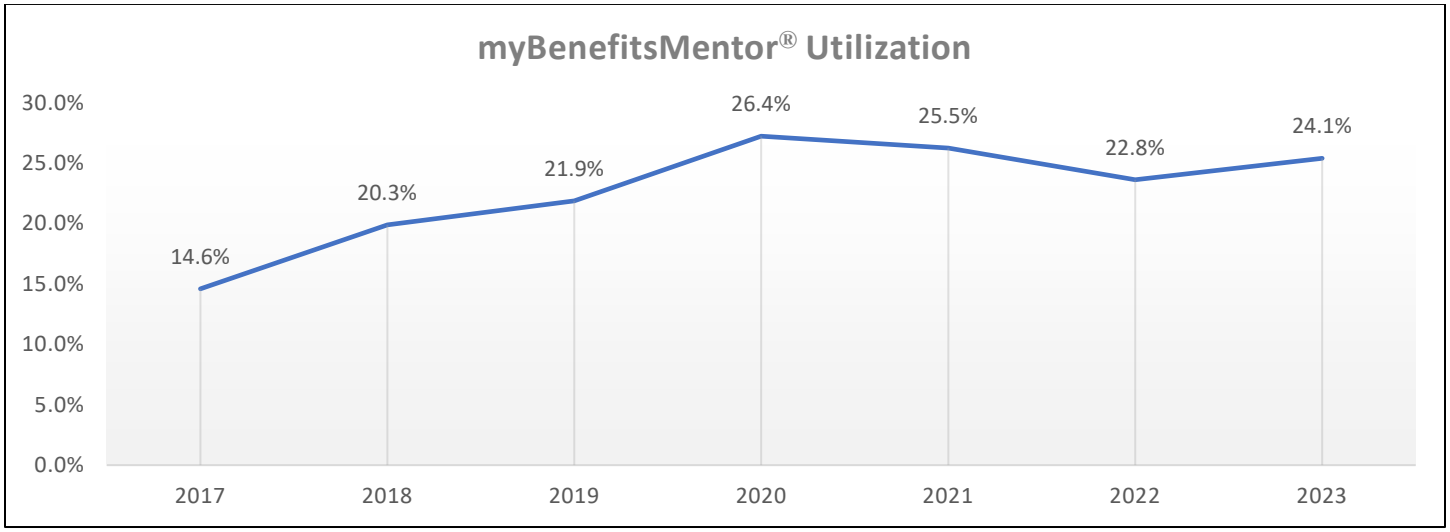
- Participated in the Primary Care Collaborative
- While conducting the annual contract review and amendment process, questions were asked to determine and assess TPA's ability to increase GHIP movement toward Category 3 and Category 4
- Updated performance guarantees with health plan TPAs to move more aggressively toward Category 3 and Category 4
- Created and distributed various communications regarding high-quality, high-value providers
- Created and distributed various communications regarding appropriate sites of care
- Worked with TPAs Highmark and Aetna to present to the SEBC their latest efforts to expand value-based contracting in Delaware, as well as on their care management programs for the GHIP

- Coordinated with the OVBHCD to present that office's view of value-based care in Delaware based on their work with the carriers
- Increased communication with the OVBHCD within the Department of Insurance (DOI) to ensure alignment of goals and accurate reporting on APMs
- Ensured accurate data collection amongst TPAs and timely reporting to the DHIN
- Enhanced monitoring of APMs in other states and kept up to date on the development of new payment models within Delaware and surrounding states

Results:

FY2023 total medical spend (i.e., allowed amount, including both member cost share and plan payments), was $1.06B, which includes $274M (26%) in Category 3 and $13M (1%) in Category 4 payment models, meaning the goal was not met. After adjusting for medical trend (5% annually), the FY2024 target (total medical spend) required to reach this goal is approximately $423M (40%) in Category 3 - APMs built on Fee-For-Service architecture and $106M (10%) in Category 4 – Population Based Payments. Additional years of data will be necessary to determine overall progress towards the goal, though both current TPAs have committed to and are actively expanding their pay-for-value contracts with providers.

