Statewide Benefits Office Strategic Plan FY2024 and FY2025 Results

Executive Summary

Based upon the actions completed by the Statewide Benefits Office (SBO) towards achieving the goals set forth by the State Employee Benefits Committee (SEBC) and the projections of meeting those goals, the SBO had devised a Fiscal Year (FY) 2024 and 2025 strategic plan that included the following actions as well as other initiatives:

Goal: Using the Alternative Payment Model (APM) Framework and FY2023 medical spend as a baseline, increase Group Health Insurance Plan (GHIP) spend through advanced APMs to be at least the following by the end of FY2025 (as % of total spend): Category 3 – 50% and Category 4 – 5%

- Included articles in the Benefits Bulletin and implemented training courses to promote educational tools and to offer access to providers who deliver high-quality, cost-efficient health care
- Distributed various communications and implemented training courses regarding Centers of Excellence (COE) and Lantern
- Worked with health plan Third Party Administrators (TPAs) to develop a communications strategy that educates members about safety and quality
- Communicated with the Delaware Office of Value Based Health Care Delivery (OVBHCD) and the Delaware Health Information Network (DHIN) to ensure data is being submitted as required
- Requested annually the health plan TPAs complete the OVBHCD affordability template specifically for the GHIP to support reporting to the SEBC on the GHIP's progress towards achieving this goal
- Worked with vendors to determine the data collected from members and outside sources are based on social determinants of health and how that data is used for their care management programs
- Required Third Party Administrators (TPAs) to share non-claim value-based payment data through the claims file to the data warehouse
- Compared GHIP costs and health trends to similar populations by analyzing publicly available data from validated sources on a semi-annual basis
- Reviewed OVBHCD Annual Report and utilized the data to negotiate contracts with medical TPAs
- Required TPAs to report quality metrics and facilities that do not meet quality and safety standards
- Monitored health care vendor performance guarantees and outcome data
- Monitored disease management program participation, utilization, and costs through quarterly reporting
- Included additional/updated performance guarantees in annual contract renewals

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

- Distributed various communications and implemented training courses to increase awareness and promote the Benefits Mentor® Consumer Decision Tool
- Included information about the Benefits Mentor® Consumer Decision Tool in new hire communications and forms
- Supported the SEBC and its Subcommittees in evaluating opportunities for changes to GHIP options that encourage meaningful differences in member cost sharing to prompt a greater need for members to utilize decision support tools
- Offered the *How to Select a Health Plan* Computer-Based Training (CBT) to educate members on healthcare consumerism

- Reviewed health plan vendor contracts for potential changes to GHIP plan components and prices prior to signing amendment
- Coordinated with the SEBC and SEBC's consulting partner, Willis Towers Watson (WTW), on potential plan design changes
- Promoted healthcare consumerism through the *Why Do We Have the Benefits That We Have?* Instructor-Led Training (ILT)
- Distributed the "Important Information Regarding Your Health Plan" emails based on member enrollment for the new plan year, new hires, and those who switched plans for a qualifying event

Goal: Reduce per-member-per-month (PMPM) cost trend for the GHIP and for plan participants for the following conditions by the end of FY2025, using FY2023 spend as a baseline: diabetes by 8% for the GHIP and 0.33% for plan participants, behavioral health by 0.5% for the GHIP and 0.02% for plan participants, and musculoskeletal by 2% for the GHIP and 0.08% for plan participants

- Distributed various communications and implemented training courses to increase awareness and promote behavioral health and diabetes resources and to promote Hinge Health
- Included an article in the *Benefits Bulletin* regarding Mental Health Awareness Month, National Chiropractic Health Month, Pain Awareness Month, and National Diabetes Month
- Distributed State and Participating Group memos and a targeted (State & Education) emails informing SOD employees of upcoming behavioral health webinars provided by ComPsych®
- Included monthly articles in the *Benefits Bulletin* promoting various behavioral health and healthy living webinars provided by Aetna.
- Worked with Aetna and Highmark to distribute Diabetes Prevention Program postcards
- Promoted new ComPsych® platform (KOA Foundations) as an interactive, digital tool to enhance members' mental health journey
- Distributed various communications to increase awareness and encourage participation in covered services, including Diabetes Prevention Programs (DPPs) (Livongo® DPP, Solera DPP, and YMCA DPP) and diabetes management programs (Livongo® Diabetes Monitoring Program and Transform Diabetes Care Program)
- Met with Delaware Chiropractic Services Network (DCSN) to discuss collaborative efforts and communications
- Reviewed peer-reviewed journals on outcome data related to GLP-1's and new treatment opportunities
- Reviewed CVS Caremark data related to the cost and utilization of weight-loss medications and GLP-1's
- Conducted outreach to state health plans and employers with similar issues around GLP-1 drug and weight loss medication cost and utilization to learn additional savings opportunities or weight management strategies
- Utilized Merative database to monitor condition-specific disease prevalence, medical service/Rx utilization and cost ongoing vs. baseline and reported notable changes to the SEBC
- Completed an annual review of Hinge Health and Behavioral Health programs and provided recommendations to the SEBC
- Sent FY2024 agency Scorecards to the lead HR Business Partner of each agency to provide awareness of top health concerns amongst their employees and promote specific benefits and resources available to their employees through the SBO and GHIP.
- Explored use of point-of-sale solutions and applications that support individuals with specific GHIP targeted conditions to help them manage their condition and behaviors during the quarterly meetings with the medical TPAs and PBM
- Provided GHIP data for and worked with DPH and DMMA to produce the "Impact of Diabetes in Delaware" 2025 Report

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

- Distributed various communications regarding health plan features, appropriate sites of care, member testimonials, wellness and condition care management programs, the value of the benefits, and resources available to GHIP members
- Distributed various communications and Implemented training courses to educate GHIP members about their benefits including Hinge Health and Lantern
- Created scorecards specific to organizations that outline how each organization ranked in key metrics
- Participated in and analyzed RAND Study which compared state data using All-Payer Claims Databases (APCD) to Medicare prices and reporting costs by state versus Medicare
- Worked with SEBC's consulting partner, Willis Towers Watson (WTW), to conduct a Market Check for FY2024 and FY2025 with CVS Caremark
- Educated pensioner population on benefits by working with the Pension Office to draft and distributed a newsletter to pensioners regarding their benefits
- Monitored utilization, costs, and outcomes associated with Lantern benefit
- Utilized Merative database to monitor utilization of various sites of care for similar services, low value services and preventative services to identify areas of unnecessary utilization and lower quality providers
- Worked with the Delaware OVBHCD on updated projections near the end of the calendar year
- Attended monthly meetings with PCRC and DHCC to keep up to date on Delaware's Primary Care Law

