The State of Delaware

Diversity, Equity and Inclusion Benefits Review – Update

SEBC Meeting

February 20, 2024

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Update for the SEBC

- Responses to prior outstanding questions from Health Policy & Planning Subcommittee members were discussed at the February 12 meeting
  - Majority of the discussion focused on mental health/emotional wellbeing benefits offered through the EAP and the medical plans
  - Several follow-up questions on that topic will be addressed with the Subcommittee in March and through an upcoming RFP for EAP services that the SBO will be releasing later this year (for a 7/1/2025 effective date)
- Feedback from Subcommittee members about findings from this review is as follows:
  - In light of the financial situation of the Health Fund, there were no recommendations for further short-term consideration (i.e., for FY25) of any benefit changes that would have a significant fiscal impact
  - There is some support for certain benefit changes that have a very small impact on cost, such as enhanced coverage of certain women's health benefits (wigs, cooling caps, mastectomy bras)
  - One Subcommittee member expressed interest in keeping family forming benefits in mind as a longer-term consideration, particularly removing the demonstration of infertility requirements for opposite sex, same sex and transgender couples, and single parent by choice
- ***For discussion:*** Input from SEBC members is being requested at today's meeting on any interest in considering several low-cost benefit enhancements supported by some Subcommittee members

Considerations identified through the DEI benefits review

Low-cost coverage enhancements supported by some HP&P Subcommittee members

Consideration	Description	Annual Cost Estimate (assuming 7/1/24 effective date)
Plan Design / Coverage		
Enhance coverage for wigs for any treatment, illness or injury resulting in hair loss and align benefit maximum across Aetna and Highmark (e.g., $1,000)	• Typically covered as an allowance (e.g., up to $1,000) provided annually	Range: $25,000 - $50,000, depending on utilization
Add coverage allowance for cooling caps (scalp hypothermia) which reduces hair loss due to chemotherapy, typically used for breast cancer patients	• Typically covered as an allowance (e.g., up to $1,000) provided annually • Often aligned with wig allowance (same amount provided for both)	Range: $25,000 - $50,000, depending on utilization
Alignment of coverage of mastectomy bra across medical carriers	• Covered under both medical carriers today, though coverage parameters vary • Aetna: Covers up to 6 bras in the first 12 months, then up to 4 bras every 12 months afterwards • Highmark: Covers up to 4 bras in first 12 months following mastectomy, then up to 2 bras every 12 months afterwards	<$10,000, depending on utilization .

- Is there interest in further consideration of any of these benefit enhancements for FY25?

Appendix

DEI Benefits Review information shared in February

Diversity, Equity and Inclusion Benefits Review

Recap

- Also called “Inclusive Benefits Review”
- Prior discussion with this Subcommittee has centered on:
  - Goals and objectives of this review, including how it supports the future state of the GHIP
  - Overview of the review process, including the specific health benefits reviewed
  - Key strengths and high-level opportunities related to current health benefits
- Further details captured in the Appendix

Diversity, Equity and Inclusion Benefits Review

Recap (continued)

- Short-term opportunities – i.e., potential changes that could be implemented for FY25 – were discussed with the Health Policy & Planning Subcommittee in November and December
- Longer-term opportunities – i.e., potential changes for FY26 or later – identified by this review will be tracked for potential consideration in the future
- Between the time that the DEI benefits review was conducted in early 2023 and now, the fiscal situation of the GHIP has materially changed
- Recognizing that some of the opportunities stemming from the DEI benefits review have cost implications, the goal for today's discussion is to update the Subcommittee on open questions from the December meeting so that the Subcommittee can weigh in on support for the potential changes stemming from the DEI benefits review as well as the timing and prioritization of the opportunities with an associated cost

Diversity, Equity and Inclusion Benefits Review

Updates on open questions from December Subcommittee meeting

Broad wellbeing –

- Emerging trends with employer-sponsored coverage of hearing aids and also Medicaid coverage and any Medicare movement toward providing coverage.

  Medicaid does cover hearing aids for all children and covered people under the age of 21, with certain limitations.

  Medicare Parts A and B do not cover hearing aids or hearing aid specific exams.

  See slide 18 for further details on emerging trends in employer-sponsored coverage and Medicaid coverage.

