Statewide Benefits Office FY2023 Strategic Plan

Executive Summary

Based upon the actions completed by the Statewide Benefits Office (SBO) in FY2022 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 FY2023 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%

- Implement training courses 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
- Monitor disease management program participation, utilization, and costs through quarterly reporting
- Add 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 health care services
- Work with health plan TPAs to develop a communications strategy that educates members about safety and quality
- Continue participation in the RAND study and utilize 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

- Distribute various communications to increase awareness and promote the myBenefitsMentor® Consumer Decision Tool
- Include information about the myBenefitsMentor® Consumer Decision Tool in new hire communications/forms
- Support 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

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

- Provide SEBC and its Subcommittees with information on the primary care landscape in Delaware
- Distribute various communications to increase awareness and encourage participation in covered services, including diabetes prevention programs (DPP) (Livongo DPP, Solera DPP, and YMCA DPP) and diabetes management programs (Livongo Diabetes Monitoring Program and Transform Diabetes Care Program)
- Promote DPH diabetes self-management program, as well as health-related classes/events offered by local hospitals
- Provide GHIP data for the HB203 "Impact of Diabetes in Delaware" Report that will go 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

- Distribute 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
- Implement training courses to educate GHIP members about their benefits

- Create and distribute scorecards specific to organizations that outline how each organization ranked in key metrics
- Develop communications, educate GHIP members, and implement Hinge Health (a virtual exercise therapy program) effective January 1, 2023
- Develop communications and begin to educate GHIP members about the bariatric surgery carve-out through SurgeryPlus effective July 1, 2023
- Work with SEBC's consulting partner, Willis Towers Watson (WTW), to bring forth options for evaluation by the SEBC to help solve for the Fiscal Year 2024 projected deficit
- Continue monitoring SurgeryPlus utilization and member engagement strategy

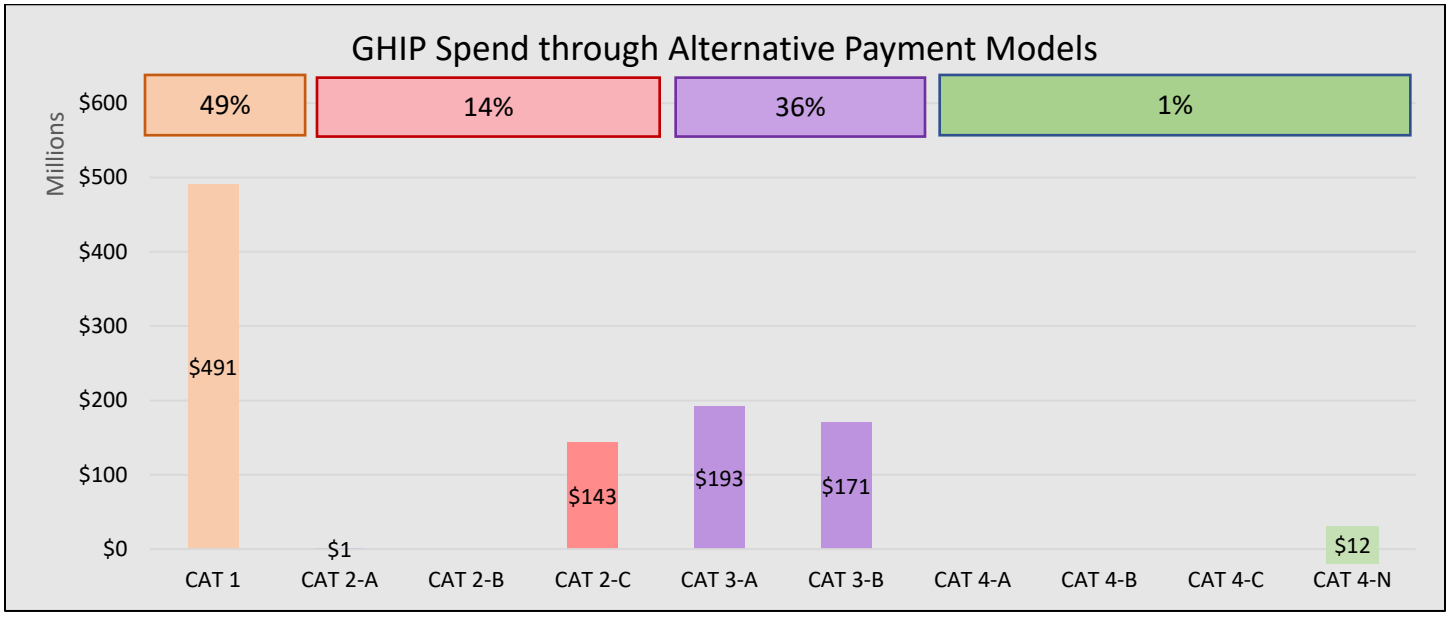
Other SBO Initiatives

- Medicare Open Enrollment
- Total Rewards Optimization (TRO) - Employee Benefits Modernization Survey
- Retiree Benefit Modifications
- Work on recommendations from Disability Insurance Program (DIP) Operational Assessment

