The State of Delaware

FY24 Planning

State Employee Benefits Committee

November 21, 2022

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Benefits Modernization Initiative / Employee Preferences Survey

Modernizing benefits initiative

Overview

- At the June 2022 SEBC meeting, an overview of this project was provided to the Committee
  - U.S. employee preferences are changing, and employers are re-evaluating and adjusting benefit offerings to meet employee needs
  - Like other employers, the State of Delaware is experiencing employee attraction and retention challenges, and evolving workforce demographics
  - SEBC is tasked with solving for the needs of both employees and retirees, ideally within the existing State funding
  - Opportunity exists to refine the benefits offered to employees and future retirees to ensure they continue to meet the needs of the State's diverse and changing workforce while allowing the State to continue attracting/retaining key talent
  - Would include a survey that would solicit input from State employees, higher education and school district personnel on benefits preferences and gaps for underserved populations
- Next steps
  - SEBC, SBO and WTW would work with the Subcommittees to evaluate options for GHIP benefits modernization for active employees and non-Medicare (pre-65) retirees
  - Recommendations would be brought before the SEBC in early 2023 which would include timing for phased-in approach starting with FY24

Modernizing benefits initiative

Updates since June 2022

- Work on the employee survey began in August 2022
  - Work group includes representation from SBO, Finance, Office of Pensions, Office of the State Treasurer, and DHR; group was selected to provide input on various topics that could be included in the benefits survey (health care, leave, deferred compensation, professional development, etc.)
  - Would solicit feedback from employees on current benefits and gauge interest in future benefits
  - Would also include questions about potential changes to their benefits upon retirement, such as eligibility for retiree medical benefits and vesting, in alignment with areas for further study that were captured in the March 2022 recommendations of the Retirement Benefits Study Committee
- To prepare the Subcommittees for this work, an overview of the project was provided during the August 2022 combined Subcommittee meeting
- Also in August, Subcommittee members were also provided with pre-read materials outlining the components and pros and cons of flexible spending accounts, health savings and reimbursement accounts and lifestyle spending accounts, which was on the agenda for discussion at a future meeting
- Subcommittees met in September to explore further plan design updates; however, further work on the project and survey had been postponed, which was reported to the SEBC in September

Next steps

- Survey work has restarted; targeting release of survey to employees in Q1 2023
- Further details on survey components and more specific timing will be provided to the SEBC and the Subcommittees in December
- SEBC to provide direction on prioritization of Subcommittee areas of focus related to modernizing benefits and other initiatives

SEBC Subcommittee Areas of Focus

Planning considerations for FY24 and beyond

Overview

- SEBC annual budget process and decisions on plan design/rate setting for the 2024 fiscal year (starts on July 1, 2023) must be completed no later than mid-March 2023
- Current long-term financial projections for the GHIP are reflecting a multi-year deficit; with no changes to current benefits, there is an inability to solve this deficit fully without additional funding
- The work of the Subcommittees is directed by the SEBC, which includes a thorough vetting of potential policy and plan changes culminating with recommendations on next steps to the SEBC
- Input from Subcommittee members during recent meetings has included topics that are not short-term in nature; included for discussion in today's material

Planning considerations for FY24 and beyond

- Following slides outline considerations for various initiatives that have been discussed in recent Subcommittee meetings, broken out by those initiatives with a shorter planning timeframe (i.e., effective 7/1/2023) and a longer planning timeframe (i.e., effective 7/1/2024 or later)
- Unless the SEBC provides direction otherwise, recommend that the Subcommittees continue focus on short-term items listed below to prepare recommendations for the SEBC no later than February 2023
- Suggest that further pursuit of longer-term items is paused pending resolution of items for FY24

Short-term: FY24

- PrudentRx
- Cell & gene therapies
- Plan design and drug formulary changes
- Plan design adjustments pending outcome of Inclusive Benefits Review
- Underwrite medical premiums separately for active employees and non-Medicare retirees

Long-term: FY25 or later

- Carving-out coverage of additional procedures to SurgeryPlus
- Implement a high deductible health plan with an HSA ("HSA plan")
- Primary care clinics
- Direct contracting with a hospital system
- Pre-65 marketplace
- Reference-based pricing
- Remove medical TPA(s) and administer plans in-house

