

Statewide Benefits Office FY22 Strategic Plan

Executive Summary

Based upon the actions completed by the Statewide Benefits Office (SBO) in FY21 towards achieving the goals set forth by the State Employee Benefits Committee (SEBC) and the current projections of meeting the goals, the SBO has devised a strategic plan that includes the following actions for the goals as well as other initiatives:

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% and Category 4 – 10%

- Conduct a RFP with the Proposal Review Committee for the Medical TPA contract
- Develop a library of instructor-led training courses that can be delivered virtually or in person to educate GHIP members about high-quality, high-value providers
- Notify GHIP membership of the release of Leapfrog's new hospital safety grades
- Distribute various communications regarding Centers of Excellence and SurgeryPlus
- Participate in the RAND study and utilize the data in the Delaware Health Care Claims database to compare our cost situation to other states

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

- Distribute various communications in April 2022 to increase awareness and promote the myBenefitsMentor® Consumer Decision Tool

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

- Establish the baseline for FY21 GHIP diabetic cost per-member-per-month
- Provide SEBC and Subcommittees with information on the primary care landscape in Delaware
- Promote various programs and services for diabetics and pre-diabetics including informational webinars, the Diabetes Prevention Program, Solera, Livongo, and DPH self-management workshops

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

- Distribute various communications regarding health plan features, appropriate sites of care, member testimonials, care management programs, the value of the benefits, and resources available to GHIP members
- Develop a library of instructor-led training courses that can be delivered virtually or in person to educate GHIP members about their benefits
- Create and distribute scorecards specific to each organization that outline how each organization ranked in achieving key metrics

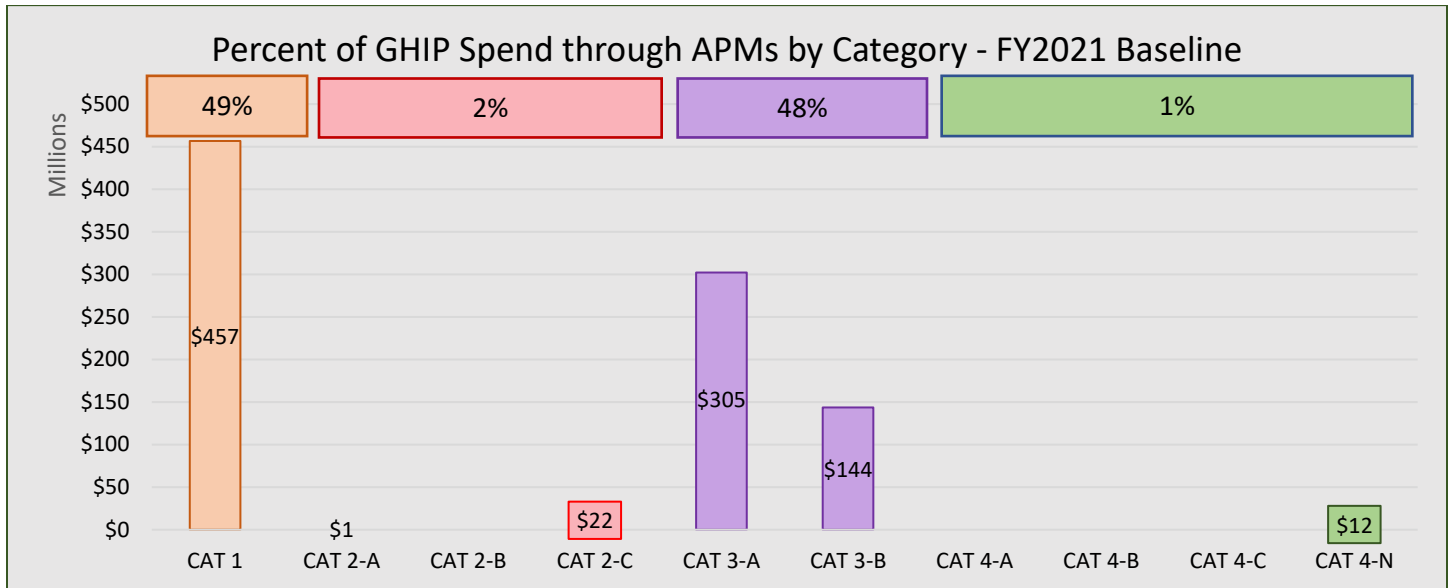
Other SBO Initiatives

- Disability Insurance Program assessment
- Dental RFP
- HIPAA risk assessment
- Healthcare and Actuarial Consulting RFP
- Retiree benefit modification study, Retirement Benefits Study Committee and changes to Medicare retiree health coverage