Other SBO Initiatives

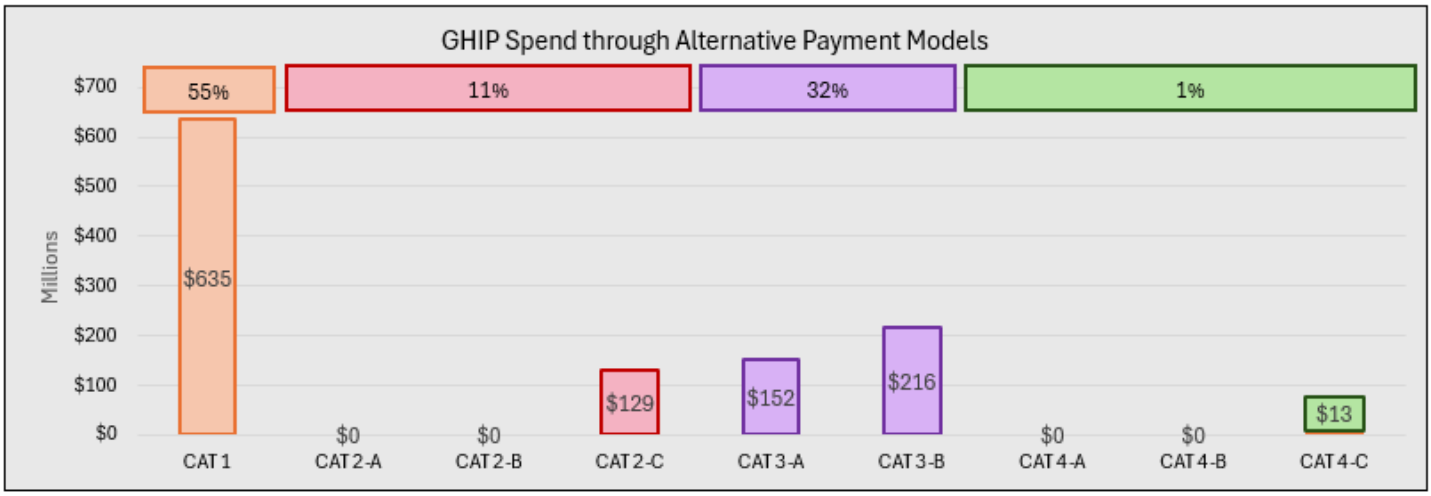
- Retiree Healthcare Benefits Advisory Subcommittee
- The Impact of Diabetes in Delaware 2025 Report
- Represented the State Employee Benefits Committee (SEBC) on the Delaware Primary Care Reform Collaborative
- Developed employee benefit's materials for New Employee Orientation
- Mental Health Parity Assessment of the GHIP medical plans
- Implemented Reciprocity Health Diabetes Prevention Pilot Program for Highmark State of Delaware Employees
- Developed quarterly SBO Training/Communications Reports and distributed to SEBC
- Developed *Section 1557 (Nondiscrimination Provision) of the Affordable Care Act* training per federal requirements
- Enhanced communications and trainings on health plan decisions and benefits
- Availability of Benefits Mentor® tool for new and current State employees
- Launched an employee benefits survey for Vision and Life Insurance Benefits
- Implemented Hinge Health virtual physical therapy program effective 1/1/23, including a recent Women's Health pelvic therapy enhancement
- Worked with DHR Talent Management and Training & HR Solutions to include benefits information in Delaware Launchpad for new hires
- Developed the *Get the Facts* webpage and communications to increase transparency with GHIP members

The FY2024 and FY2025 strategic plan reflects the desire of the SBO and the SEBC to continue enhancing the mission of offering State of Delaware employees, retirees, and their dependents adequate access to high-quality healthcare that produces good outcomes at an affordable cost, promotes healthy lifestyles, and helps them be engaged consumers. The following pages detail the tactics and actions taken by the SBO in FY2024 and FY2025 to support these goals and an evaluation of the results that followed.

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

- **Category 3 (APMs Built on Fee-for-Service Architecture): 50%**
- **Category 4 (Population-Based Payment): 5%**

The following chart reflects total GHIP medical spend (i.e., allowed amount, including both member cost share and plan payments) under Highmark, Aetna and Lantern, incurred in FY2024 (July 1, 2023 – June 30, 2024) under each category of the Alternative Payment Model Framework; FY2025 results will be released in CY2026.



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

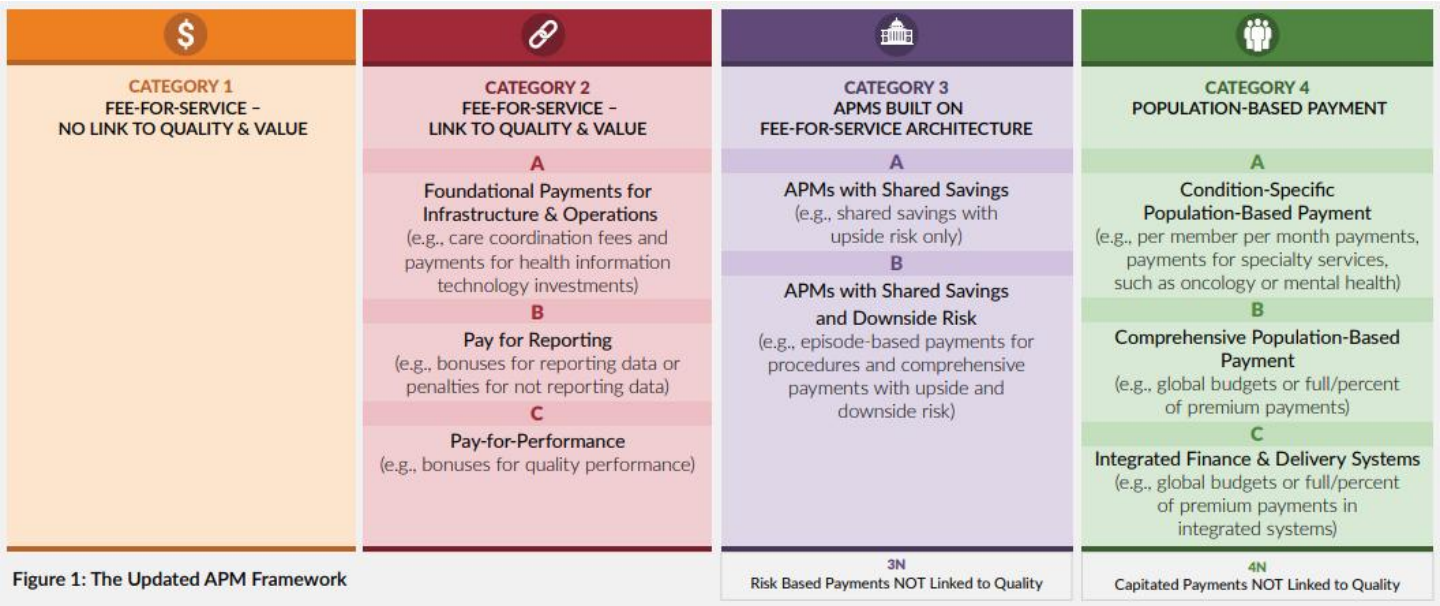


Figure 1: The Updated APM Framework

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

Why is this goal important?