Short-term initiatives: FY24

Initiative	Potential Scope of Impact		Pros	Cons
PrudentRx	**Medical plans**	PPO, HMO, CDH Gold, FSB	• Members who opt into the PrudentRx program can enjoy $0 copays (no member cost share) for specialty drugs, regardless of whether drug manufacturer copay assistance is available. (The cost of drugs with no copay assistance programs will be subsidized by the plan's net savings from drugs with copay assistance. According to PrudentRx, about 94% of specialty brand drug scripts have copay assistance.) • CVS-estimated net annual savings for PrudentRx is $6.6m (excluding HIV and fertility medications; requires member engagement to enroll in the program, and savings estimate assumes 100% enrollment)	• Requires the SEBC to create a new specialty drug coverage tier at 30% coinsurance (which reduces to $0 if a member enrolls in PrudentRx) • Requires members to take action to enroll in PrudentRx program when prompted by PrudentRx outreach, otherwise members will pay 30% coinsurance for the specialty drug • About 1,600 members in FY22 filled prescriptions that would be subject to the program (Rx count excludes fertility and HIV medications) • Members would lose the benefit of one "grace fill" at retail for all specialty drugs except HIV medication (which is available at any retail pharmacy through CVS's Open Network)
	GHIP participants	Active employees, non-Medicare pensioners (and covered dependents)		
	Potential effective date	7/1/2023 (FY24)		
Cell and Gene Therapies *Details from Aetna and Highmark on the number of members potentially impacted and the potential savings to the GHIP are being requested.*	**Medical plans**	PPO, HMO, CDH Gold, FSB	• Most of the major national and regional medical carriers have cost management strategies available to plan sponsors today, including utilization management such as prior authorization or site-of-care steerage; both Aetna and Highmark require prior authorization for these therapies today • As an optional program, Aetna offers a narrow network of providers with negotiated pricing and navigation and travel assistance to members for a subset of gene therapies	• If any of these drugs are being utilized by GHIP participants today, there would be the potential for member disruption as a result of these utilization management programs
	GHIP participants	Active employees, non-Medicare pensioners (and covered dependents)		
	Potential effective date	7/1/2023 (FY24)		

Short-term initiatives: FY24

Initiative	Potential Scope of Impact		Pros	Cons
Plan design and drug formulary changes *Includes but not limited to potential changes to the following elements of the medical/Rx plans: deductibles, coinsurance, copays, site-of-care steerage changes (copay changes, adding new services to steerage options such as ASCs[1]), weight management strategy (such as adding coverage for weight loss drugs to the drug formulary).*	**Medical plans**	PPO, HMO, CDH Gold, FSB	• Helps reduce magnitude of FY24 rate action (i.e., lowers required premium increase) • Only affects utilizers of medical/Rx benefit • Encourages health care consumerism by increasing member financial accountability for services incurred	• Produces plan savings through shifting a portion of cost to plan participants • May be more difficult for plan participants who are lower paid and/or on a fixed income to pay for necessary medical care • May cause some members to avoid seeking medical care out of concern for incurring additional out-of-pocket cost • Specifically for prescription drug formulary changes, may add cost to the plan for expanding coverage for weight loss medications
	GHIP participants	Active employees, non-Medicare pensioners (and covered dependents)		
	Potential effective date	7/1/2023 (FY24)		
Plan design adjustments pending outcome of Inclusive Benefits Review	**Medical plans**	PPO, HMO, CDH Gold, FSB	• Low/minimal cost impact changes given low utilization of plan design features that could potentially change (such as gender reassignment surgery), but high value for targeted underserved members of the GHIP • Supports the State's Inclusion and Diversity efforts • Increased wellbeing, engagement, and productivity for impacted members	• Not necessarily a cost savings item, and some recommendations may require a small cost investment
	GHIP participants	Active employees, non-Medicare pensioners (and covered dependents)		
	Potential effective date	7/1/2023 (FY24)		

1 ASCs = Ambulatory Surgery Centers.

Short-term initiatives: FY24

Initiative	Potential Scope of Impact		Pros	Cons
Underwrite medical premiums separately for active employees and non-Medicare retirees *GHIP active and pre-65 retirees are currently rated together as one risk pool, with consistent budget rates and contributions for each population. Based on WTW's FY22 Q4 financial report, pre-65 retirees cost significantly more than active employees on a per member per year (PMPY) basis ($10,752 vs. $6,924 PMPY, respectively). Based on current rating methodology, a 17.2% rate increase is needed 7/1/2023 for all statuses, plans and coverage tiers, to solve for the projected FY24 deficit of $143.5m (based on long-term projections presented to SEBC 11/21/22).*	**Medical plans**	PPO, HMO, CDH Gold, FSB	• Rating actives and pre-65 retirees on their own experience does not require legislative change • Rating each population individually would create separate budget rates that match experience for each population, while maintaining existing cost share by plan set by House Bill 81 • Rating active and pre-65 retirees separately based on their own experience would lower the rate increase necessary for active employees to +10.5% (as of October 2022) • Reduction in active contributions relative to current rating methodology could be used to offset increases in cost attributable to potential plan design changes (e.g., deductibles) • While pre-65 retirees would see a significant increase in their contributions if rated separately from actives, there are options available to the State to mitigate this impact for retirees, while creating savings opportunities for the State, including the pre-65 retiree marketplace	• Rating active and pre-65 retirees separately based on their own experience would increase the rate increase necessary for non-Medicare retirees to +40.4% (as of October 2022)
	GHIP participants	Active employees, non-Medicare pensioners (and covered dependents)		
	Potential effective date	7/1/2023 (FY24)		

