The State of Delaware

Proposed GHIP Strategic Framework FY2026 – FY2029

State Employee Benefits Committee Meeting

November 25, 2025

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Contents

Overview of the FY2025-2026 GHIP Strategic Framework

- The State Employee Benefits Committee had adopted the **Group Health Insurance Plan (GHIP) Strategic Framework** to outline GHIP goals and guiding principles
- Framework included:
  1. **Mission statement** – unchanged since originally adopted in December 2016
  2. **Goals** – last updated in December 2023, uses FY2023 data as baseline for measurement
  3. **Strategies** – last updated in December 2023, based on goals
  4. **Tactics** – last updated in December 2023, based on strategies
- The four-part format of the Framework[1] reflected preferences of SEBC members from 2016

Mission Statement:

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.

Purple text = core concepts defined further in Appendix

Purpose - provide SBO guiding principals supporting:

- Evaluation of GHIP's coverages and design against innovations in the employer sponsored healthcare benefits space
- Measurement of program goals against established benchmarks
- Development of thoughtful RFPs and recommendations that encourage progress towards agreed upon priorities

1 The FY2024-FY2025 GHIP Strategic Framework can be found here: https://dhr.delaware.gov/benefits/sebc/documents/strategic-framework.pdf?ver=0117

Strategic Framework in Context

How is the Strategic Framework Used?

The SBO creates a work plan from the goals, strategies, and tactics established in the Strategic Framework and develops action items that are relevant, measurable and timebound that guide the work of the Office

What are the confines of the Strategic Framework?

The Strategic Framework is designed to advance the GHIP mission while operating within our legal/authoritative, fiscal, and administrative confines

Legal and authoritative confines	▪ State and federal law (e.g., removing a plan option specified by Delaware Code, adjustments in payroll contributions) ▪ CMS or State of Delaware Department of Insurance (DOI) regulations ▪ Procurement and contracting laws and best practices ▪ Privacy and data protection laws (e.g., HIPAA) ▪ The State's contractual authority (e.g., vendor contracts with providers for pricing or payment models outside the scope of authority) ▪ The SBO's and SEBC's legal authority
Fiscal confines	▪ Premium rate setting limitations ▪ State budget context ▪ Cost-effectiveness and ROI considerations
Administrative confines	▪ IT and data system capabilities ▪ Staffing levels and expertise ▪ Administrative process timelines (e.g., procurement and contracting cycles)

Recent and current dynamics affecting the GHIP

Industry drivers	▪ Continued provider organization consolidation in the health care market reduces choice and ability for carriers to negotiate ▪ Labor shortages and supply chain disruption are priced in as provider contracts are negotiated ▪ The rise of GLP-1 utilization and associated costs increase budget pressures across the spectrum of plan sponsors ▪ High-cost trends encourage focus on alternative plan designs and value-based provider contracting ▪ Start-ups and disruptive models continue to yield new approaches to program management and care delivery; innovations in the market create pressure for traditional carriers/vendors to replicate results
Delaware state-level drivers	▪ Ongoing consolidation of Delaware providers with hospital systems buying up independent practices ▪ Reformation of SEBC membership and procedures in 2024 provides more direct involvement by members in decision making ▪ Passage of SB 120 which focuses on strengthening the primary care system within the State. ▪ Pervasive state budget pressure due to changes in federal funding have caused Governor to request cost management strategies to reduce budgets across state departments/programs
Key changes to GHIP design and offerings	▪ Implemented Aetna One Advisor ▪ Expanded Lantern services including Hinge Health ▪ Mandated Bariatric services be accessed via Lantern ▪ Implemented Health Advocate for EAP support ▪ General changes to plan design structure to ensure compliance with MHPAEA

Goal 1: Improve the **health** of GHIP members

Strategy 1: Strengthen primary care engagement and promote preventive care	
Tactics	**Considerations**
• Encourage members to establish and maintain a relationship with a **primary care** provider (PCP) • Promote **annual physical exams** and all age-based annual **wellness** requirements (e.g., mammograms, colonoscopies)	• Delaware's primary care is experiencing challenges including a shortage of primary care physicians, increased wait times for appointments, and disparities in access for certain populations.
Measures: Primary care physician utilization statistics, annual physical exam rate, percent of population primary care attribution	