Traditionally, employer-sponsored health benefits have often cycled between strategies that hold healthcare providers accountable for managing cost and quality of care ("supply" strategies) and strategies that hold plan participants accountable for managing cost and quality of care ("demand" strategies). Interventions that operate in a silo by addressing only supply or only demand do not work well. To simultaneously control cost in a sustainable way, the provider must be more accountable and member healthcare shopping habits must change. Alternative payment models (also known as "value-based payment models") are grounded in supply-based strategies that leverage higher quality care to drive changes in demand, reduce the total cost of care for the GHIP and plan participants, and align with the GHIP's Mission Statement to '*Offer State of Delaware employees, retirees, and their dependents adequate access to high-quality healthcare that produces good outcomes at an affordable cost, promotes healthy lifestyles, and helps them be engaged consumers.'*

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

Tactics to meet the goal:

- Explored ways to hold medical TPAs accountable for expanding their pay-for-value contracts with providers
- Continued to promote educational tools and resources that help members identify high-quality, high-value providers
- Continued to require medical TPAs to submit GHIP claim data to the DHIN and to the Delaware Office of Value Based Health Care Delivery
- Continued to periodically evaluate the readiness of the provider marketplace in Delaware to assume additional financial risk
- Leveraged the Delaware Health Care Claims database and other publicly available sources of data (e.g., RAND, NASHP) to compare cost across other state populations
- Worked with providers and TPAs to ensure non-claims payments were collected and reported to the DHIN, the GHIP health care claims data warehouse, and the Delaware Office of Value Based Health Care Delivery
- Continued to offer access to providers who deliver high-quality, cost-efficient health care (e.g., Centers of Excellence)

Actions SBO has taken to achieve the goal:

- Participated in the Primary Care Reform Collaborative (PCRC)

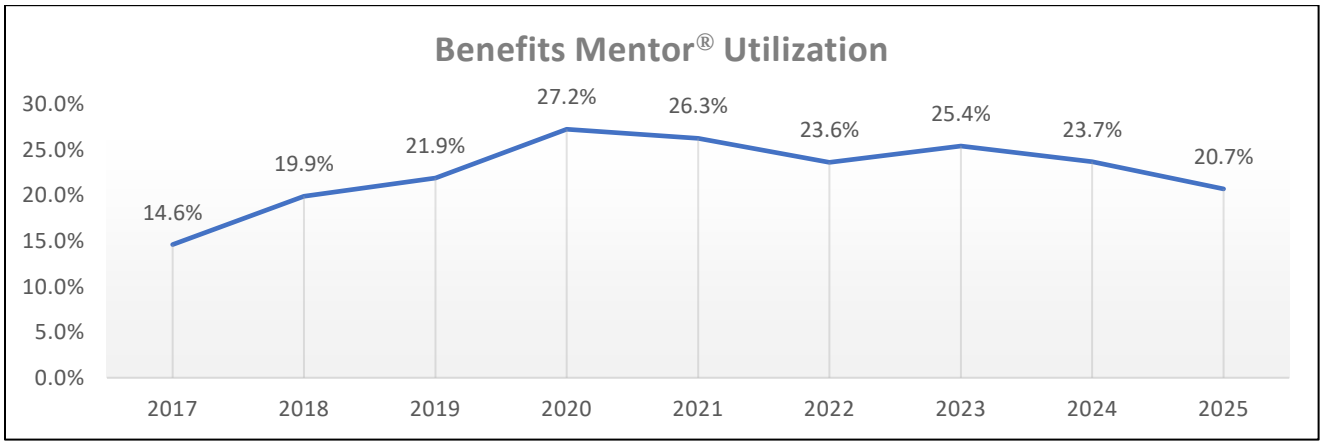
- Worked with Highmark and Aetna in their FY2025 plan agreements to ensure they are providing education to providers on the benefits of participating in a contract with an Alternative Payment Model (APM)
- Assessed TPA's ability to increase GHIP movement toward Category 3 and Category 4 during the annual contract review and amendment process
- Updated performance guarantees with health plan TPAs to move more aggressively toward Category 3 and Category 4
- Created and distributed various communications regarding high-quality, high-value providers
- Created and distributed various communications regarding appropriate sites of care
- Worked with TPAs Highmark and Aetna to present to the SEBC their latest efforts to expand value-based contracting in Delaware, as well as on their care management programs for the GHIP
- Coordinated with the OVBHCD to present that office's view of value-based care in Delaware based on their work with the carriers
- Increased communication with the OVBHCD within the Department of Insurance (DOI) to ensure alignment of goals and accurate reporting on APMs
- Ensured accurate data collection amongst TPAs and timely reporting to the DHIN
- Enhanced monitoring of APMs in other states and kept up to date on the development of new payment models within Delaware and surrounding states

Results:

FY2024 total medical spend (i.e., allowed amount, including both member cost share and plan payments), was $1.14B, which includes $367M (32%) in Category 3 and $13M (1%) in Category 4 payment models, meaning the goal was not met though significant progress was made towards the Category 3 goal (up from 26% in FY2023).
After adjusting for medical trend (5% annually), the FY2025 target (total medical spend) required to reach this goal is approximately $601M (50%) in Category 3 - APMs built on Fee-For-Service architecture and $60M (5%) 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.

GHIP Strategic Framework - FY2024 and FY2025 Goal Dashboard

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



Why is this goal important?

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

Tactics to meet the goal:

- Continued to communicate the value of benefits provided along with member education resources
- Continued to promote healthcare consumerism and the importance of making informed decisions when enrolling in or changing benefits
- Periodically evaluated opportunities for changes to GHIP medical plan options and price tags to encourage meaningful differences to prompt a greater need for members to utilize decision support
- Continued exploring new decision support tools and/or engagement solutions as the vendor marketplace for this continues to evolve
- Steered new employees to these tools
- Promoted this tool in 2024 and 2025 Open Enrollment

Actions SBO has taken to achieve the goal:

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

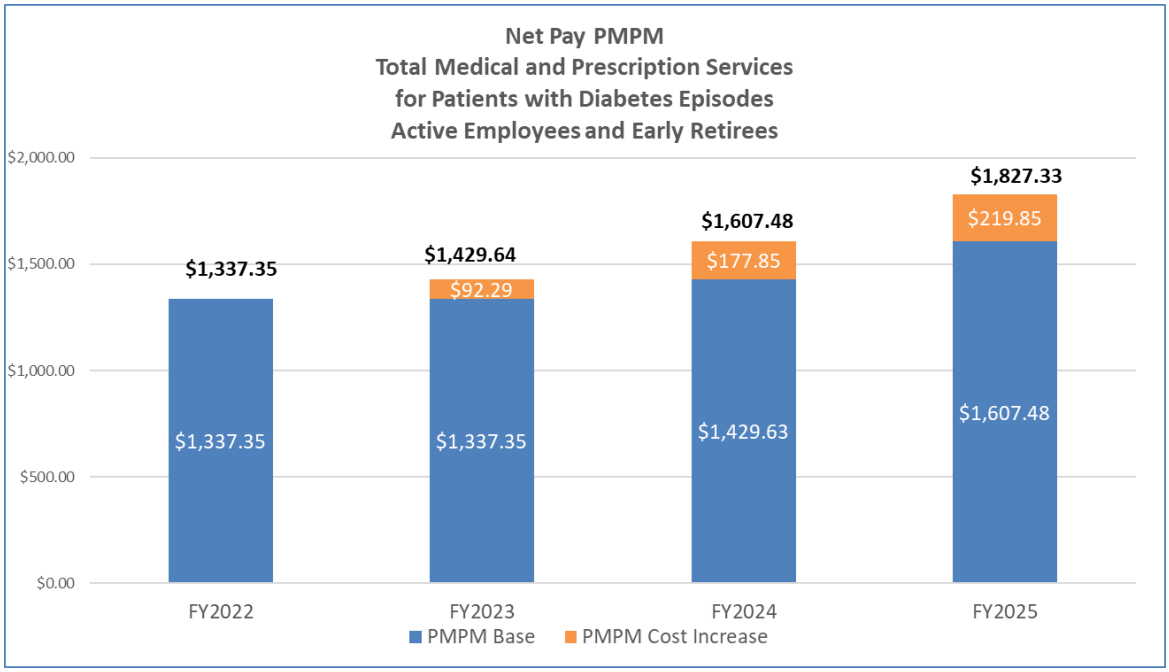
Results:

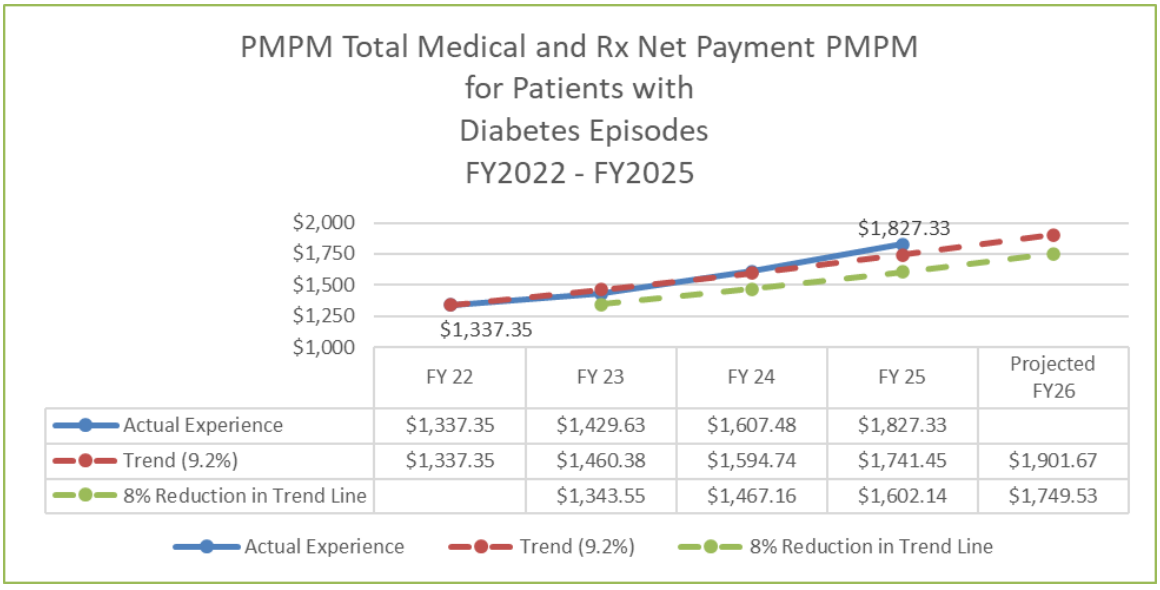
While utilization overall has dipped, the extent of change may not be reflective of individual groups. For example, historically, state agencies and higher education institutions have had greater utilization than school districts, Delaware Transit Corporation (DTC), and early retirees. For 2025 (FY26 Open Enrollment) state agency utilization was 26.1% and higher education utilization was 27.7% with an overall rate of 26.1% excluding DTC and early retirees.

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

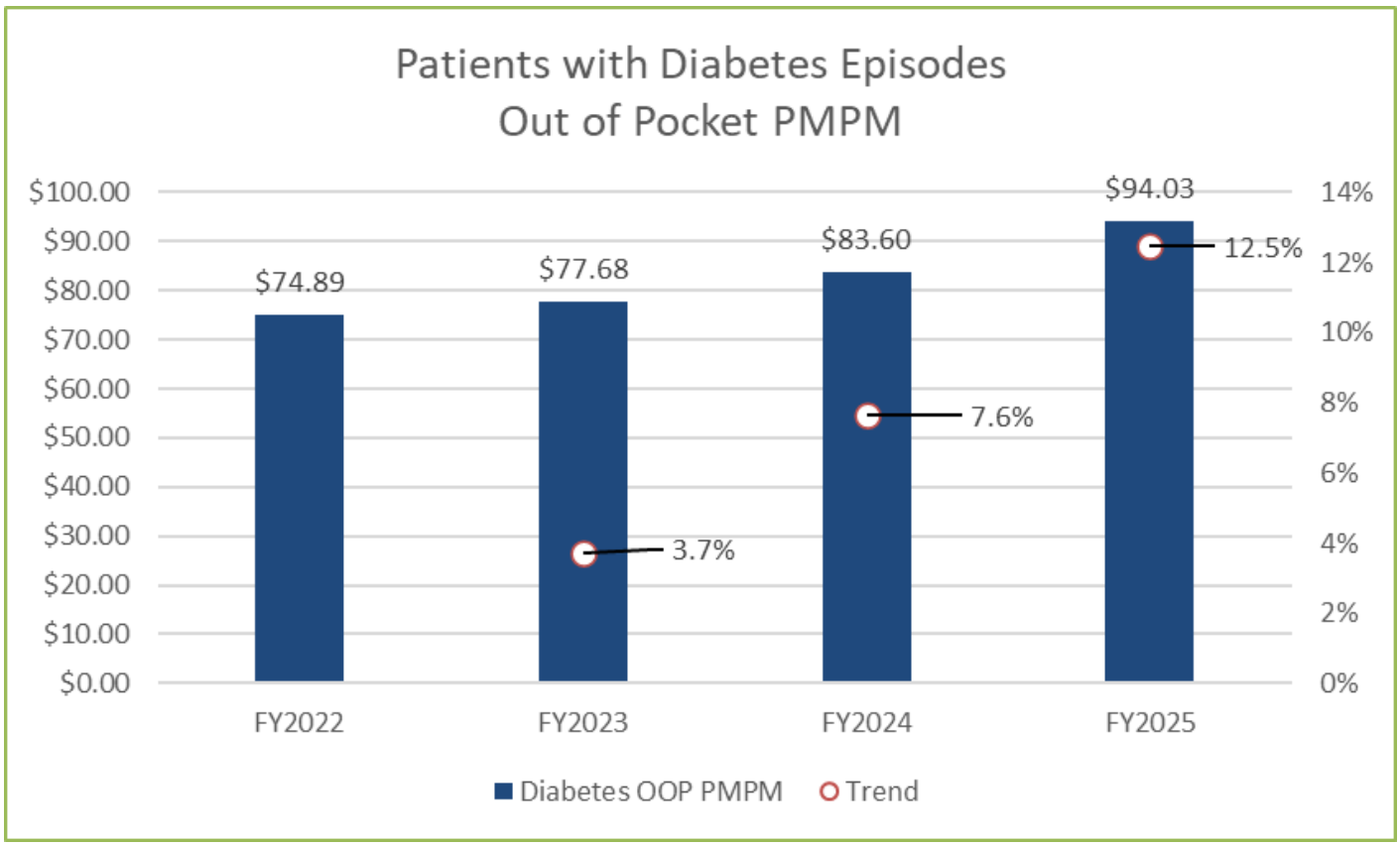
- **Diabetes: 8% for the GHIP / 0.33% for plan participants**
- **Behavioral health: 0.5% for GHIP / 0.02% for plan participants**
- **Musculoskeletal: 2% for the GHIP / 0.08% for plan participants**

Diabetes





	FY 22	FY 23	FY 24	FY 25	Projected FY26
Actual Experience	$1,337.35	$1,429.63	$1,607.48	$1,827.33	
Trend (9.2%)	$1,337.35	$1,460.38	$1,594.74	$1,741.45	$1,901.67
8% Reduction in Trend Line		$1,343.55	$1,467.16	$1,602.14	$1,749.53



Why is this goal important?

Diabetes prevention and management is an important area of focus for the State of Delaware. Successful prevention and mitigation of diabetes can significantly reduce medical costs and improve quality of life. In FY2025, 8,589 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 $272.1 million. An additional 9,928 members were prediabetic at a total cost of treatment of $117.1 million. Together, these members represented 16.4% of the total active employee and early retiree population and accounted for 37.8% of total healthcare expenditures. The State of Delaware and the State Employee Benefits Committee (SEBC) are committed to offering convenient, evidence-base programs to help our members manage diabetes and live healthy lives.
Both musculoskeletal conditions and behavioral health disorders have been identified as areas of concern. Since 2022, the net payment PMPM for patients with musculoskeletal conditions increased by 40.4%, from $1,620 to $2,275 and the net payment PMPM for patients with behavioral health disorders increased by 26.9%, from $975 to $1,228. In FY2025, the total net payment for musculoskeletal episodes was $60.8 million and the total net payment for behavioral health services was $23.3 million.