Long-term initiatives: FY25 or later

Initiative	Potential Scope of Impact		Pros	Cons
Carving-out coverage of additional procedures to SurgeryPlus *Types of procedures for carve-out recommended by SurgeryPlus: Total Joint (hip/knee replacements, revisions) and Spine.*	**Medical plans**	PPO, HMO, CDH Gold, FSB	• Ensures members are using high quality, cost-efficient providers for these procedures • Members pay $0 out-of-pocket cost for using a SurgeryPlus provider • Consistent member experience and concierge support from SurgeryPlus • SurgeryPlus estimated annual savings of approximately $7M+ includes a broader scope of joint procedures including shoulder and ankle surgeries; WTW to validate this estimate and confirm financial impact if only some joint procedures (e.g., hip, knee) were carved out • Following implementation of bariatric surgery carve-out to SurgeryPlus, SEBC can leverage lessons learned to improve member experience under additional carve-outs	• May cause some disruption to members who have already decided upon a surgeon for these types of surgeries and may need to change surgeons to one participating with SurgeryPlus • May be no ability to make exceptions and allow these procedures, like bariatric, to be covered and paid under the health plans • Mandatory nature of the SurgeryPlus program warrants reconsideration of whether additional financial incentives continue to be paid to plan participants who access the program (may be seen by members as a takeaway) • Few plan sponsors have opted to carve out coverage for two or more types of surgeries to SurgeryPlus; vendor has limited experience coordinating beyond bariatrics with Aetna and Highmark • The universe of CPT codes for total joint and spine is broader than with bariatric surgery and may be administratively more difficult for the TPAs to turn off coverage • May be more difficult to communicate to members the types of procedures subject to this requirement • May cause noise among the orthopedic community in Delaware • Per SurgeryPlus policy, members for whom the GHIP pays secondary are not eligible for the SurgeryPlus program • TBD: adequacy of SurgeryPlus provider network in Delaware to accommodate SurgeryPlus recommendations for other carve-out procedures
	GHIP participants	Active employees, non-Medicare pensioners (and covered dependents)		
	Potential effective date	7/1/2024 (FY25) or later (allows time for review of results from bariatric surgery carve-out)		

Long-term initiatives: FY25 or later

Initiative	Potential Scope of Impact		Pros	Cons
Implement a high deductible health plan with an HSA ("HSA plan")	**Medical plans**	New plan option; SEBC to decide whether to offer in lieu of or alongside of CDH Gold plan	• Provides tax advantaged vehicle for plan participants to save and pay for qualified health care expenses • Strong emphasis on member financial accountability for health care utilization choices and selection of most appropriate sites of care • Will reduce claim costs for HSA plan participants through higher deductible and potentially avoided unnecessary care • May be a tool for attraction/retention of State employees, particularly younger, healthier employees (matches demographic of typical HSA plan enrollees)	• Requires extensive member education efforts and decision-support tools before, during and post-implementation • May cause some participants to delay or avoid seeking necessary care over concerns about out-of-pocket cost • Some participating groups may lack a mechanism for allowing participants to make pre-tax payroll contributions to an HSA; SEBC to consider whether this plan option would be offered to participating groups • If offered in lieu of CDH Gold plan, may be viewed as a takeaway for long-term CDH Gold participants who have built up large HRA balance (per IRS, HRA-to-HSA fund transfers are prohibited since 2012) • If offered alongside of CDH Gold plan, will create additional administrative effort for SBO, State payroll and HR/Ben Reps to maintain this as a 5th plan option • Due to IRS requirement that HSA plan participants pay fair market value for covered medical/Rx expenses until deductible is met, adjustments to member cost sharing for the following benefits offered at no cost would need to be made for HSA plan participants: SurgeryPlus benefits and Hinge Health; this would also include PrudentRx, if implemented
	GHIP participants	Active employees, non-Medicare pensioners (and covered dependents)		
	Potential effective date	7/1/2024 (FY25) or later (requires time for vendor selection, implementation and member education)		

Long-term initiatives: FY25 or later

Initiative	Potential Scope of Impact		Pros	Cons

Primary care clinics
 	
SEBC and Subcommittees have previously evaluated options for expanding primary care access via employer-sponsored clinics via a Request-for-Information from primary care clinic vendors (2017). Several primary care clinic vendors presented before the combined Subcommittees during 2019. Additional work has been conducted to study plan participants' access to primary care and continues to be monitored by the SBO and presented to the Subcommittees on a regular basis.
 	