Goal: In light of the GHIP's changing demographic profile, strive for an incremental increase in unique users utilizing a specific point-of-enrollment and/or point-of-care engagement platform/consumerism tool by at least 5% annually



Why is this goal important?

Use of consumerism tools like Merative's myBenefitsMentor® directly relates to the SEBC goal of promoting healthy lifestyles and helping members to be engaged consumers. Engaged consumers are more aware of their healthcare options. The myBenefitsMentor® online consumer decision tool is available to State employees, Delaware Transit Corporation employees, and State non-Medicare eligible pensioners as part of annual Open Enrollment and throughout the year. The tool allows eligible individuals to estimate and compare the cost of their health plan options (the amount deducted from their pay and out-of-pocket costs for office visits and services). The tool provides eligible individuals with a view of past expenses, helps to estimate costs for anticipated health care (such as a planned surgery or birth of a child) and matches their health needs with the plan that will provide the needed care at the lowest cost to the individual.

Tactics to meet the goal:

- Continued to communicate the value of benefits provided along with member education resources
- Continued to promote healthcare consumerism and the importance of making informed decisions when enrolling in or changing benefits
- Periodically evaluated opportunities for changes to GHIP medical plan options and price tags to encourage meaningful differences to prompt a greater need for members to utilize decision support
- Continued exploring new decision support tools and/or engagement solutions as the vendor marketplace for this continues to evolve
- Steered new employees to these tools

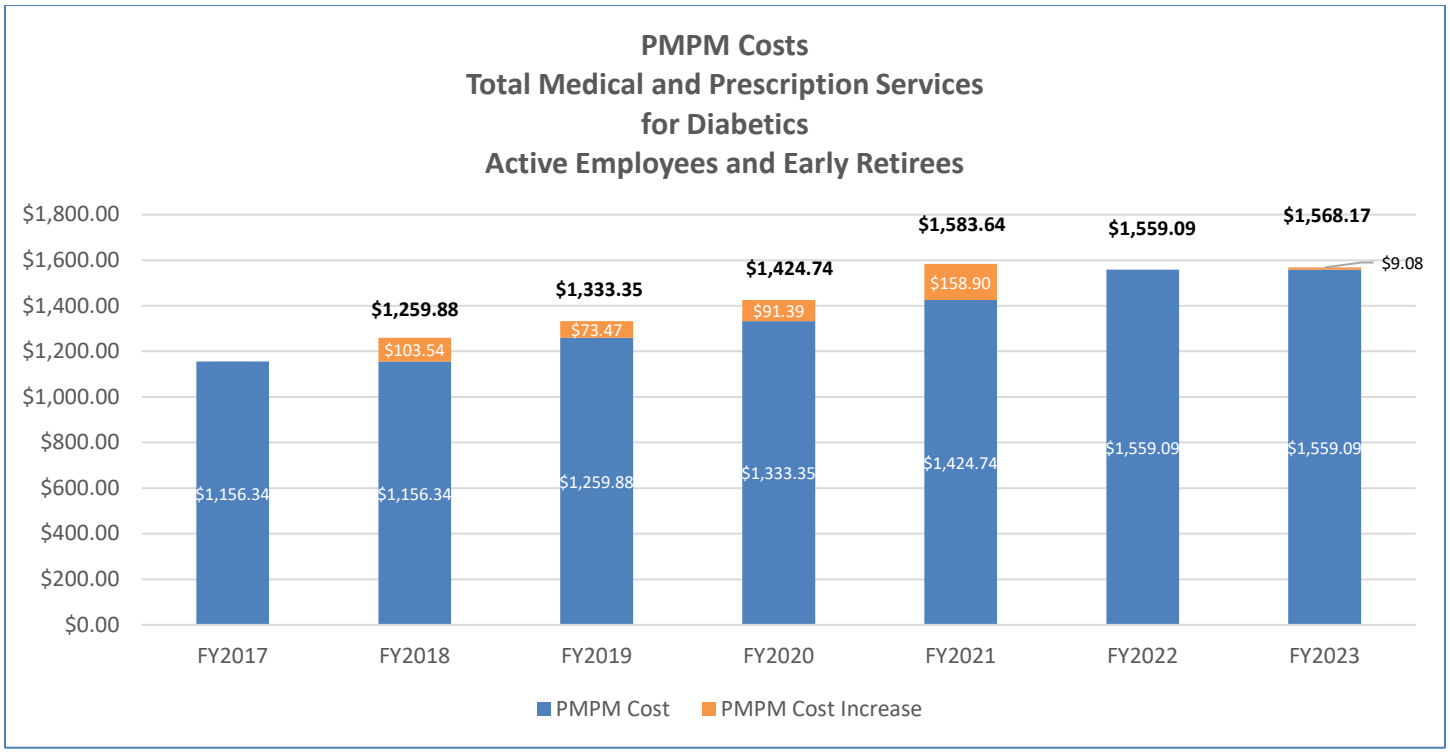
Actions SBO has taken to achieve the goal:

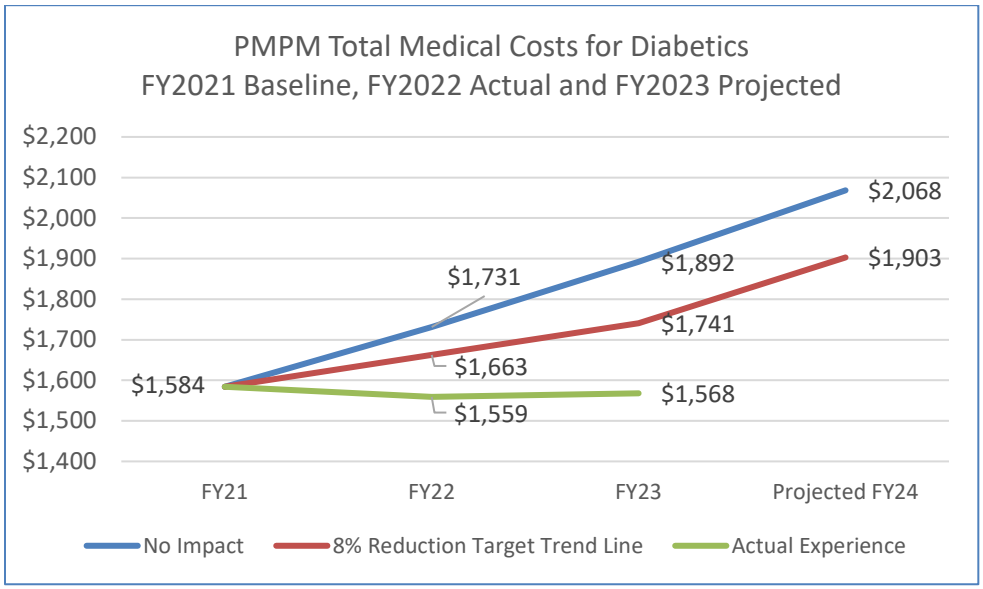
- Sent emails to benefit-eligible employees about myBenefitsMentor®
- Included information about myBenefitsMentor® in pensioner Open Enrollment packets
- Implemented the myBenefitsMentor® platform availability to new hires
- Communicated availability of myBenefitsMentor® at various meetings and training sessions
- Assigned online training courses containing information about myBenefitsMentor® and its availability
- Provided organizations with statistics related to their employee's utilization of myBenefitsMentor®
- Created and distributed various communications regarding the value of benefits and resources available to GHIP members
- Supported the SEBC and its Subcommittees in evaluating opportunities for changes to GHIP health plan options that encourage meaningful differences in member cost sharing to prompt a greater need for members to utilize decision support tools

Results:

While there was an increase in utilization of the myBenefitsMentor® tool in 2023 over the prior year, we did not meet this goal as utilization only increased by 1.3%.