Strategy 2: Engage members across the health continuum and provide services and education specific to their needs	
Tactics	**Considerations**
• Explore conducting **Health Risk Assessment** surveys • Promote wellness and condition management services to all members • Work with the TPAs to explore delivering **targeted** education and support to members of varying health status • **Promote wellness** for low-risk members • Enhance support for **"rising-risk**" members (for example, prediabetics) • Identify **high-cost claimants** and those with **chronic disease** and engage them in the medical TPA's Care Management (CM) programs	• The need to balance targeted communication and support strategies with member privacy considerations • SBO/SEBC reliance on TPAs to conduct targeted interventions
Measures: GHIP population risk score over time, portion of GHIP population in Healthy/Low Risk status, disease staging data, portion of High-Risk population that engages in clinical management programs if available, health risk assessment participation rate, pre- and post-communications trend data	

Goal 1: Improve the **health** of GHIP members

Strategy 3: Identify unmet or inequitable healthcare needs of members	
Tactics	**Considerations**
• Closely monitor member engagement with any available Medical TPA **Social Determinants of Health (SDOH) surveys** • Assess impact of **SDOH** on member health and access to care • Identify at-risk populations that may face health equity challenges and work with medical TPAs to connect members to support services through **Care Management programs.** • **Address "care deserts"** by expanding virtual care and localized support such as provider networks.	• SDOH can tend to be underreported • Adding SDOH to the database may come with a cost • The need to balance targeted communication and support strategies with member privacy considerations • SBO/SEBC reliance on TPAs to conduct targeted interventions
Measures: Overlay of housing and census tract data approximating social-economic status	

Strategy 4: Optimize vendor contracting to improve targeted member outreach	
Tactics	**Considerations**
• Embed **targeted communication** and education support in Medical TPA RFP • Leverage carrier and vendor communications to provide **segmented strategic outreach** targeting locations or groups where risk and rising risk concentration is the highest	• SBO/SEBC reliance on TPAs to conduct targeted interventions • The need to balance targeted communication and support strategies with member privacy considerations
Measures: Quarterly communications and training report, pre- and post-communications trend data	

Goal 2: Ensure members receive **high-quality** and safe care that is cost-effective and improves outcomes

Strategy 1: Optimize sites of care utilization and empower members to make high-value care choices

Tactics	Considerations
• Identify high-cost, low-value site-of-care patterns (e.g. ER use for non-emergent needs) and work with the TPAs to **develop targeted interventions**	• Strategies that rely on consumeristic behavior are less impactful when plan designs are rich
• Embed Centers of Excellence (COE) **utilization targets** in Medical TPA RFP	• SBO/SEBC reliance on TPAs to conduct targeted interventions
• Evaluate implementing a modern **provider search tool** to support site of care decisions	• Current availability of cost transparency tools that are specific to GHIP members may be limited.
• Promote publicly available provider quality and safety comparison tools (e.g., Leapfrog's Hospital and Surgery Center Ratings, Leapfrog's Hospital Safety Grade, Healthgrades, CMS Provider Compare, etc.)	• Implementation of a modern provider search tool would come at a cost

Measures: Site of Care Steerage Report, Centers of Excellence & Lantern utilization and outcomes statistics, HEDIS quality measures

Strategy 2: Advance alternate payment models (APMs) that reward quality and outcomes

Tactics	Considerations
• Work with the TPAs to increase GHIP spend in **Value-Based Payment Models** (ACOs, bundled payments)	• SBO/SEBC have limited influence over provider agreement to Value-Based Payment model adoption

Measures: Delaware Office of Value-Based Health-Care Delivery data, value-based care versus fee-for-service payment data

Goal 3: Manage **healthcare costs** for GHIP and members

Strategy 1: Optimize benefit design to promote cost-effective, high-value care	
Tactic	**Considerations**
• Offer **consumer-driven plan options** such as an HSA-compliant plan option • Explore the **differentiation of plan options** by payroll deductions and out-of-pocket exposure. • Review copay, deductible and coinsurance structures to **ensure alignment** with cost and quality goals • Explore **designing member benefits** and incentives that encourage use of high-value care and discourage low-value or avoidable utilization (for example, increase ER copays) • **Incentivize smart provider and site selection** with tools and plan features that guide members to high-value care	• Some GHIP members may value an HSA-compliant plan and the opportunity to save in a highly tax-advantaged account • A deep exploration of revising premium determination methodology, realigning actuarial values, and reviewing quarterly financial and key trends reports would likely require the addition of SEBC workgroups
Measures: Compare year-over-year GHIP PMPY trend to market benchmarks	