- Subcommittee member expressed interest in learning more about when acupuncture is covered under the GHIP and under Medicare, Medicaid.

  See slide 18 for further details on coverage provisions for acupuncture. Both Aetna and Highmark offer resources to find discounted acupuncture services. Medicare Part B covers up to 12 acupuncture visits in 90 days for chronic low back pain. Medicare covers an additional 8 sessions if Medicare beneficiary shows improvement. If Medicare beneficiary isn't showing improvement, Medicare won't cover the 8 additional treatments. Medicare beneficiary can get a maximum of 20 acupuncture treatments in a 12-month period. Currently, this is only limited to chronic low back pain.

  Acupuncture is not part of the federally mandated set of Medicaid benefits, but Delaware has recently added it as a covered benefit under this program.

Diversity, Equity and Inclusion Benefits Review

Updates on open questions from December Subcommittee meeting

Family forming benefits -

- Case study specific to family forming benefits for opposite and same sex couples and plan design/coverage.

  See appendix slide 14

Mental health / emotional wellbeing –

- Review GHIP participant frequency of reaching current 5 visit limit under the EAP

  Average utilization for EAP sessions is 3.5 visits for the 2023 calendar year

  Data on number of EAP users who continue therapy through their health plan provider network once EAP covered session limit is reached is not tracked

Diversity, Equity and Inclusion Benefits Review

Updates on open questions from December Subcommittee meeting

Mental health / emotional wellbeing (continued) –

- Review GHIP participant utilization of computerized (digital) cognitive behavioral therapy utilization
  - *Computerized cognitive behavioral therapy ("cCBT") is available to members through the EAP; effective 1/1/2024, this is being offered through the Koa Foundations interactive digital platform*
  - *Provides guided online programs that members can access through the ComPsych Guidance Resources secure portal; topics covered include, but are not limited to, stress management, anxiety, sleep hygiene, and chronic pain*
  - *There is no limit to members' access to cCBT programs, and utilization does not count toward the number of EAP covered sessions; members may use both cCBT and in-person covered sessions at the same time*
  - *Data below reflects cCBT utilization since program was launched (12/28/2020) through 9/30/2023 (most recent information available):*
    - *210 members enrolled in cCBT*
    - *202 members began at least one cCBT program*
    - *90 members were returning (repeat) users of cCBT*
      - *14 of the 90 returning within the first 90 days (average of 3 log-ins per member)*
      - *4 of the 90 completing an activity within a program (average of 8 activities completed per member)*

Diversity, Equity and Inclusion Benefits Review

Updates on open questions from December Subcommittee meeting

Mental health / emotional wellbeing (continued) –

- Clarify EAP vendor costs to increase from 5 to 10 covered sessions

  The estimated incremental cost to increase the EAP visit limit from 5 to 10 covered sessions is approximately $192,000 annually, based on:

  - *Increase in EAP administrative fee from $0.65 to $0.99 per employee per month for increasing from 5 to 10 covered sessions, respectively*
  - *Estimated number of employees and non-Medicare retirees: 47,069 (based on December 2023 enrollment, assumes EAP offered only to non-Medicare participants in a GHIP health plan)*

  Comparing this incremental cost to the potential increased cost if these additional visits were shifted to the medical plan:

  - *Average total (allowed) cost per outpatient mental health visit covered under the GHIP medical plans[1] (paid in CY2023): $108/visit for mental health services, $139/visit for substance abuse treatment*
    - *About 92% of MHSA visits are for mental health, not substance abuse; overall MHSA weighted average: $110/visit*
  - *Estimated number of additional outpatient mental health visits: 368 visits (based on the CY2022 EAP utilization rate, adjusted for increase in the covered population)*
  - *Estimated total allowed cost for additional visits shifted to the medical plan: $40,480 (before member cost sharing)*

1 Source: December 2023 Monthly Key Trends Report, paid claims through December 2023 (rolling 12-month basis), from Merative.