Goal: Reduction of Group Health Insurance Plan (GHIP) diabetic cost per-member-per-month (PMPM) by 8% by the end of FY2023 using FY2021 spend as a baseline





Why is this goal important?

Diabetes prevention and management is an important area of focus for the State of Delaware. Successful prevention and mitigation of diabetes can significantly reduce medical costs and improve quality of life. In FY2023, 7,045 members of the GHIP active employee and early retiree population (and their dependents) had an episode of treatment for diabetes. Conservatively, the total cost of treatment for these members was an estimated $209.8 million. An additional 9,497 members were prediabetic at a total cost of treatment of $92 million. Together, these members represented 15.1% of the total active employee and early retiree population and accounted for 35.8% of total healthcare expenditures. The State of Delaware and the State Employee Benefits Committee (SEBC) are committed to offering convenient, evidence-base programs to help our members manage diabetes and live healthy lives.

Tactics to meet the goal:

- Continued measuring diabetes prevalence, medical service/Rx utilization and cost ongoing vs. baseline
- Continued the Health Policy & Planning Subcommittee's task of evaluating primary care access in Delaware
- Continued to educate members on the availability of preventive care and condition-specific resources through the GHIP and other community resources (e.g., hospital-based health and wellness courses)
- Continued to offer condition-specific resources for diabetes and metabolic syndrome through the State Group Health plan (e.g., Livongo®, YMCA Diabetes Prevention Program, Solera, Aetna One Advisor, Highmark CCMU), including coverage of select diabetes prescriptions and supplies at no cost to members

Actions SBO has taken to achieve the goal:

- Continued Transform Diabetes Care and communicated its availability to EGWP members
- Communicated the availability of various diabetic services available through the health plan
- Communicated the availability of diabetic services through the vision plan
- Collaborated with the Division of Public Health (DPH) and the Division of Medicaid and Medical Assistance (DMMA) on the Impact of Diabetes in Delaware 2023 Report
- Collaborated with health and prescription plan administrators, the YMCA of Delaware, Livongo®, Transform Diabetes Care, and Solera to provide and promote diabetic prevention and management services to eligible members
- Participated in the Greater Philadelphia Business Coalition of Health's Employer Action Collaborative on Obesity and Diabetes Interest Group
- Promoted availability of wellness events at Delaware hospitals

Results:

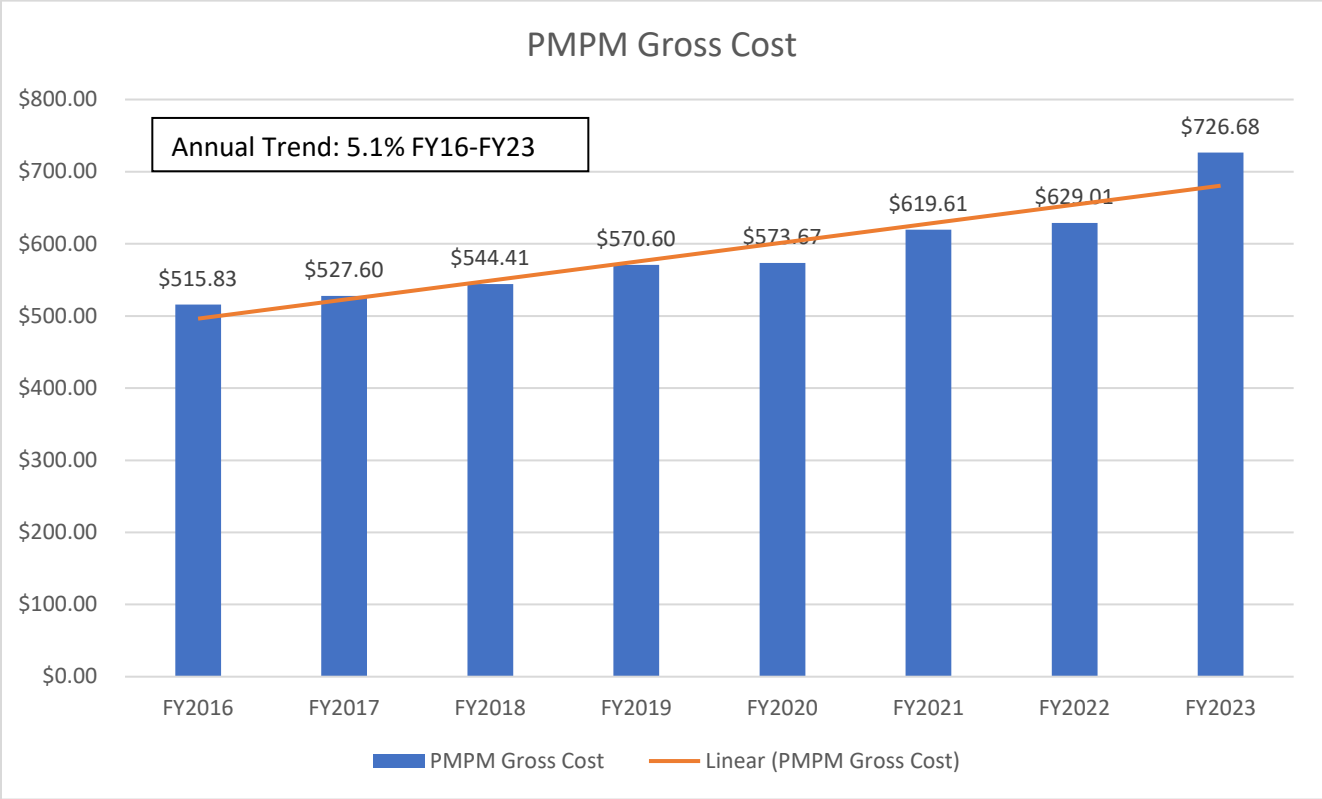
As a baseline, the FY2021 spend is $1,584 PMPM for diabetics. The FY2023 target of $1,741 PMPM for diabetics is based on an 8% overall reduction in projected FY2023 PMPM costs with an annual inflationary trend of 9.2% for combined medical and drug claims included. The inflationary factor is based on the average annual trend for medical and drug costs for diabetics of 9.2% from FY2017 to FY2021. The projected PMPM target of $1,741 for FY2023 results in an effective average annual trend of 5% for diabetics. For FY2023, there was a slight increase from FY2022 in PMPM spending for diabetics, from $1,559 in FY2022 to $1,568 in FY2023. As this increase is significantly below the 8% targeted trend and the PMPM target of $1,741, this goal was met.

Additional years of data may be necessary to determine our overall progress towards the goal. We have noticed that members with diabetes have higher rates of utilization when compared to the total GHIP population for all hospital admissions,

avoidable admissions, readmissions, emergency room visits, prescriptions, Primary Care Provider (PCP) visits, urgent care visits, outpatient lab and imaging visits, etc. As a direct result, members with diabetes have significantly higher medical and prescription drug costs. For some utilization categories (i.e., office visits and prescription drug scripts), considerably higher utilization rates among members with diabetes may reflect improved quality of and access to care, as well as improvements in diabetes self-management efforts. Over time, we expect to see a decline in the rate in which diabetic member costs increase as we work towards increasing member participation and engagement in diabetes management programs.

Goal: Limit total cost of care inflation for GHIP participants at a level commensurate with the Health Care Spending Benchmark by the end of FY2023 by focusing on specific components, which are inclusive of, but not limited to:

- **Outpatient facility costs**
- **Inpatient facility costs**
- **Pharmaceutical costs**



Why is this goal important?