Strategy 2: Manage specialty pharmacy and high-cost drug spend	
Tactic	**Considerations**
• Explore strategies to manage **GLP-1 costs** and utilization • Explore PBM and pharmacy cost reduction strategies in **Senate Joint Resolution 7** • Explore and make recommendations to the General Assembly about **legislative strategies**	• Rapidly changing market and legal landscape for weight loss medications • Procurement and contracting cycles • Legal and administrative capabilities and limits
Measures: Key Trends report, Diabetes and obesity semi-annual dashboards, GLP-1 analysis, Incurred Claims report	

Goal 3: Manage **healthcare costs** for GHIP and members

Strategy 3: Identify high-cost conditions and implement solutions	
Tactic	**Considerations**
• Continue to **track high-cost** conditions, procedures, and trends. • Evaluate and offer point solutions and patient support programs that focus on high-cost conditions such as **Diabetes, Behavioral Health and Musculoskeletal (MSK)** • Adopt **innovative cost-saving** carrier programs and vendor partners as appropriate • **Increase utilization** of the Diabetes Prevention Program (DPP), Employee Assistance Program (EAP), Lantern Surgeons of Excellence, and Hinge Health	• Point solutions and carrier programs may come with an initial up-front cost
Measures: Compare Diabetes and MSK PMPY costs against available condition specific benchmarks, disease state progression analyses of Diabetes and MSK spend, enrollment and utilization data for programs, program evaluation, high-cost claimant report, specific-condition dashboards	

Strategy 4: Optimize vendor management, contracting, and performance oversight to manage spend	
Tactic	**Considerations**
• Optimize **vendor contracts** to obtain optimal network discounts, and administrative fees, and contract terms • Leverage PBM RFP to **minimize pharmacy spend** and allow for direct contracting with manufacturers for certain drugs • Ensure **payment integrity** of carriers and PBMs to prevent waste, fraud, and abuse • Perform medical and PBM **claims audits**; perform implementation audit after a vendor change	• Optimizing vendor contracts may be constrained by administrative process timelines (e.g., procurement and contracting cycles)
Measures: Audits, payment integrity algorithms	

Goal 3: Manage **healthcare costs** for GHIP and members

Strategy 5: Engage members to use care appropriately to reduce preventable costs	
Tactic	**Considerations**
• Promote the health data warehouse **plan decision support tool** during Open Enrollment (OE) cycles that include material changes in plan options • Educate members on **price variation** across sites of care and providers to support informed choices • Promote **alternate sites of care** such as ambulatory surgery centers, urgent care centers, and telehealth • Educate members on how **smart choices** impact GHIP sustainability and employee contributions • Promote use **cost transparency tools** • **Support agency HR leaders** with consumerism resources to drive member engagement and decision-making	• Health data warehouse plan decision support tool utilization plateaus when there have not been recent plan design changes • Strategies that rely on consumeristic behavior are less impactful when plan designs are rich • Available and appropriate cost transparency tools may currently be limited • External cost transparency vendors will require an RFP and incur incremental cost and direct ROI or cost mitigation results may be difficult to determine
Measures: Health data warehouse plan decision support tool engagement statistics in years when there are material changes to plan options, provider search tool engagement statistics, avoidable ER Utilization analysis, Teledoc utilization analysis, pre- and post-communications trend data	

Goal 4: Ensure **transparency and continuous improvement** toward achieving goals by monitoring, measuring and reporting progress

Strategy 1: Establish a performance measurement and reporting framework	
Tactics	**Considerations**
• Develop **action items** for each tactic and create an implementation plan • Develop **key performance indicators** and benchmarks aligned with strategic goals	