Tactics to meet the goal:

- Continued to measure condition-specific disease prevalence, medical service/Rx utilization, and cost ongoing vs. baseline

- Continued to educate members on the availability of preventive care and condition-specific resources to support lifestyle risk reduction through the GHIP and other community resources (e.g., hospital-based health and wellness courses, Delaware's Help is Here for addiction support)
- Continued to offer condition-specific resources for diabetes and metabolic syndrome through the State Group Health plan (e.g., Livongo®, Transform Diabetes Care, Diabetes Prevention Program, Aetna One Advisor, Highmark CCMU), including coverage of select diabetes prescriptions and supplies at no cost to members, to support healthy lifestyles
- Continued to offer access to physical therapy in multiple formats (e.g., in-person, virtual through Hinge Health at no cost to members)
- Continued to engage with the Delaware Chiropractic Network on collaborative efforts to make GHIP members aware of the benefits of chiropractic care and the service covered under the GHIP
- Continued to evaluate solutions available through the GHIP TPAs and other third-party vendors to supplement the network of behavioral health providers available to members
- Continued to measure GHIP use, cost, and outcomes from weight management drugs
- Continued to monitor emerging areas of GHIP spend such as treatments for obesity for consideration of expanding this goal in the future
- Distributed State and Participating Group memos and a targeted (State & Education) emails informing SOD employees of upcoming behavioral health webinars provided by ComPsych®
- Promoted new ComPsych® platform (KOA Foundations) as an interactive, digital tool to enhance members' mental health journey
- Began the implementation of a new Employee Assistance Program (EAP) through Health Advocate, which includes numerous opportunities for Behavioral Health management at no cost to members

Actions SBO has taken to achieve the goal:

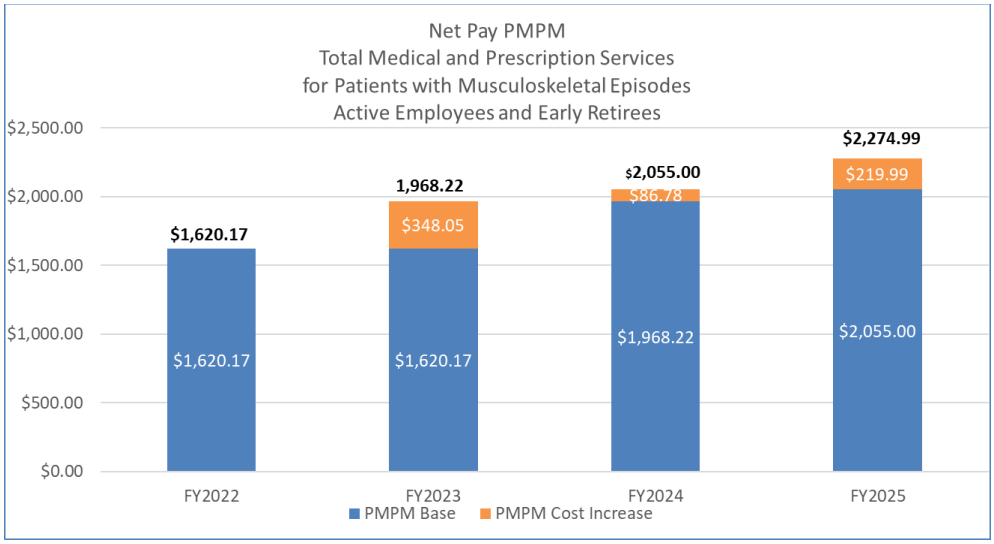
- Continued Transform Diabetes Care and communicated its availability to EGWP members
- Communicated the availability of various diabetic services available through the health plan
- Communicated the availability of diabetic services through the vision plan
- Collaborated with the Division of Public Health (DPH) and the Division of Medicaid and Medical Assistance (DMMA) on the Impact of Diabetes in Delaware 2025 Report
- Collaborated with health and prescription plan administrators, the YMCA of Delaware, Livongo®, Transform Diabetes Care, and Solera to provide and promote diabetic prevention and management services to eligible members
- Participated in the Greater Philadelphia Business Coalition of Health's Employer Action Collaborative on Obesity and Diabetes Interest Group
- Promoted availability of wellness events at Delaware hospitals
- Communicated and promoted the availability of behavioral health resources available to GHIP members
- Communicated and promoted the availability of physical therapy available through the health plan and Hinge Health
- Reviewed CVS Caremark data related to the cost and utilization of weight-loss medications and GLP-1s and outreached to other state health plans and employers to learn additional savings opportunities or weight management strategies
- Pilot Reciprocity program for 100 Highmark members who are State of Delaware employees to prevent diabetes and improve metabolic health
- Increased promotion of the free Hinge Health virtual exercise therapy program for GHIP members to address chronic and acute pain and manage Musculoskeletal conditions

- Included monthly articles in the Benefits Bulletin promoting various behavioral health and healthy living webinars provided by Aetna.
- Increased promotion of the Employee Assistance Program and other behavioral health management tools
- Promotion of condition specific webpages on the SBO Website to promote available programs through the GHIP TPAs for Musculoskeletal, Behavioral Health, Diabetes, Cancer, Family Planning, Weight Management, and Heart Health.
- Promotion of webinars offered through Aetna concerning topics, such as health living and eating, physical activity and behavioral health.

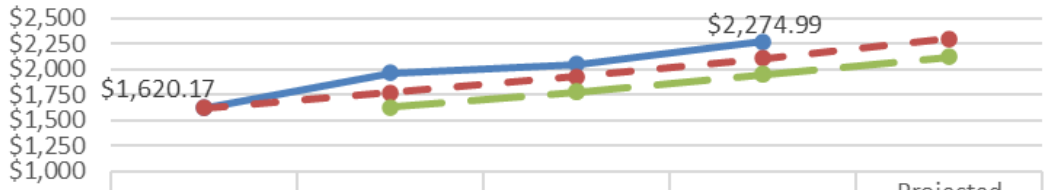
Results:

As a baseline, the FY2022 net payment PMPM was $1,337 PMPM for patients with diabetes episodes. The PMPM increased 6.9%, 12.4%, and 13.7% to $1,429, $1,607, and $1,827 in fiscal years 23, 24 and 25, respectively. exceeding both the 9.2% inflationary trend and the objective of an 8% reduction in trend. From FY2022 to FY2025, the medical payment trend was 26.6% (an increase from $946 PMPM to $1,200 PMPM) and the prescription drug trend was 60.3% (an increase from $390 PMPM to $626 PMPM). Out of pocket PMPM costs are also increasing, with a 7.6% increase in FY2024 and a 12.5% increase in FY2025, meaning costs are rising for members as well as the State*.
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. During FY22-FY23, the GHIP was still partially experiencing "pent-up" demand during/after the COVID shutdown which should be considered as well as the impact of GLP-1's. Though not new for diabetes, increased utilization of these drugs for diabetes is likely a main factor impacting Rx trend.
*Target cost trend reduction for plan participants reflects the GHIP weighted average actuarial value of approximately 96%; i.e., for every $1.00 spent on healthcare by GHIP participants, the State pays $0.96 toward the cost and plan participants pay the remainder.