Open questions remain regarding potential clinic locations, scope of services, vendor partners and financial feasibility of this offering despite some clinic operators' offers to fund start-up costs for the State.
	Medical plans	HMO and CDH Gold only	• Expands access to primary care for a subset of GHIP participants, which supports the GHIP Strategic Framework goal related to reducing the per-member cost for plan participants with diabetes
			• Aetna proposed an arrangement with Everside Health, a primary care clinic operator, in their response to the 2021 Medical TPA RFP; some considerations:
			  • Everside Health has agreed to absorb any start-up cost associated with building out the clinics, so the State would only pay for ongoing access
			  • Current offer from Aetna/Everside Health (without further negotiation) includes performance guarantees for member engagement and return on investment; Subcommittee recently inquired about opportunity to expand those guarantees such that they are tied to reducing total cost of care for Aetna members, which would require additional negotiation to explore with Aetna/Everside Health
				• Aetna proposed an arrangement with Everside Health, a primary care clinic operator, in their response to the 2021 Medical TPA RFP; some considerations:
				  • Since this arrangement was included in Aetna's 2021 Medical TPA RFP response with Everside Health as an Aetna subcontractor, it is only available to Aetna plan participants
				  • Would add $7m+ in annual cost to the plan for ongoing access; may be offset by savings over the long term but requires further WTW validation of savings estimate
				  • Without any additional medical plan design changes, there is no way for the SEBC to guarantee a minimum level of participation as members wouldn't be required to use the clinics for care
				  • It is possible that the clinics could recruit primary care providers from the local Delaware community, which could reduce overall primary care capacity in the state by limiting those providers to Aetna GHIP members only
				• Exploring options for the entire covered population (not just Aetna members) will take more time for planning and vendor selection, along with a larger investment in ongoing operating expenses or access fees

	GHIP participants	Active employees, non-Medicare pensioners (and covered dependents)		
	Potential effective date	7/1/2024 (FY25) or later (requires time for vendor selection, clinic build-out, implementation and member education)		

Long-term initiatives: FY25 or later

Initiative	Potential Scope of Impact		Pros	Cons
Direct contracting with a hospital system *In anticipation of establishing a direct contract with a hospital system, the SEBC would need to revisit and refresh prior analyses of the Delaware provider marketplace to understand hospital system readiness and experience with direct contracts, member access and potential disruption, cost and quality measures by hospital system and capabilities to support member services such as appointment availability, specialist access, call-center support and care management.*	**Medical plans**	Medical options affected depends on the nature of the contract	• Would provide transparency into provider pricing arrangements for the services governed under the direct contract • GHIP may achieve more favorable pricing than the medical TPAs could with a direct contract (but no guarantee)	• Delaware has limited options for directly contracting with a hospital system in the state's highly concentrated provider market (ChristianaCare and BayHealth are already capturing the majority of GHIP hospital-based claims) • Plan design changes may be necessary to ensure adequate member volume can be directed through the direct contract (would provide the State with greater negotiating leverage) • Highmark and Aetna may not be willing to administer the terms of the direct contract, which would potentially require a new standalone limited network plan. To administer this, the State would need to contract with a different third-party administrator for claims processing and payment under the direct contract and any wrap-around network services • Significant administrative effort will be required to negotiate a direct contract, establish a wrap-around provider network to fill any gaps in services offered that aren't available through the direct contract, manage the ongoing administration and measure the results • Extensive member education and communications will be required to ensure plan participants are effectively informed of any plan design changes or considerations associated with the direct contract
	GHIP participants	Active employees, non-Medicare pensioners (and covered dependents)		
	Potential effective date	7/1/2024 (FY25) or later (requires significant effort to implement, operate and manage)		