Strategy 2: Strengthen data analytics capabilities	
Tactics	**Considerations**
• Evaluate opportunities to increase **analytic capabilities** through additional tools as opportunities arise • Evaluate opportunities to improve **data integration** across systems as opportunities arise • Optimize **vendor contracting** to enhance data to make data and files more useful (for example, sharing lab data with the State's health data warehouse)	• Enhanced analytic capabilities typically come at a cost

Goal 4: Ensure **transparency and continuous improvement** toward achieving goals by monitoring, measuring and reporting progress

Strategy 3: Use evaluation and feedback to refine strategies and tactics	
Tactics	**Considerations**
• Conduct regular evaluations to **assess progress** and realign resources • Integrate member **feedback and evaluation** findings into future Strategic Framework planning • **Adjust strategies and tactics** based on data, feedback, opportunities, and challenges	• Requires regular discussions and revisions with the SEBC

Strategy 4: Enhance transparency through regular reporting	
Tactics	**Considerations**
• Develop **dashboards** aligned with strategic goals • **Summarize progress** on the Strategic Framework quarterly to State Employee Benefits Committee or a designation Subcommittee/Workgroup • Provide detailed results in an **annual results report** • **Communicate progress** to GHIP members and the public	

Areas of Focus for FY2026 – FY2027

GHIP Strategic Goals

SBO will be seeking SEBC guidance on:

	Improving Member Health	High-quality Care	Healthcare Costs	Transparency and Reporting
Conducting Medical TPA RFP, selection, and contract negotiations	✓	✓	✓	
Evaluating APMs, alternative plan designs, and network strategies via Medical TPA RFP		✓	✓	
Expanding the roles of Lantern and/or considering additional site-of-care steerage strategies	✓	✓	✓	
Conducting PBM RFP, selection, and contract negotiations			✓	
Exploring the implementation of an HSA-compliant plan			✓	
Evaluating and augmenting care navigation tools and cost transparency vendors	✓	✓	✓	✓
Enhancing GLP-1 utilization management			✓	
Evaluating Social Determinants of Health and mitigating impacts	✓	✓	✓	✓
Contracting directly with pharmaceutical manufacturers for certain medications			✓	

Next Steps

- Feedback from today's discussion will be incorporated into updated version of the GHIP Strategic Framework to be reviewed with the SEBC in December
- SEBC to consider voting to adopt updated version of the GHIP Strategic Framework at the December 16, 2025 meeting

Appendix: General

GHIP mission statement

Core concepts defined

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.

Core Concept	Definition
Adequate access	Access to various types of healthcare providers that meets generally accepted industry standards (e.g., *x* number of *y* PCPs, specialists, hospitals within *z* miles of GHIP participant's home zip code).
High quality healthcare that produces good outcomes	Healthcare that meets nationally recognized standards of care established by various governmental and non-governmental health care organizations (e.g., AHRQ, NCQA, The Leapfrog Group).[1]
Affordable cost	Annual health care cost trend that is lower than national average for both GHIP participants and the State. For GHIP participants, at minimum, medical plans meet the minimum value and affordability requirements under PPACA; cost reflects both out-of-pocket cost sharing via plan features and employee payroll contributions. For the State, program costs are monitored and budgeted to promote greater fiscal certainty.
Healthy lifestyles	Combination of behaviors that reduce health risk factors, including regular exercise, proper nutrition, avoidance of tobacco, moderation of alcohol use, preventive care, and active management of chronic conditions.
Engaged consumers	GHIP members who have taken ownership of their health by using all available resources provided by the State (e.g., provider cost/quality data, SBO consumerism website and online training course) to make informed decisions on how, where and when they seek care.

[1] AHRQ = Agency for Healthcare Research and Quality, a Federal agency within the U.S. Department of Health and Human Services (HHS).
NCQA = National Committee for Quality Assurance, a 501(c)(3) not-for-profit organization.
The Leapfrog Group is a nonprofit watchdog organization and a national advocate of hospital transparency in cost, quality and safety data to support informed decision-making among healthcare consumers.