Musculoskeletal



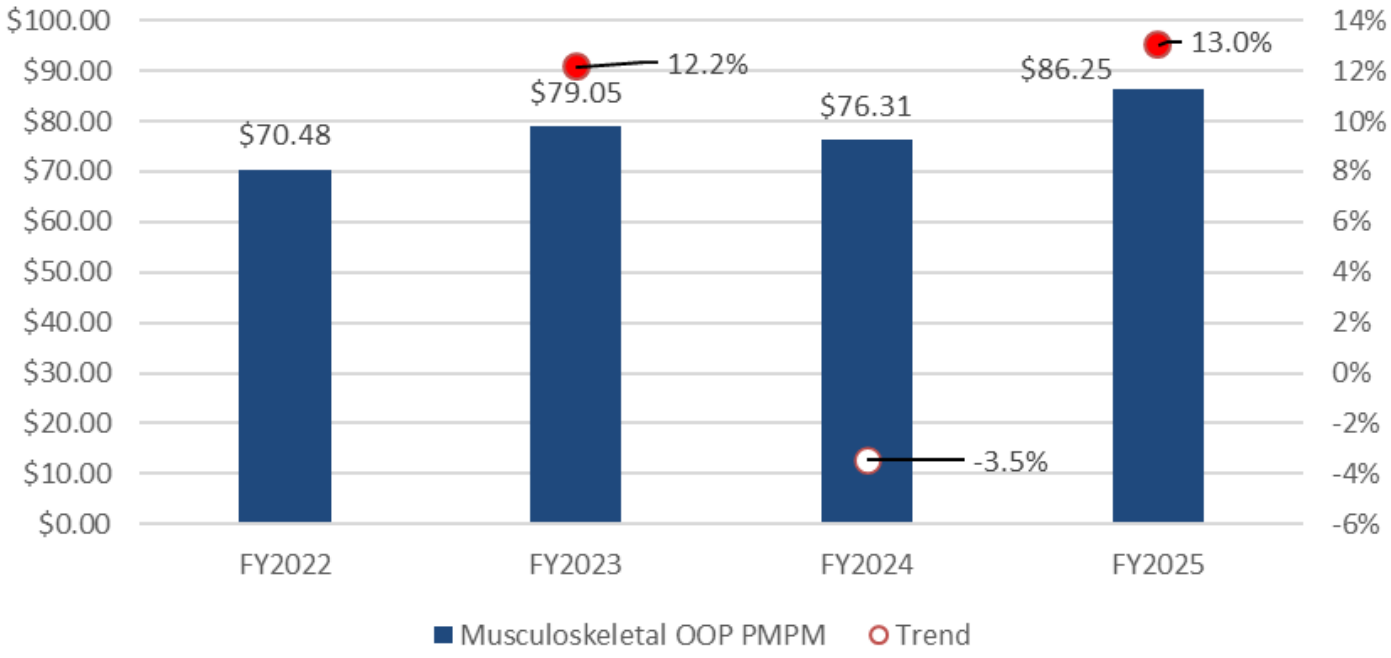
PMPM Total Medical and Rx Net Payment PMPM for Patients with Musculoskeletal Episodes FY2022 - FY2025



	FY 22	FY 23	FY 24	FY 25	Projected FY26
Actual Experience	$1,620.17	$1,968.22	$2,055.00	$2,274.99	
Trend (9.2%)	$1,620.17	$1,769.23	$1,931.99	$2,109.74	$2,303.83
8% Reduction in Trend Line		$1,627.69	$1,777.43	$1,940.96	$2,119.53

Actual Experience Trend (9.2%) 8% Reduction in Trend Line

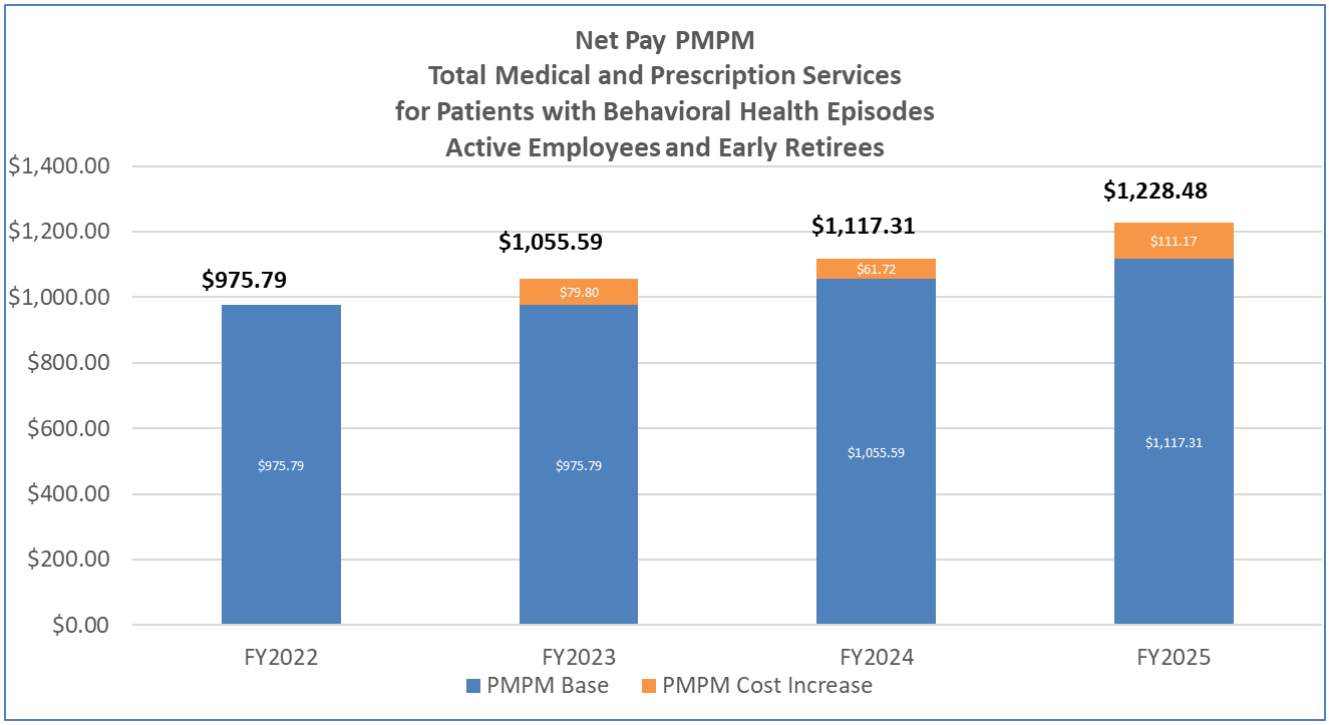
Patients with Musculoskeletal Episodes Out of Pocket PMPM