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 FY2022 (July 1, 2021 – June 30, 2022) 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:

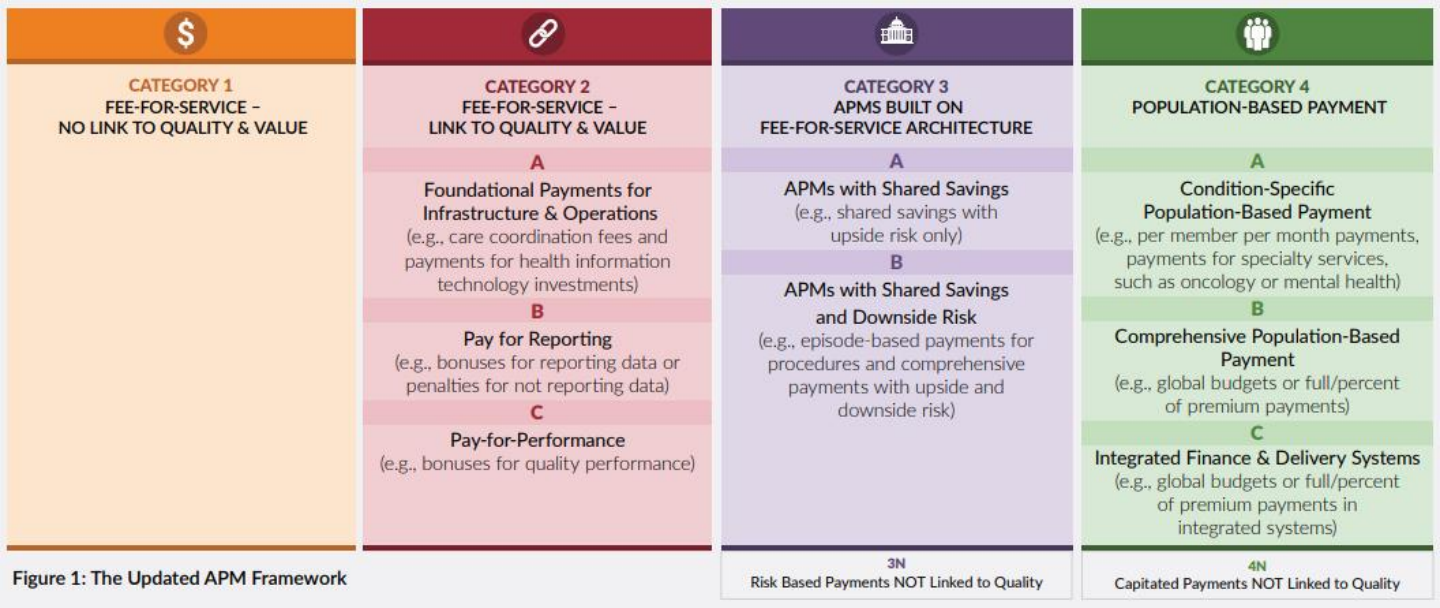


Figure 1: The Updated APM Framework

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 health plan 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 health plan 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