The State of Delaware shares in the cost of health plan expenses with employees and retirees. State of Delaware employees and non-Medicare retirees contribute a maximum of 13.25% of the total monthly premium for the health plan selected (the amount deducted from pay/pension checks). The State of Delaware pays the remainder, ranging from 86.75% to 96% of the total monthly premium. With healthcare cost trend rising on average 6% annually and the State Group Health Insurance Plan's (GHIP) gross claims estimated to exceed $1.2 billion in FY2024, the State of Delaware has less available funds to invest in pay increases and cost of living adjustments. As partners, the State of Delaware and their enrolled health plan members can work together to slow the growth of healthcare expenses. The SBO asks members to be engaged healthcare consumers by using in-network providers, selecting the appropriate sites of care and seeing their primary care provider regularly to receive preventive care and assistance with managing chronic health conditions.

Tactics to meet the goal:

- Continued to educate GHIP members on lower cost alternatives to the emergency room for non-emergency care (e.g., telemedicine, urgent care centers, retail clinics)
- Continued to educate members on the availability of GHIP care management and risk reduction programs
- Continued to explore, implement and promote medical TPA programs and plan designs that help steer members to most appropriate sites of care without impacting quality of care delivered
- Continued to monitor utilization of SurgeryPlus and drive engagement through additional member education and ongoing review of incentives
- Evaluated competitiveness of State Group Health medical and Rx vendors' pricing for covered services and drugs against their competitors

Actions SBO has taken to achieve the goal:

- Created and distributed various communications regarding the appropriate sites of care including the availability of telemedicine services, the importance of preventive care and care management, and the availability and benefits of SurgeryPlus
- Created webinars to promote wise healthcare consumerism
- Provided materials and resources through SBO's website regarding quality, patient safety, and patient engagement
- Continued to hold medical TPAs accountable for expanding their pay-for-value contracts with providers
- Continued to promote tools and resources that help members identify high-quality, high-value providers
- Continued to require medical TPAs to submit GHIP claim data to the DHIN and to support value-based provider contracts (e.g., ACOs) where applicable
- Continued monitoring of SurgeryPlus benefit utilization and member engagement

Results:

Against an established national baseline trend of 6%, the GHIP has successfully fielded a lower trend (5.1%) over the past seven years from FY16 to FY23. However, against the Department of Health and Social Services (DHSS) established Health Care Spending Benchmark of 3.1% for Calendar Year 2023, the GHIP fell short*. Healthcare costs and trends are continuing to rise nationally and for the GHIP. Over the last few years, a variety of factors influenced upward trends, including:

- Physician/hospital supply shortage:
    - Hospitals and physicians are expected to seek higher rate increases (potentially also at a higher frequency) in contract negotiations.
    - Workforce shortages and physician consolidation can further amplify the effect.
    - Further, provider "burnout" and increased patient demand are expected to keep the pressure up on clinical workforces across the industry.
- Increasing cost of pharmaceuticals:
    - Employers are experiencing inflationary pressure from the rising median price of new drugs, as well as the increasing price of existing drugs.
    - Combined with the accelerated approvals of new cell and gene therapies, pharmacy trends are not expected to slow down in the next 3 to 5 years.

**The data collected and interpreted by the SBO and their vendors for this report is measured on a fiscal year basis and cannot be adequately compared against a calendar year benchmark.*

In addition to these trends, utilization of GLP-1 drugs for weight loss is expected to grow in the next 3 to 5 years given the positive efficacy data.

Please note that the Fund reflected a $32.2M COVID-19 expenditure reimbursement in FY22 which further contributes to the magnitude of increase when comparing FY22 to FY23.

Please also note that observed trend captures gross medical and prescription drug claims per member and excludes pharmacy rebates and Employer Group Waiver Plan (EGWP) payments.