Diversity, Equity and Inclusion Benefits Review

Updates on open questions from December Subcommittee meeting

Mental health / emotional wellbeing (continued) –

- Perspective on increasing EAP covered sessions vs. shifting utilization to the medical plans vs. further promotion of cCBT
  - *Increasing the number of covered counseling sessions under the EAP would remove a potential financial barrier for members to accessing care (i.e., covered at no member cost sharing)*
  - *Assuming no increase in EAP utilization if the number of covered sessions increases, covering those visits under the EAP instead of the medical plan may be more expensive for the GHIP*
  - *Based on a prior review of the overlap between the GHIP medical carrier networks and EAP participating providers, a limited number of providers participate in both (~10%) – there is not typically a high degree of overlap between a medical carrier network and a traditional EAP network*
    - *The EAP vendor marketplace is evolving, and some of the newer EAP vendors have established integration protocols with a number of national and large regional medical carriers to process EAP providers as in-network providers*
    - *Consider exploring these capabilities further during the next EAP procurement process*
  - *cCBT is a component of a best-in-class EAP solution; consider further promotion of existing offering to increase utilization*
  - *Re-evaluate promotion of cCBT as an alterative to increasing EAP covered session limit if future cCBT utilization increases meaningfully*

1 Source: December 2023 Monthly Key Trends Report, paid claims through December 2023 (rolling 12-month basis), from Merative.

Diversity, Equity and Inclusion Benefits Review

Updates on open questions from December Subcommittee meeting

Dental

- Further review into discrepancy between dental portion costs and medical portion costs based on Subcommittee feedback on low utilization and if that correlates to high medical cost.
    - *The biggest driver of the difference between the dental and medical cost estimates for expanding coverage of care for missing teeth due to congenital abnormalities is the annual benefit maximum for each type of plan*
    - *Medical plan has an annual out-of-pocket maximum that limits the member's out-of-pocket cost, but does not place an annual limit on the plan's payments toward that member's benefits*
    - *Dental plan has an annual benefit maximum that limits the plan's benefit payments toward a member's dental care each year; as a result, the dental cost estimate is much lower than the medical cost estimate for comparable services*
    - *The existence of an annual benefit maximum on the State's dental plans is aligned with industry standard dental plan provisions*

Appendix

Case study on employers who have offered expanded coverage of fertility treatment

Manufacturing company looking to modernize family building benefits

Background

- Following a DEI benefits review, the manufacturing client wanted to modernize their family building benefits to offer a more robust and equitable plan design for their employees and their families
- Client's objectives:
  - Support their employees on their family building journey.
  - Support healthy pregnancies and improve birth outcomes.
  - Provide parenting and return to work support.
  - Enhance and integrate their ecosystem offerings.

How WTW helped

- WTW met with the client to establish benefit design objectives and goals for the family building offering and educated them on the maternity and fertility market landscape, also including trends and best practices around adoption and surrogacy, cryopreservation and donor tissue purchase
- Kicked off a three-phased project including:
  - Vendor showcase and client-specific opportunity analysis
  - Debrief call to discuss findings and narrow vendors under consideration
  - Additional follow-ups for BAFO, PGs, and any client requested clarifications and compliance considerations
  - Vendor implementation oversight
  - Guidance on program components, integrations, communications and data exchanges
  - Ongoing post-launch support

Results of the project

- Client decided to elect a family building solution best aligned with their needs
- Based on enhanced understanding of family building best practices and implementation of these vendors, the client was able to:
  - Offer an equitable and inclusive benefit design for all types of families.
  - Remove requirement of medical diagnosis of infertility in order for members to access fertility benefits.
  - Expand adoption and surrogacy amounts.
  - Increase Rx coverage for fertility medications.
  - Add coverage for cryopreservation and donor tissue purchase (while coordinating with their counsel on any compliance and tax implications).

Appendix

DEI Benefits Review information shared in December

Considerations identified through the DEI benefits review

Family forming benefits

Consideration	Description	Annual Cost Estimate (assuming 7/1/24 effective date)
Plan Design / Coverage		
Remove the demonstration of infertility requirements for opposite sex, same sex and transgender couples, and single parent by choice	• About 54% of employers cover fertility services beyond diagnosis of infertilty[1] • Expands access to this benefit to any covered member regardless of sexual orientation or marital status	Range: $1.5m - $3.0m, depending on utilization. Further discussion on potential utilization required. Compare to FY22 spend on infertility treatments of about $3.0m.
Evaluate holistic family forming programs available through medical carrier partnerships	• Offers support for accessing fertility treatments through high quality providers and in coordination with the member's medical provider network • CVS Health/Aetna offers partnership with Progyny • Highmark offers partnership with WINFertility	Varies based on utilization and vendor(s) selected. Based on limited feedback from the Subcommittee about this topic, WTW suggests moving this item to a longer-term consideration and revisiting in FY25.