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 FY2021 (July 1, 2020 – June 30, 2021) 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:

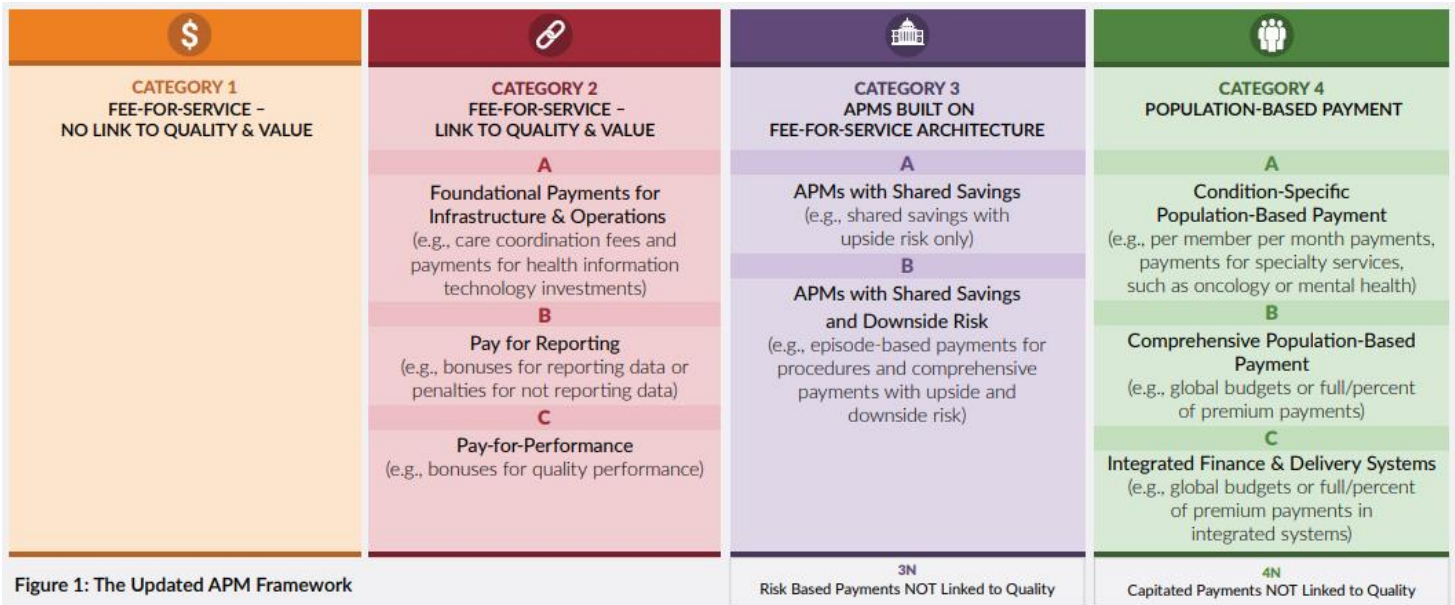


Figure 1: The Updated APM Framework

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

Why is this goal important?

Traditionally, employer-sponsored health benefits have often cycled between strategies that hold health care 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 health care 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 health care policy makers throughout the state.