Looking Ahead: FY2024 Strategic Plan

The FY2024 strategic plan reflects the desire of the Statewide Benefits Office (SBO) and the State Employee Benefits Committee (SEBC) to continue enhancing the mission of offering 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. Based upon the actions completed by the SBO in FY2023 towards achieving the goals set forth by the SEBC and the current projections of meeting the goals, the SBO has devised a FY2024 strategic plan that includes the following actions for the goals and strategies:

Goal: Using the Alternative Payment Model (APM) Framework and FY2023 medical spend as a baseline, increase GHIP spend through advanced APMs to be at least the following by the end of FY2025 (as % of total spend):

- **Category 3: 50%**
- **Category 4: 5%**

- Continue to support the DHIN, including encouraging participation by Highmark and Aetna, and other data-driven approaches to provider care delivery
- Continue to support efforts of the GHIP third-party administrators (TPAs) to establish advanced APM contracts (e.g., bundled payments, shared savings with downside risk, global budgets) with Delaware providers
- Continue to ensure members are aware of how to find high quality, high value providers
- Consider opportunities to partner directly with Delaware providers to promote greater adoption of advanced APMs
- Continue to evaluate opportunities to drive a higher proportion of GHIP spend from retrospective payments for quality care delivered (Category 3) to prospective payments for care and/or global budgets (Category 4)

Goal: Reduce per-member-per-month (PMPM) cost trend for the GHIP and for plan participants for the following conditions by the end of FY2025, using FY2023 spend as a baseline:

- **Diabetes: 8% for the GHIP / 0.33% for plan participants**
- **Behavioral health: 0.5% for the GHIP / 0.02% for plan participants**
- **Musculoskeletal: 2% for the GHIP / 0.08% for plan participants**

- Continue to leverage vendor-provided and community-based prevention and lifestyle risk management programs for diabetes and behavioral health conditions
- Continue to explore ways to expand access to behavioral healthcare, including reducing and/or removing financial barriers for plan participants
- Continue to promote use of Centers of Excellence for treatment of musculoskeletal conditions
- Continue to encourage member awareness and use of self-care resources and lifestyle risk reduction programs for these conditions to promote healthy lifestyles
- Leverage data on GHIP member demographics (where available) and social determinants of health to identify specific population segments and their unique needs to inform future program offerings and member communications/outreach to address health disparities
- Continue to explore opportunities to expand access to primary care for GHIP participants and support the efforts of Delaware's Primary Care Reform Collaborative

Goal: Limit total cost of care inflation for GHIP participants at a level commensurate with the Health Care Spending Benchmark by the end of FY2025 by focusing on specific components, which are inclusive of, but not limited to:

- **Outpatient facility costs**
- **Inpatient facility costs**
- **Pharmaceutical costs**
- **Bariatric surgery costs**

- Continue managing GHIP TPAs and medical/Rx coverage provisions to encourage use of the most appropriate sites of care and/or types of treatment for members' individual health needs
- Continue to offer and promote resources that will support member efforts to improve and maintain their health
- Continue to monitor GHIP claims experience to identify areas of unnecessary utilization
- Continue to promote use of Centers of Excellence for bariatric surgery
- Continue to monitor opportunities for carving out coverage of additional services to Centers of Excellence beyond bariatric surgery based on cost, access and utilization by GHIP participants

Goal: In light of the GHIP's changing demographic profile, strive for an incremental increase in unique users utilizing a specific point-of-enrollment and/or point-of-care engagement platform / consumerism tool by at least 5%

- Continue to drive GHIP members' engagement in their health and benefit coverage decisions
- Continue to ensure members understand benefit offerings and value provided
- Continue to promote and educate members on the importance of using decision support tools for plan selection and provider price/quality comparison
- Consider ways to meaningfully differentiate the GHIP medical plan options to meet the diverse needs of GHIP participants, and targeted programs to support special needs
- Monitor and evaluate opportunities with the State's benefit vendors that extend beyond just health plan consumer decision support