- At the November meeting, one Subcommittee member voiced support for further consideration of removing the requirement of demonstrating a diagnosis of infertility
- Is there interest among Subcommittee members in further analysis of the potential GHIP cost and utilization related to removing this requirement, including collection of comparative data from other large employers who have made this change?

1. Source: 2022 WTW Emerging Trends in Healthcare Survey.

Considerations identified through the DEI benefits review

Women's health

Consideration	Description	Annual Cost Estimate (assuming 7/1/24 effective date)
Plan Design / Coverage		
Enhance coverage for wigs for any treatment, illness or injury resulting in hair loss and align benefit maximum across Aetna and Highmark (e.g., $1,000)	• Typically covered as an allowance (e.g., up to $1,000) provided annually	Range: $25,000 - $50,000, depending on utilization
Add coverage allowance for cooling caps (scalp hypothermia) which reduces hair loss due to chemotherapy, typically used for breast cancer patients	• Typically covered as an allowance (e.g., up to $1,000) provided annually • Often aligned with wig allowance (same amount provided for both)	Range: $25,000 - $50,000, depending on utilization
Alignment of coverage of mastectomy bra across medical carriers	• Covered under both medical carriers today, though coverage parameters vary • Aetna: Covers up to 6 bras in the first 12 months, then up to 4 bras every 12 months afterwards • Highmark: Covers up to 4 bras in first 12 months following mastectomy, then up to 2 bras every 12 months afterwards	<$10,000, depending on utilization .

- At the November meeting, two Subcommittee members voiced support for further consideration of these plan design enhancements
- Is there broader support among Subcommittee members for these changes?

Considerations identified through the DEI benefits review

Broad wellbeing

Consideration	Description	Annual Cost Estimate (assuming 7/1/24 effective date)
Plan Design / Coverage		
Expand hearing aid benefit to adults over age 23 (Highmark) / 24 (Aetna)	• Proposed enhancement would remove age limit • Consider administering with a dollar limit (e.g., up to $3,000 max, every 3 years)	High end estimate: Coverage with no age limit, no dollar maximum: up to $750,000 for non-Medicare population, up to $1.0m for Medicare population.
Expand coverage for alternative medicine to include acupuncture	• Proposed enhancement would add coverage for a specific number of visits • Aetna: see comments below; Highmark: not covered	Range: $0.5m - $1.0m, depending on utilization and plan design (e.g., up to 10 visits)

- At the November meeting, several questions were raised about hearing aids, including the future outlook on the affordability of these devices and the expansion of Medicare coverage to include them
  - There has been significant growth in the over-the-counter market for hearing aids and more published literature around the prevalence of hearing loss, including linking hearing loss with dementia[1]
  - While Medicare still excludes coverage of hearing aids and most employer-sponsored plans only cover prescribed hearing aids with large out-of-pocket expenses, given the above activities, more employers may explore revisiting coverage in the future
  - Is there interest among Subcommittee members in further analysis of the potential GHIP cost and plan design alternatives related to expanding hearing aid coverage?
- Also in November were questions about the differences in coverage of acupuncture across the GHIP non-Medicare medical plans
  - Following the meeting, Aetna provided details from its coverage policy on acupuncture to clarify current GHIP coverage (see box at right for excerpt) beyond in lieu of anesthesia

Excerpt from Aetna's Coverage Policy on Acupuncture

Aetna considers acupuncture (manual or electroacupuncture) medically necessary for *any* of the following indications:

1. Chronic (minimum 12 weeks duration) neck pain; *or*
2. Chronic (minimum 12 weeks duration) headache; *or*
3. Low back pain; *or*
4. Nausea of pregnancy; *or*
5. Pain from osteoarthritis of the knee or hip (adjunctive therapy); *or*
6. Post-operative and chemotherapy-induced nausea and vomiting; *or*
7. Post-operative dental pain; *or*
8. Temporomandibular disorders (TMD).