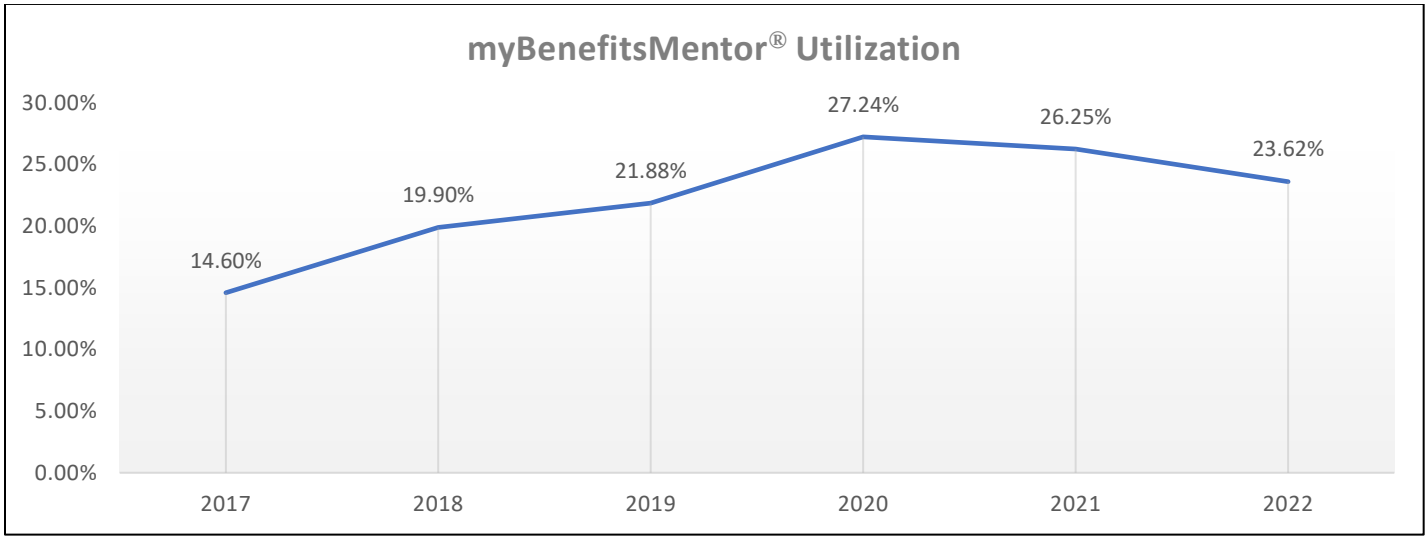
Actions SBO has taken to achieve the goal:

- Participated in the RAND 4.0 study and the Primary Care Collaborative
- While conducting the RFPs, questions were asked to determine and assess TPA's ability to move the GHIP toward Category 3 and Category 4
- While conducting the RFPs, questions were asked 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 health plan TPAs
- Finalized contract and performance guarantees with health plan TPAs
- Created and distributed various communications regarding high-quality, high-value providers

Results:

FY2022 total medical spend (i.e., allowed amount, including both member cost share and plan payments), is $1,008M, which includes $363M (36%) 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 $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 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 throughout the year. The tool 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 health plan options and price tags to encourage meaningful differences to prompt a greater need for members to utilize decision support

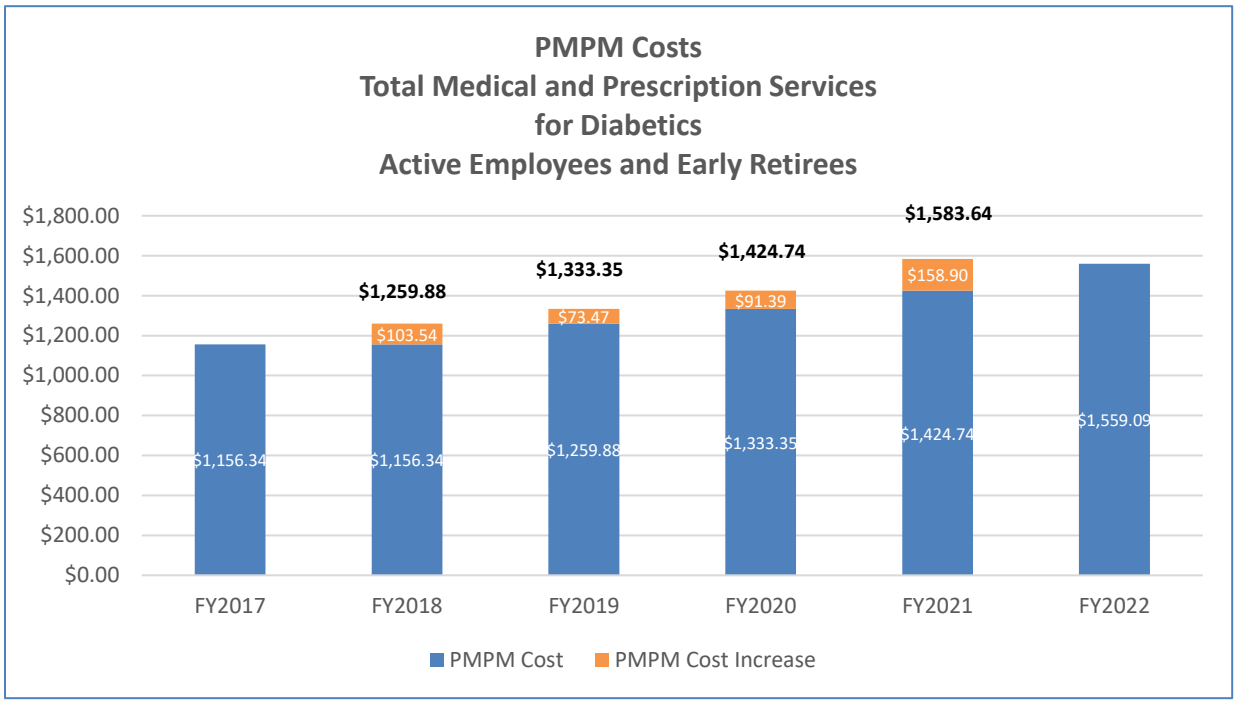
Actions SBO has taken to achieve the goal:

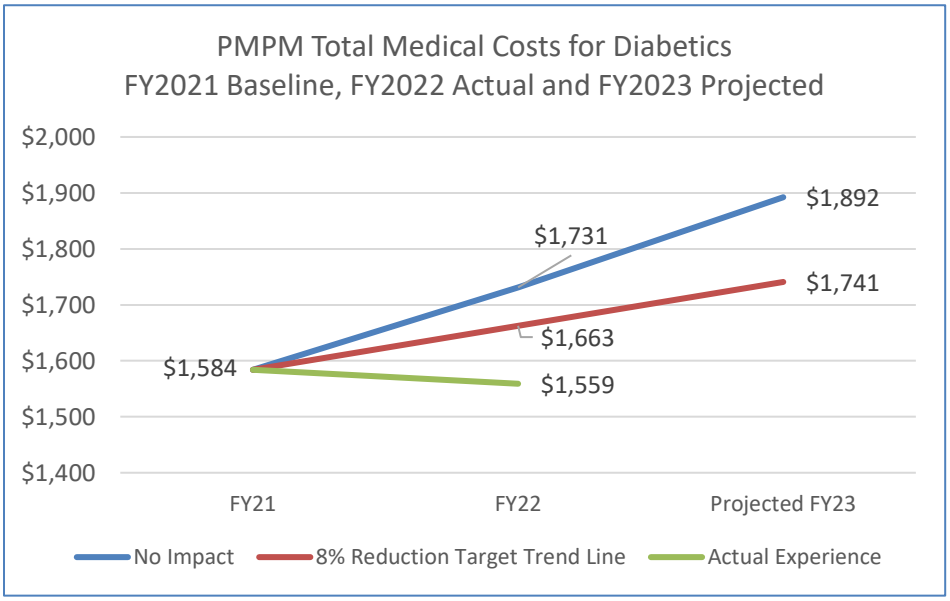
- Sent emails to benefit-eligible individuals about myBenefitsMentor®
- While developing the health plan TPA RFP, questions were added to evaluate the vendor's ability and effectiveness at having members utilize a decision support tool
- Implemented the myBenefitsMentor® platform availability to new 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:

We did not meet this goal in 2022. There was a decrease in utilization of the myBenefitsMentor® tool of 2.63%.

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 FY2022, 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 $184.3 million. An additional 9,600 members were prediabetic at a total cost of treatment of $78 million. Together, these members represented 14.7% of the total active employee and early retiree population and accounted for 34.1% 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:

- 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 Transform Diabetes Care and communicated its availability to EGWP members
- As a result of the competitive RFP process for the State's health plan TPAs in 2022, many program enhancements around disease/care management to support members overall health and conditions like diabetes will be implemented in FY2023
- Communicated the availability of various diabetic services available through the health plan
- Communicated the availability of diabetic services through the vision plan
- Provided State agencies 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®, Transform Diabetes Care, and Solera to provide and promote diabetic prevention and management services to eligible members
- Participated in the Delaware National Diabetes Prevention Program State Engagement and Pillar Meetings coordinated by Delaware's Division of Public Health (DPH)
- Promoted availability of wellness events at Delaware hospitals

Results:

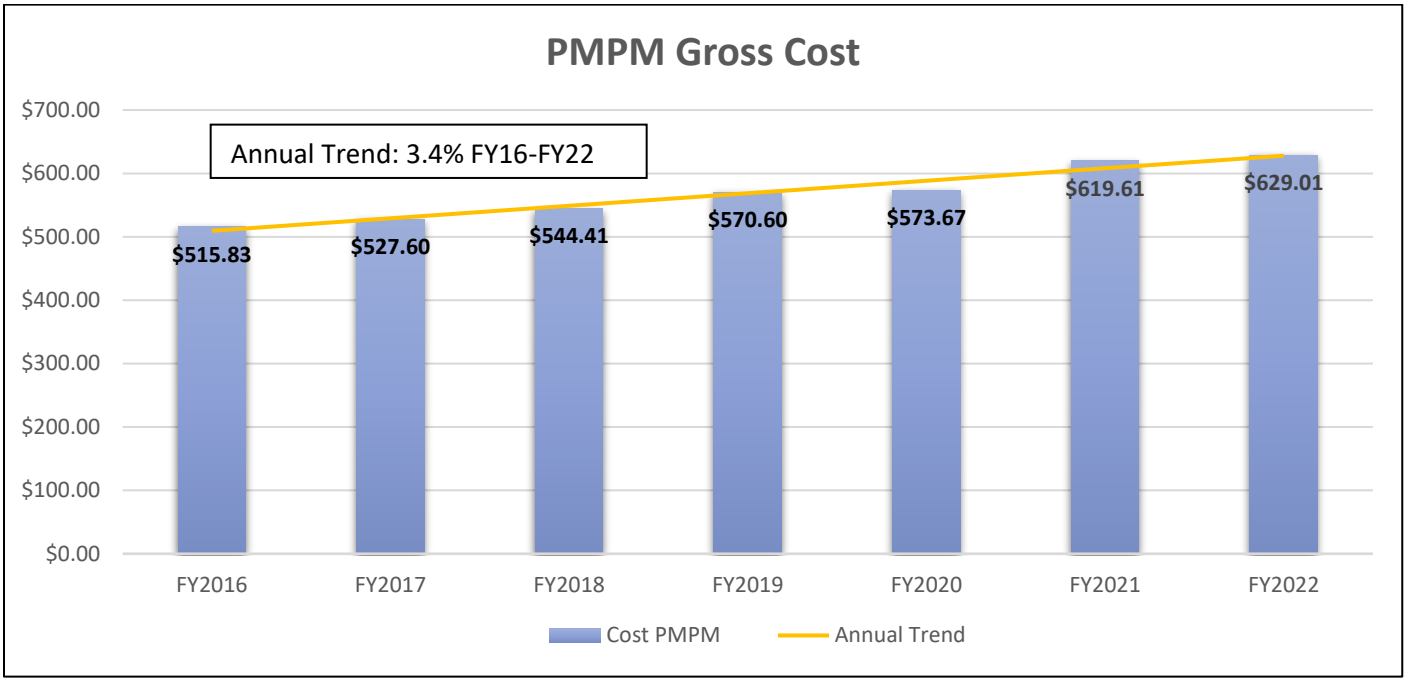
As a baseline, the FY2021 spend is $1,584 PMPM for diabetics. The FY2023 target of $1,741 PMPM for diabetics is based on an 8% overall reduction in projected FY2023 PMPM costs with an annual inflationary trend of 9.2% for combined medical and drug claims included. The inflationary factor is based on 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. For FY2022, there was a slight decrease from FY2021 in PMPM spending for diabetics, from $1,584 in FY21 to $1,559 in FY2022.

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 $1.1 billion in FY2023, 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 and Rx vendors' pricing for covered services and drugs against their competitors
- Continue to explore, implement, and promote health plan 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 members 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 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 webinars to promote healthcare consumerism
- Provided materials and resources through SBO's website regarding quality, patient safety, and patient engagement
- Reviewed and analyzed CVS's savings programs and point-of-sale utilization management
- Participated in RAND 4.0 study and utilized the data in the Delaware Health Care Claims database to compare our cost situation to other states
- While conducting the health plan TPA RFP, questions were asked to determine and assess TPA's ability to promote site-of-care steerage and carriers' discounts for covered services in the aggregate relative to current GHIP pricing
- Continued monitoring of SurgeryPlus benefit utilization and member engagement

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, FY21, and FY22. From FY16 through FY22, GHIP gross claims per member increased by 3.4% annually. However, this figure includes the COVID-19 expenditure reimbursement payments of $32.2M, which were paid to the Fund in FY22. Reflecting the true FY22 gross claims, the GHIP gross claims per member increased by only 3.9% annually from FY16 through FY22. Therefore, the GHIP has successfully achieved a 2% reduction to gross GHIP trend through FY22. Note, observed trend captures gross medical and prescription drug claims per member and excludes pharmacy rebates and Employer Group Waiver Plan (EGWP) payments.