Legislative considerations of the GHIP strategic development process

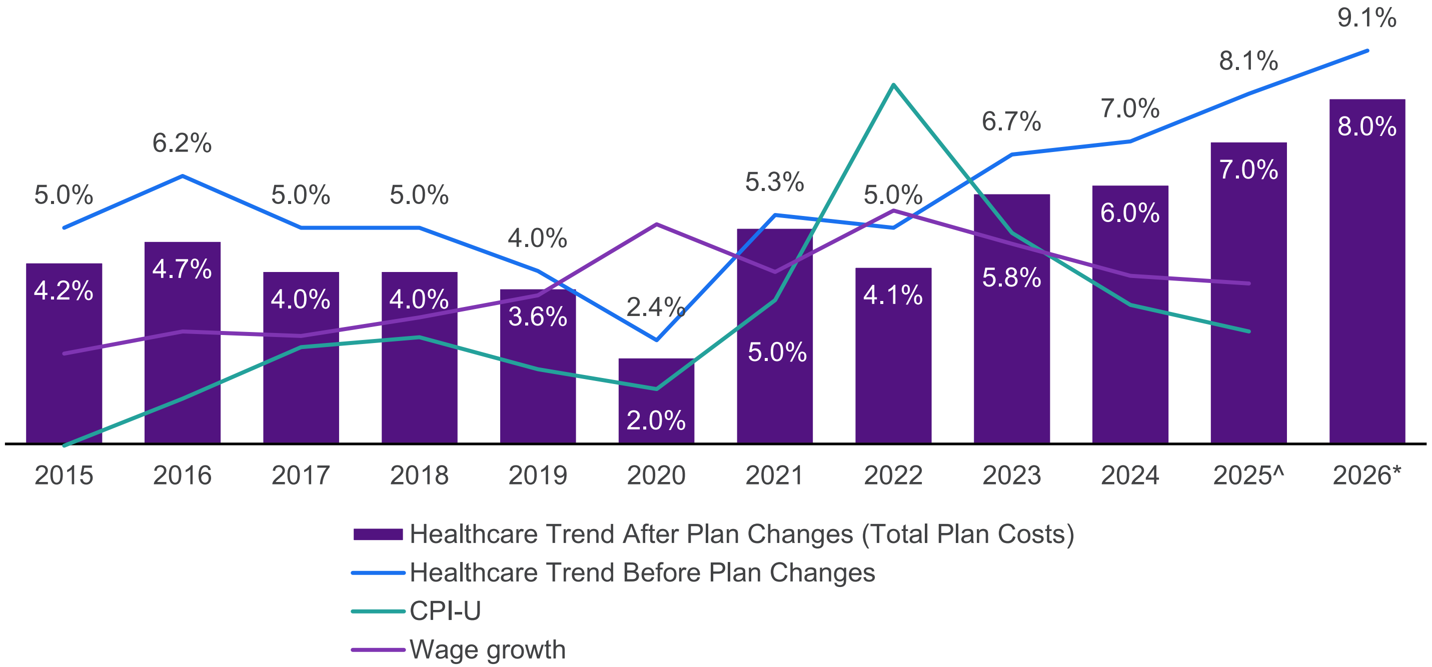
Potential actions	Illustrative example(s)	Requires legislative change?
Traditional plan design changes	Increase deductible by $100	No
Non-traditional plan design changes	Implement reference-based pricing Add a third coverage tier for a narrow network	No
Adding a new medical plan	Adding CDHP/HSA or adding a PPO option that has a narrow network	**No**
Removing a plan option specified by the Delaware Code	Removing the First State Basic plan	Yes
Freezing enrollment in a medical plan	1. Freeze to new entrants 2. Freeze to new hires	Yes
Adding a vendor	Wellness vendors, price transparency tools, condition-specific point solutions	No
Adjustments in employee contributions	Increasing the payroll deduction for an employee from 12% to 15%	Yes
Adjustments in dependent contributions	Increasing the increasing the incremental dependent payroll deduction cost sharing by 10%	Yes
Addition of surcharges	1. Add a tobacco and/or spousal surcharge 2. Wellness “dis-incentive” for non-participation	Maybe
Addition of an incentive program or a percentage of savings achieved by using a COE	1. Paying an employee $100 to get their biometric screening from their PCP 2. Paying an employee $100 for using a COE	Maybe
Modify and/or implement a more aggressive medical or Rx utilization management program	1. Mandating utilization of COEs for certain surgeries 2. Tighten prior authorization requirements for certain high-cost drugs. 3. Discontinue coverage of certain high-cost drugs	No