Long-term initiatives: FY25 or later

Initiative	Potential Scope of Impact		Pros	Cons
Pre-65 marketplace	**Medical plans**	PPO, HMO, CDH Gold, FSB	• Offers plan participants a broad choice of insurers, options and coverage levels through the expanded public exchange marketplace • Reduces administrative burden on the SBO and Pension Office to manage annual enrollment and member communications • The State can continue providing a subsidy through a tax-free HRA to help pensioners pay for coverage • Savings for any pensioner who qualifies for premium tax credits and elects to forgo the HRA for a public marketplace plan • Mitigates impact of possible future rate action if non-Medicare pensioners are rated separately from active employees • Pensioners have the flexibility to choose and change plans that offer benefits that matter the most for individual pensioners • Reduces the State's OPEB liability	• Will require a procurement since none of the State's current vendor partners offer this capability today • Since non-Medicare pensioners are currently eligible for the same medical plan options as active employees, implementing a pre-65 marketplace will not eliminate the administrative burden required to manage the medical plan options currently available to non-Medicare pensioners • Any changes to the current medical benefits that non-Medicare pensioners receive may prompt complaints from pensioners • TBD: Changes to the GHIP Eligibility & Enrollment rules, and Delaware Code, may be necessary to allow for this option (for confirmation by the State's legal counsel)
	GHIP participants	Non-Medicare pensioners and covered dependents only		
	Potential effective date	7/1/2025 (FY26) or later (requires time for selection of a vendor partner that would provide navigation and enrollment support, implementation and member education)		

Long-term initiatives: FY25 or later

Initiative	Potential Scope of Impact		Pros	Cons
Reference-based pricing *Ways to implement:* • *Via Highmark and Aetna for a limited list of outpatient medical procedures and imaging services (e.g., MRI, CT scans)* • *Via other third-party administrators that do not maintain networks or provider agreements and negotiate provider acceptance of reference price without balance billing to the member; may be applicable to a narrow or broad set of procedures and/or provider types*	**Medical plans**	Medical options affected depends on the scope of the reference-based price caps	• Only constrains prices of the provider organizations with the highest amount of leverage • Does not add costs to bring lower-paid providers up to the set level • If administered by Highmark and Aetna, could implement for high tech imaging services (specifically MRI and CT scans), which is a pain point for members and the State • Nearly all outpatient medical procedures available for reference-based pricing under Highmark and Aetna are also available through SurgeryPlus at no cost to members • If administered by another third-party administrator, at least one of those administrators offers support for members who are balanced billed and will take the lead on challenging providers' billing collections departments	• Few employers have implemented reference-based pricing through Aetna or Highmark (requires more recent update from the carriers, but there were only one or two plan sponsors across either carrier's book of business who had this in place when we last inquired in late 2018) • May require a procurement if the State decided to implement via another third-party administrator outside of Highmark and Aetna • Other third-party providers that administer reference-based pricing typically rely on inefficiencies in hospital billing departments to successfully push through a small number of patients who are paying the reduced reference price for services (i.e., customer's balance bill may be 1 of 50 outstanding balance bills that a hospital has to chase, so volume is low enough right now for most hospitals to accept the third-party administrator's payment of the reference price and move on) • Other third-party providers that administer reference-based pricing require members to reach out to the TPA when members receive a balance bill; this requires effort to educate members and places responsibility on the member to be aware of the process for obtaining further support. This could also generate member complaints if the process takes longer than anticipated
	GHIP participants	Active employees, non-Medicare pensioners (and covered dependents)		
	Potential effective date	7/1/2025 (FY26) or later (TBD based on scope of procedures / provider types included, vendor partner selection, and reference-based price ceilings)		

Long-term initiatives: FY25 or later

Initiative	Potential Scope of Impact		Pros	Cons
Remove medical TPA(s) and administer plans in-house	**Medical plans**	PPO, HMO, CDH Gold, FSB	• May provide the SEBC with more control over the administration of the GHIP, but at a significant cost	• Virtually all self-funded plan sponsors that are the size of the GHIP partner with medical TPAs to administer their medical plans • Requires extensive operations, administrative and clinical support that the SBO/DHR is likely not set up to manage based on current staffing; this support would include mechanisms for enrolling members, issuing ID cards, paying claims, administering utilization and care management, maintaining a provider network (either rent or build), establishing clinical policy guidelines to support coverage decisions, reviewing clinical appeals, taking calls from members that would have otherwise called Highmark or Aetna for assistance, and providing after hours support for urgent coverage or clinical issues
	GHIP participants	Active employees, non-Medicare pensioners (and covered dependents)		
	Potential effective date	7/1/2025 (FY26) or later (requires significant effort to implement, operate and manage)		

Next steps

- SEBC to provide direction on prioritization of Subcommittee areas of focus