For complete details, see:
https://www.aetna.com/cpb/medical/data/100_199/0135.html

1 Sources: Jiang et al. "Association between hearing aid use and all-cause and cause-specific dementia: an analysis of the UK Biobank cohort." *Lancet Public Health* 2023; 8: e329–38. https://doi.org/10.1016/S2468-2667(23)00048-8. Huang et al. Hearing Loss and Dementia Prevalence in Older Adults in the US. *JAMA*. 2023 Jan 10;329(2):171-173. https://doi.org/10.1001/jama.2022.20954.

Considerations identified through the DEI benefits review

Gender-affirming care / LGBT+

Consideration	Description	Annual Cost Estimate (assuming 7/1/24 effective date)
Communications		
Review/enhance supervisor toolkit and training to support employees who are transitioning	• Toolkit is now available through ComPsych and on SBO's website (https://dhr.delaware.gov/benefits/compsych/documents/lgbtqia-workplace-toolkit.pdf) • SBO is exploring other trainings available through the medical TPAs, and DHR's DEI team	N/A
Provide targeted communications, education, and resources for LGBT+ health	• The SBO will build out a "Your Health" webpage that will include LGBT+ resources	N/A
Reporting / Monitoring		
Work with PHRST, Merative, Aetna, and Highmark to determine acceptance of non-binary gender markers in vendors' coding system and reporting	• In general., medical vendors are slowly expanding their capability to accept all markers in their systems • Medical carriers have confirmed that claims systems have turned off any restrictions for gender-based claim coding and have advised that "U" can be accommodated in their enrollment system • Ensure alignment between HRIS system and carrier's capabilities	N/A

Considerations identified through the DEI benefits review

Mental health / emotional wellbeing

Consideration	Description	Annual Cost Estimate (assuming 7/1/24 effective date)
Communications		
Work with Aetna and Highmark to evaluate provider network diversity (e.g., race and language) and ability for members to find culturally competent providers (race/ethnicity, LGBT+, etc.)	• Current vendor capabilities vary • SBO/WTW to continue to discuss current and future roadmap for these capabilities with Aetna, Highmark and ComPsych	N/A
Plan Design / Coverage		
Explore enhanced EAP models with higher session limit	• Current plan provides 5 covered sessions per issue per person per household per year • A growing number of employers are offering higher numbers of covered sessions (e.g., 8-10 visits)	Range: $0.3m - $0.4m (incremental to current EAP fees), depending on covered visit limit

Considerations identified through the DEI benefits review

Dental

Consideration	Description	Annual Cost Estimate (assuming 7/1/24 effective date)
Communications		
Ensure consistent communication of ability to receive extra cleanings and information for members who self-report as having a qualifying chronic condition (e.g., diabetes, heart disease, pregnancy) across dental carriers	• SBO/WTW engaging with dental carriers to all relevant member communications about these benefits is obtained and made available via the SBO website	N/A
Plan Design / Coverage		
Expand coverage for all missing teeth (no limitations)	• Includes both dental coverage and medical coverage (removal of exclusion for dental care in cases of congenital anomalies)	State cost: About $1.0m to remove medical plan exclusion for dental care in cases of congenital abnormalities. Member cost: Estimated increase in DPPO dental premiums of about $2.18 annually (total cost: $86,000). DHMO cost is TBD but it is anticipated that it would be a similar level of increased premiums.
Confirm Delta Dental and Dominion's capacity to support mobile dentistry to certain populations/locations if there is a need	• Option for employers to offer expanded access to members residing in areas with limited dental providers • Both Delta Dental and Dominion National have confirmed they partner with third parties to deliver mobile dentistry services	TBD based on need and estimated participation, which may vary by location

DEI benefits review – next steps

- Is there broader Subcommittee support for any of the following benefit enhancements with an associated cost?

- If there is broader support, what does the Subcommittee suggest in terms of timing and prioritization for further review and consideration by the SEBC?