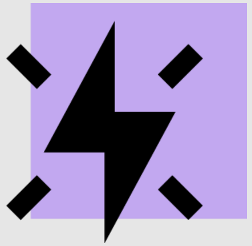
New opportunity

Healthcare cost increases are at the highest point in over a decade

Cost pressure

Healthcare cost trends approach levels not seen since the early 2000s





73% **of companies are feeling more cost pressure today than at any point in the past 10 years**

Note: Percentages of healthcare trend are median numbers.
Source: WTW 2025 Best Practices in Healthcare Survey; Bureau of Labor Statistics, Consumer Price Index for All Urban Consumers (CPI-U)

Appendix: Benchmarking

(2025 WTW Financial Benchmark Analysis results)

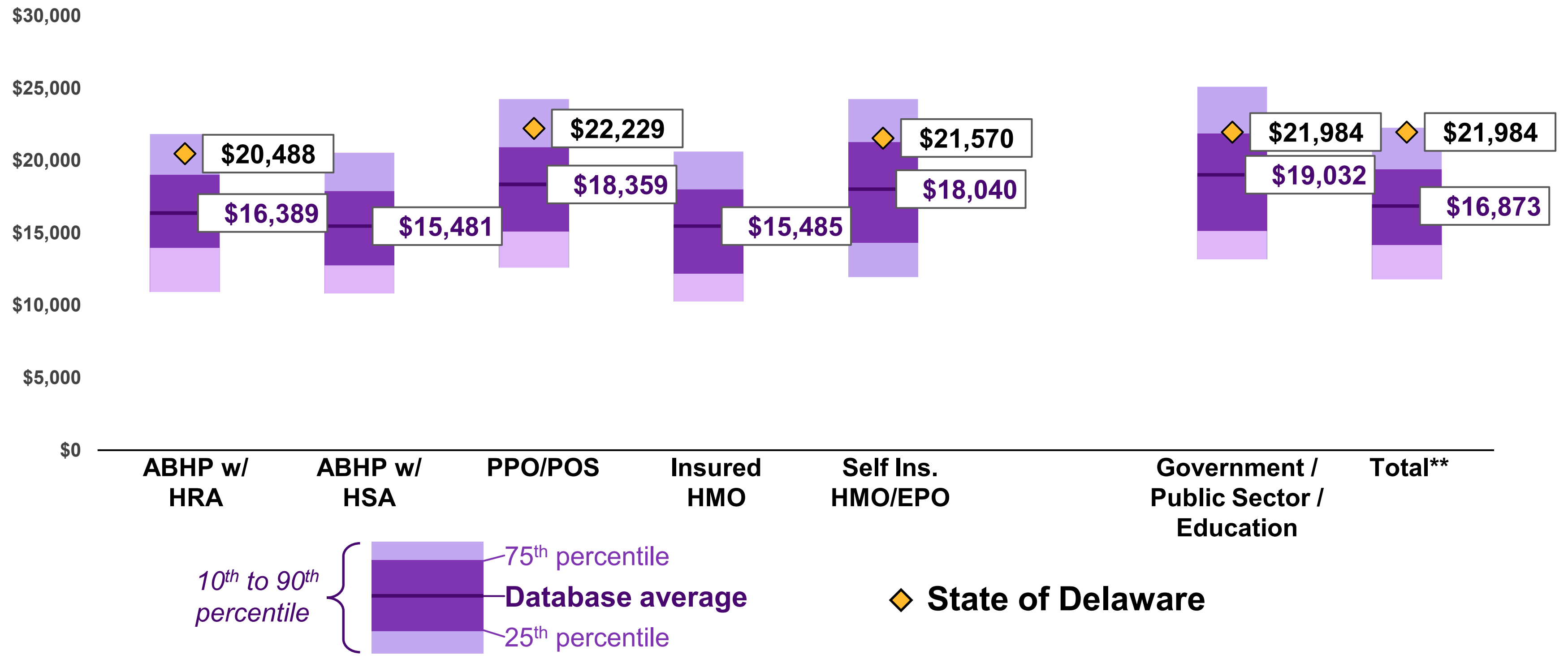
Medical cost benchmarks

CONSIDER:

- Costs are average per employee per year, across all enrollees
- These are unadjusted costs based on premiums and/or premium equivalents

Total cost per covered employee per year*

? How do your gross plan costs (employer subsidy and employee contributions) compare?