Tactics to meet the goal:

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

Actions SBO has taken to achieve the goal:

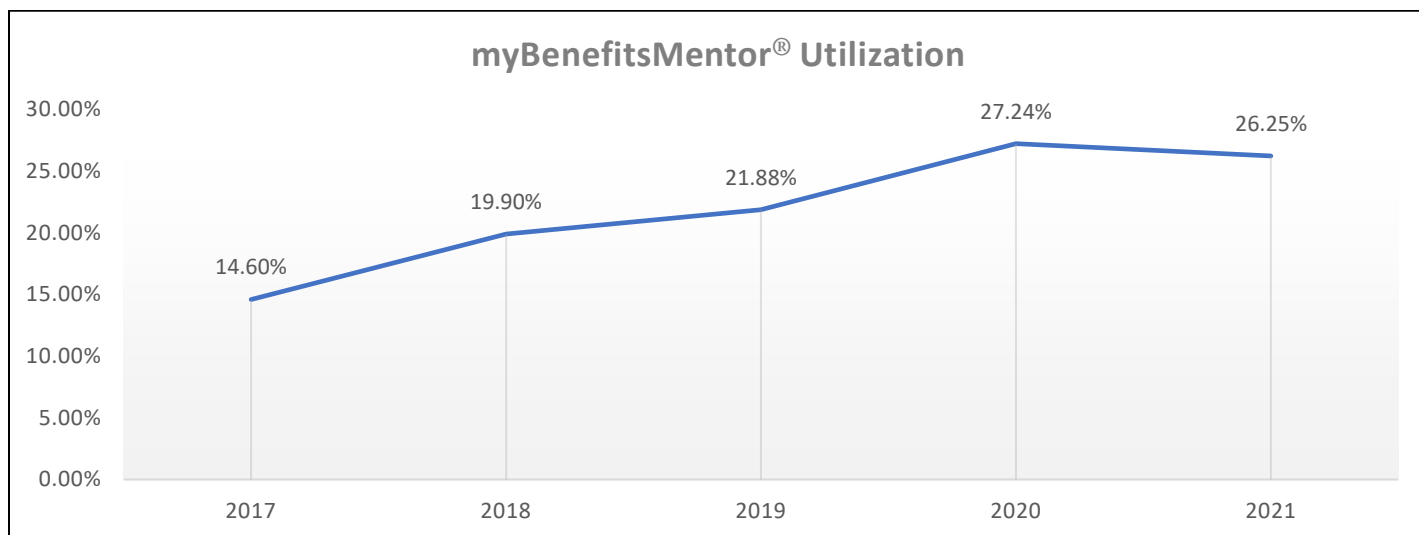
- Participated in the RAND 3.0 study and the Primary Care Collaborative
- Developed and issued a RFI to help create future RFPs based on TPA’s ability to expand their pay-for-value contracts with providers and to evaluate the readiness of provider marketplace in Delaware to assume additional financial risk
- While developing the RFPs, questions were added to determine and assess TPA’s ability to move the GHIP toward Category 3 and Category 4
- While developing the RFPs, questions were added to determine and assess TPA’s ability to submit GHIP claim data to the DHIN and support value-based provider contracts where applicable
- Specified quality and safety requirements in the RFP scope of services for medical TPAs

- Created and distributed various communications regarding high-quality, high-value providers

Results:

As a baseline, the FY2021 total medical spend (i.e., allowed amount, including both member cost share and plan payments), is \$941M, which includes \$449M (48%) in Category 3 and \$12M (1%) in Category 4 payment models. After adjusting for medical trend (5% annually), the FY2023 target (total medical spend) required to reach this goal is approximately \$415M (40%) in Category 3 - APMs built on Fee-For-Service architecture and \$104M (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

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 IBM Watson Health's myBenefitsMentor® directly relates to the State Employee Benefits Committee (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 employees as part of annual Open Enrollment and allows employees 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 employees 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 employee.

Tactics to meet the goal:

- Continue to promote healthcare consumerism and the importance of making informed decisions when enrolling in or changing benefits
- Continue to communicate the value of benefits provided along with member education resources
- Steer new employees to these tools
- Explore and implement new decision support tools and/or engagement solutions as the vendor marketplace for these continues to evolve
- Periodically evaluate 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

Actions SBO has taken to achieve the goal:

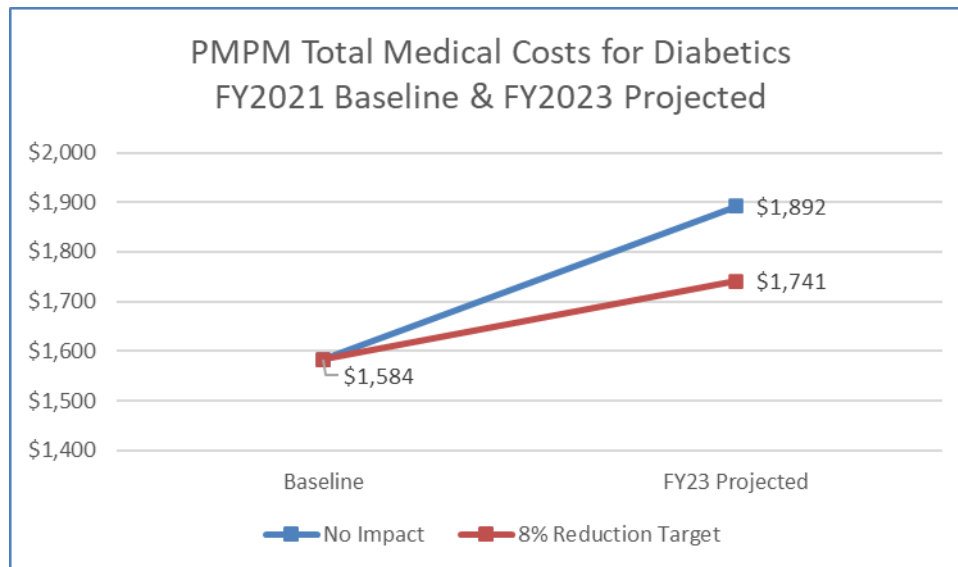
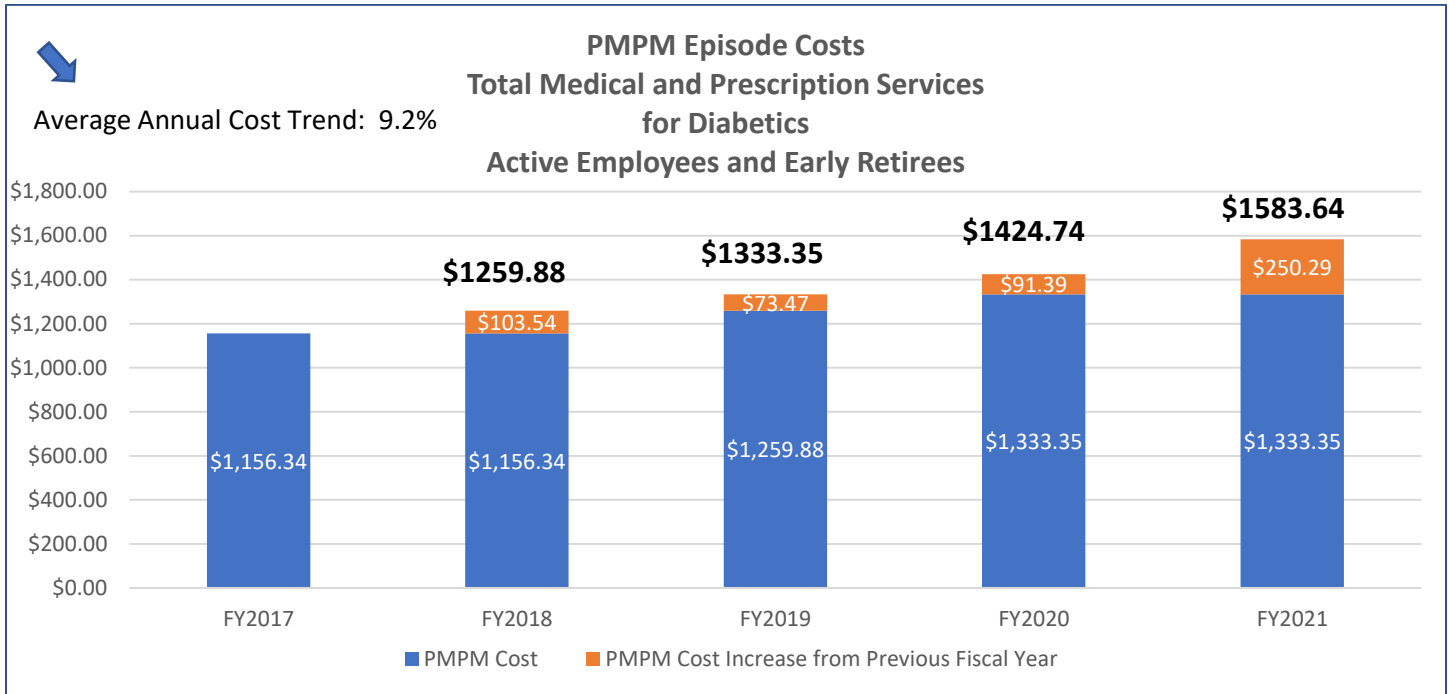
- Sent letters and emails to benefit-eligible individuals about myBenefitsMentor®
- While developing the medical RFP, questions were added to evaluate the vendor's ability and effectiveness at having members utilize a decision support tool