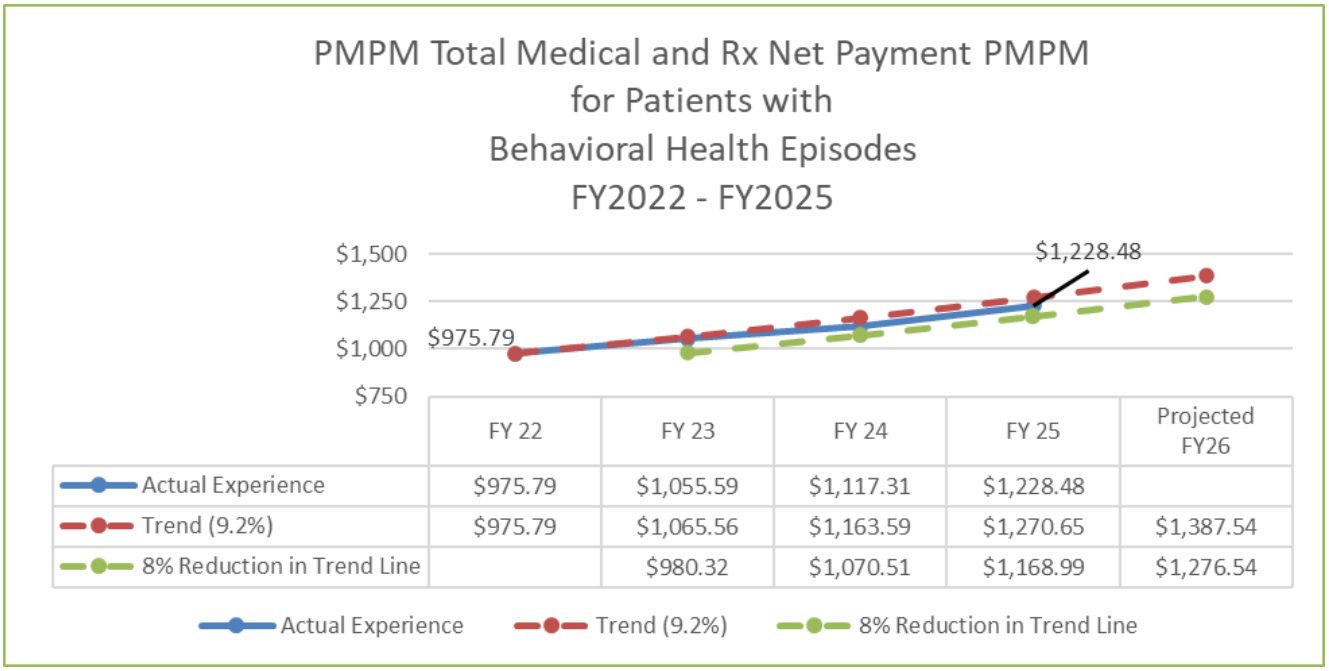


Results:

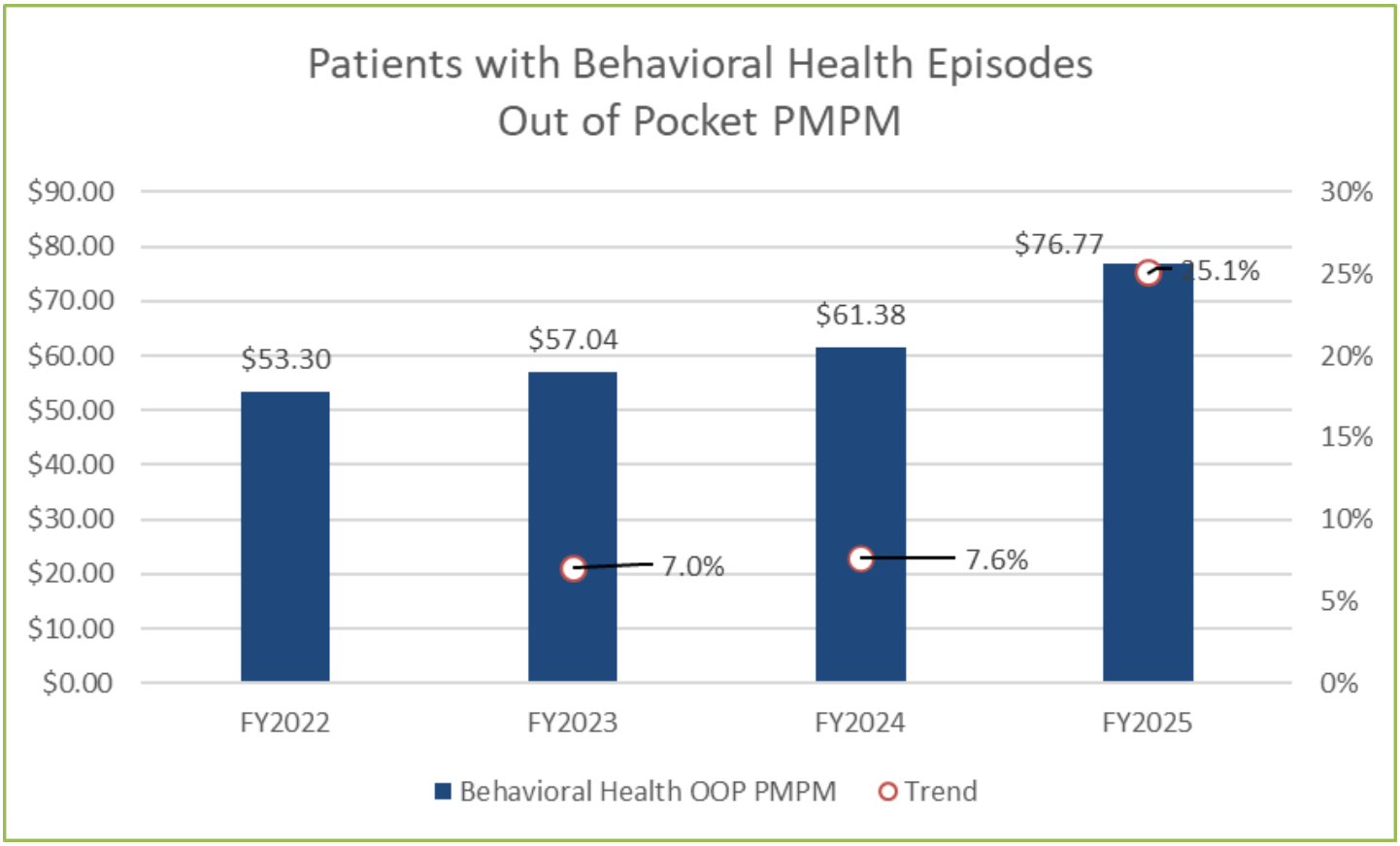
As a baseline, the FY2022 net payment PMPM was $1,620 PMPM for patients with musculoskeletal episodes. The PMPM increased 21.5%, 4.4%, and 10.7% to $1,968, $2,055, and $2,274 in fiscal years 23, 24 and 25, respectively, exceeding both the 9.2% inflationary trend and the objective of an 2% reduction in trend. Since FY2022, the out-of-pocket payment PMPM for patients with musculoskeletal episodes has increased 22.4%, from $70.48 to $86.25.