Benefit	Consideration	Annual Cost Estimate (assuming 7/1/24 effective date)
Family forming benefits	Remove the demonstration of infertility requirements for opposite sex, same sex and transgender couples, and single parent by choice	Range: $1.5m - $3.0m, depending on utilization. Further discussion on potential utilization required. Compare to FY22 spend on infertility treatments of about $3.0m.
Women's health	Enhance coverage for wigs for any treatment, illness or injury resulting in hair loss and align benefit maximum across Aetna and Highmark (e.g., $1,000)	Range: $25,000 - $50,000, depending on utilization
Women's health	Add coverage allowance for cooling caps (scalp hypothermia) which reduces hair loss due to chemotherapy, typically used for breast cancer patients	Range: $25,000 - $50,000, depending on utilization
Women's health	Alignment of coverage of mastectomy bra across medical carriers	<$10,000, depending on utilization
Broad wellbeing	Expand hearing aid benefit to adults over age 23 (Highmark) / 24 (Aetna)	High end estimate: Coverage with no age limit, no dollar maximum: up to $750,000 for non-Medicare population, up to $1.0m for Medicare population.
Broad wellbeing	Expand coverage for alternative medicine to include acupuncture	Range: $0.5m - $1.0m, depending on utilization and plan design (e.g., up to 10 visits)
Mental health / emotional wellbeing	Explore enhanced EAP models with higher session limit	Range: $0.3m - $0.4m (incremental to current EAP fees), depending on covered visit limit
Dental	Expand coverage for all missing teeth (no limitations)	State cost: About $1.0m to remove medical plan exclusion for dental care in cases of congenital abnormalities. Member cost: Estimated increase in DPPO dental premiums of about $2.18 annually (total cost: $86,000). DHMO cost is TBD but it is anticipated that it would be a similar level of increased premiums.

Inclusive benefits review – goals and objectives

- Do our current benefit programs meet the needs of a diverse workforce?
- How do benefits impact our ability to attract and retain employees?
- Does the current benefits package support an inclusive and diverse culture, and align with the State's Diversity, Equity, and Inclusion goals?
- Are there opportunities to improve the wellbeing of State employees (financial, physical, and/or emotional wellbeing)?

Support Development of GHIP Future State

Meaningful Choice – Several medical plan options that are meaningfully different in terms of price tags and benefit value (including an IRS-qualified HSA plan)

Personalized Benefit Offerings – After-tax Lifestyle Savings Account aimed at meeting the participants' life needs in any given year (e.g., child/elder care, student loan repayment, pet insurance, etc.)

Voluntary Benefits – Strategic approach driven by employee demographics, supported by robust benchmarking, market knowledge and enrollment services

Flexible Subsidization – Employees receive fixed amount towards suite of core and voluntary benefit offerings such that employees can purchase based on their own unique needs

Meets Variety of Needs – Scope of benefit offerings are flexible to meet the needs and preferences of the State's diverse workforce

Inclusive benefits review – overview of process

Health benefits reviewed	Areas for potential future study/review
• Family forming benefits • Gender-affirming care / LGBT+ • Women's health • Mental health / emotional wellbeing • Broad wellbeing • Dental	• Disability plan and policies • Leave/time off programs • Retirement readiness and benefit offerings • Caregiving benefits • Perks/ancillary benefits • Benefits education, communications and resources

Benefits are reviewed on a "**good, better, best**" scale for select provisions through a DEI lens, using:

- Corporate indices, such as Human Rights Campaign's Corporate Equality Index
- Published clinical guidelines and best practices (e.g., WPATH)
- Employer prevalence data and surveys
- Employee surveys and input

Strengths in current offerings

Health benefit reviewed	Strengths
Family forming benefits	• Generous fertility benefit implemented in August 2019 with medical and Rx maximums above benchmark for members that meet requirement of demonstrated infertility
Gender-affirming care / LGBT+	• Transgender surgery coverage generally aligned with WPATH[1] Standards of Care v.7 based on Aetna and Highmark's standard policies
Women's health	• Current benefits cover many services to support women's health and wellbeing at all life stages
Mental health / emotional wellbeing	• Robust mental health and substance abuse support through Aetna, Highmark, CVS and ComPsych EAP
Broad wellbeing	• Robust clinical programs and wellbeing offering to support members in managing physical health through best-in-class partnerships • Workplace Wellbeing Policy executed in July 2022
Dental	• Current dental benefits aligned with most best practices through DEI lens, recognizing that the State has more flexibility with the Delta Dental plans vs. Dominion HMO

1. The World Professional Association for Transgender Health (WPATH) is currently the main group creating evidence-based guidelines for treatment of transgender individuals.