- Communicated availability of myBenefitsMentor® at various meetings and training sessions
- Assigned online training courses 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

Results:

We did not meet this goal in 2021. There was a decrease in utilization of the myBenefitsMentor® tool of 0.99%.

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. In FY2021, over 6,300 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 \$184.1 million. An additional 9,200 members were prediabetic at a total cost of treatment of \$82.9 million. Together, these members represented 14.4% of the total active employee and early retiree population and accounted for 35.7% of total healthcare expenditures. The State of Delaware and the State Employee Benefits Committee (SEBC) are committed to offering convenient, evidence-based programs to help our members manage diabetes and live healthy lives.

Tactics to meet the goal:

- Continue to offer condition-specific resources for diabetes and metabolic syndrome through the State Group Health plan (e.g., Livongo, Diabetes Prevention Program (DPP), CCMU), including coverage of select diabetes prescriptions and supplies at no cost to members
- Continue 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)
- Continue measuring diabetes prevalence, medical service/Rx utilization and cost ongoing vs. baseline
- Continue the Health Policy & Planning Subcommittee task of evaluating primary care access in Delaware

Actions SBO has taken to achieve the goal:

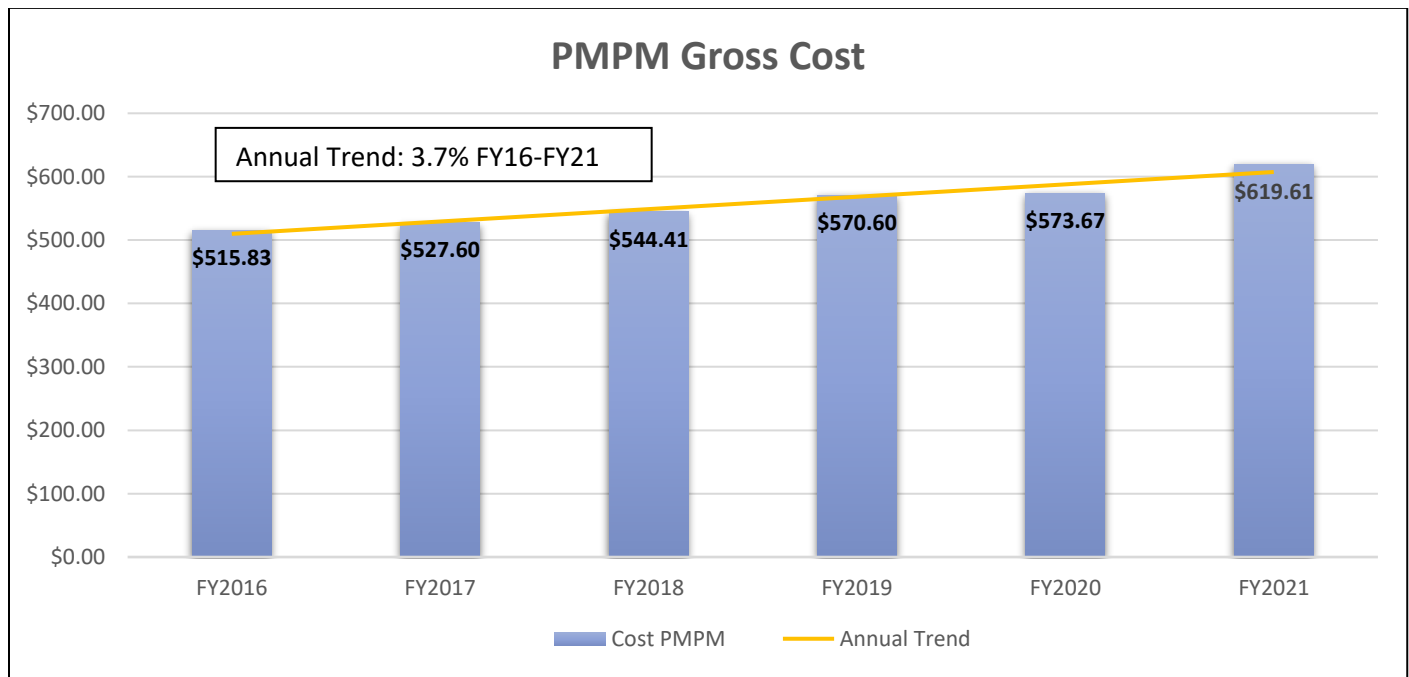
- Launched Solera and communicated its availability to Aetna members
- Communicated the availability of various diabetic services available through the medical plan
- Communicated the availability of diabetic services through the vision plan
- Provided State agencies and school districts with benchmark and organizational specific data on key metrics related to their employee population's use of services, health risk and condition treatment compliance
- Collaborated with health and prescription plan administrators, the YMCA of Delaware, Livongo® and Solera to provide diabetic prevention and management services to eligible members
- Compiled the HB203 report and provided it to the Delaware Legislature
- Presented information on the State DPP at the DPH Diabetes Conference
- 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 results in an effective average annual trend of 5% for diabetics. 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 the healthcare cost trend rising on average 6% annually and the State Group Health Insurance Plan (GHIP) expenditures estimated to reach \$900 million in FY2021, 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 Statewide Benefits Office (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:

- Evaluate competitiveness of the State Group Health medical and Rx vendors' pricing for covered services and drugs against their competitors
- Continue 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)
- Continue to educate GHIP members on lower cost alternatives to the emergency room for non-emergency care (e.g., telemedicine, urgent care centers, retail clinics)
- Continue to educate member on the availability of GHIP care management and risk reduction programs

- Continue to monitor utilization of SurgeryPlus and drive engagement through additional member education and ongoing review of incentives

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
- Provided state agencies and school districts with benchmark and organizational specific data on key metrics related to their employee population's use of services, health risk and condition treatment compliance
- Created and assigned online training regarding the benefits of healthcare consumerism
- Provided materials and resources through SBO's website regarding quality, patient safety and patient engagement
- Conducted RFPs to evaluate vendors' pricing based on covered services and drugs from competitors
- Participated in RAND 3.0 study and utilized the data in the Delaware Health Care Claims database to compare our cost situation to other states

Results:

The 2% reduction in gross trend for the GHIP is measured against an established baseline trend of 6%, yielding a target annual GHIP trend of 4% or less over the measurement period. It is important to note that the 6% baseline trend was established before the onset of the COVID-19 pandemic, which had significant impacts on health care utilization and expenditures in FY20 and FY21. From FY16 through FY21, GHIP gross claims per member increased by 3.7% annually. However, this figure includes the COVID-19 expenditure reimbursement payment of \$23.3M, which was paid to the Fund in June 2021 based on actual COVID-19 related expenses paid through March 2021. Reflecting the true FY21 claims cost, including FY21 COVID-19 expenditures of \$28.3M, the GHIP gross claims per member increased by only 4.1% annually from FY16 through FY21. Since COVID-19 expenditures were excluded from the baseline trend and will ultimately be reimbursed in full, the GHIP has successfully achieved a 2% reduction to gross GHIP trend through FY21. Note, observed trend captures gross medical and prescription drug claims per member and excludes pharmacy rebates and Employer Group Waiver Plan (EGWP) payments.