Behavioral Health





	FY 22	FY 23	FY 24	FY 25	Projected FY26
Actual Experience	$975.79	$1,055.59	$1,117.31	$1,228.48	
Trend (9.2%)	$975.79	$1,065.56	$1,163.59	$1,270.65	$1,387.54
8% Reduction in Trend Line		$980.32	$1,070.51	$1,168.99	$1,276.54



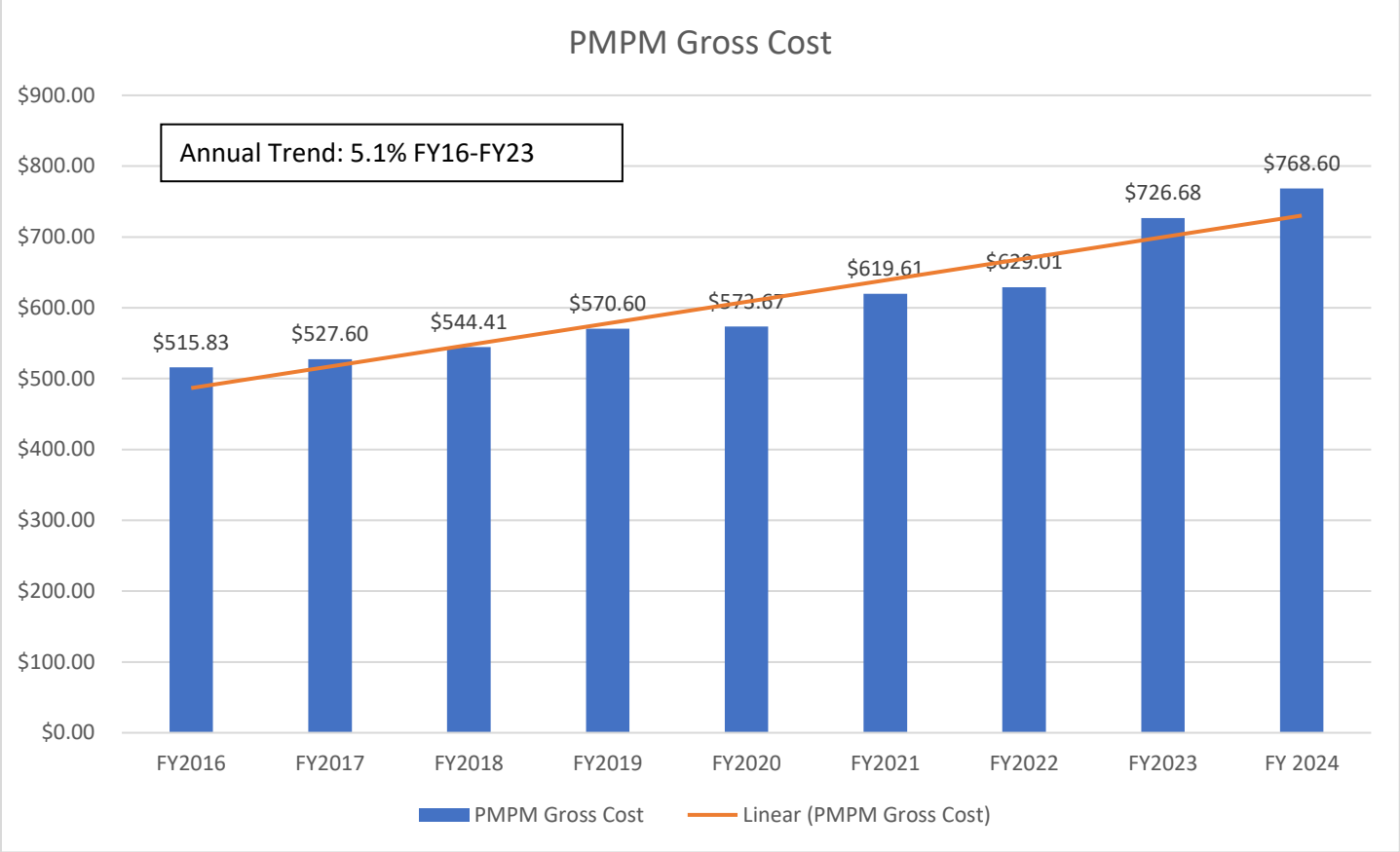
Results:

As a baseline, the FY2022 net payment PMPM was $53 PMPM for patients with behavioral health episodes. The net payment PMPM increased 8.2%, 5.8%, and 9.9% to $1,055, $1,117, and $1,228 in fiscal years 23, 24 and 25, respectively, below the 9.2% inflationary trend but above the objective of an .5% reduction in trend. Since FY2022, the out-of-pocket PMPM for patients with behavioral health disorders has increased 44% from $55.30 to $76.77.

GHIP Strategic Framework - FY2024 and FY2025 Goal Dashboard

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

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



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% or more annually and the State Group Health Insurance Plan's (GHIP) gross claims estimated to near $1.5 billion in FY2026, the State of Delaware has less available funds to invest in pay increases and cost of living adjustments. As partners, the State of Delaware and their enrolled health plan members can work together to slow the growth of healthcare expenses. The SBO asks members to be engaged healthcare consumers by using in-network providers, selecting the appropriate sites of care, and seeing their primary care provider regularly to receive preventive care and assistance with managing chronic health conditions.

Tactics to meet the goal:

- Continued to educate GHIP members on lower cost alternatives to the emergency room for non-emergency care (e.g., telemedicine, urgent care centers, retail clinics)
- Continued to educate members on the availability of GHIP care management and lifestyle risk reduction programs
- Continued to explore, implement, and promote medical TPA programs and plan designs that help steer members to most appropriate sites of care (without impacting quality of care delivered)

- Continued to monitor utilization of third-party Centers of Excellence benefit and drive engagement through additional member education and ongoing review of incentives
- Evaluated competitiveness of GHIP medical and Rx vendors' pricing for covered services and drugs against their competitors
- Continued to measure and report on utilization of various sites of care for similar services, low-value services, and preventable services (e.g., “never events”) to identify areas of unnecessary utilization and lower quality providers
- Continued to evaluate the cost and implications for the GHIP to voluntarily comply with Delaware’s Primary Care law

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 Lantern
- Facilitated webinars to promote wise healthcare consumerism
- Provided materials and resources through SBO’s website regarding quality, patient safety, and patient engagement
- Continued to hold medical TPAs accountable for expanding their pay-for-value contracts with providers
- Continued to promote tools and resources that help members identify high-quality, high-value providers
- Continued to require medical TPAs to submit GHIP claim data to the DHIN and to support value-based provider contracts (e.g., ACOs) where applicable
- Continued monitoring of Lantern benefit utilization and member engagement
- Conducted a Market Check for FY2024 and FY2025 through WTW with CVS Caremark
- Utilized Merative database to monitor utilization of various sites of care for similar services, low-value services, and preventable services

Results:

Against an established national baseline trend of 6%, the GHIP has successfully achieved a lower trend (5.1%) over the past eight years from FY16 to FY24. However, the GHIP’s observed trend was higher than the Department of Health and Social Services (DHSS) established Health Care Spending Benchmark of 3.0% for Calendar Year 2024*. Healthcare costs and trends are continuing to rise nationally and for the GHIP. Industry and government analysts anticipate healthcare unit cost in the US to increase 6% or more again in 2025 and 2026.

A variety of factors have influenced the recent upward trends, including:

- Healthcare labor costs:
  - Workforce shortages were exacerbated by the pandemic and expected to persist.
  - Further, provider “burnout” and increased patient demand are expected to keep the pressure up on clinical workforces across the industry.
- Provider Consolidation:
  - Provider organizations continue to merge, reducing competition and increasing contract negotiating power.
  - Anticipated defunding of public health programs will likely lead to closures of rural hospitals as conglomerate owners focus on profitability. Increased demand and decreased access will add to cost pressures.

- Increasing cost of pharmaceuticals:
    - Employers are experiencing inflationary pressure from the rising median price of new drugs, as well as the increasing price of existing drugs.
    - Combined with the accelerated approvals of new cell and gene therapies, higher pharmacy trends are expected to persist over the next 3 to 5 years.
    - GLP-1 drugs continue to see sharply increasing utilization as effectiveness and indications evolve – utilization and associated costs are expected to continue to increase over the next 3 to 5 years.

In addition to these factors, uncertainty remains around the impact of federal changes to Medicaid and the possible expiration of ACA subsidies at the end of 2025 which may further drive cost increases for employer plans over the next few years.

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

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

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