✓ Your actual costs are 30% above the benchmark average, 16% above average for your industry.

*Unadjusted
**Total costs represent an enrollment weighted average of all plan types

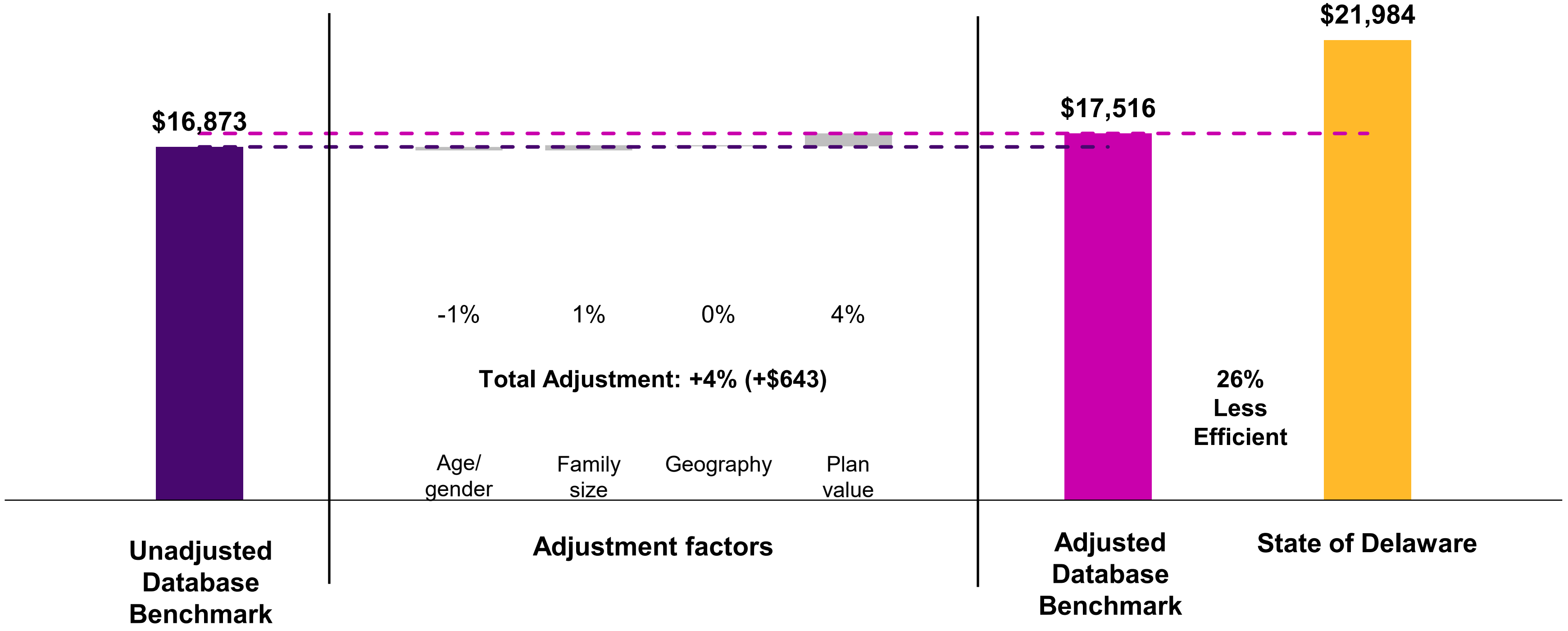
Medical cost benchmarks

CONSIDER:

- Are there opportunities to improve your cost efficiency for the next plan year?
- Is your plan efficiency an opportunity to highlight the strength of your program performance?

Program efficiency

? After adjustments, how efficient is your total plan overall?
What is the financial impact of moving to benchmark performance?



✓ Your total program is 26% less efficient than the average database performance, equating to $215 million of potential cost avoidance compared to other employers. Relative to top quartile performers, your total program is 40% less efficient, translating into a potential cost avoidance of $304.8 million.

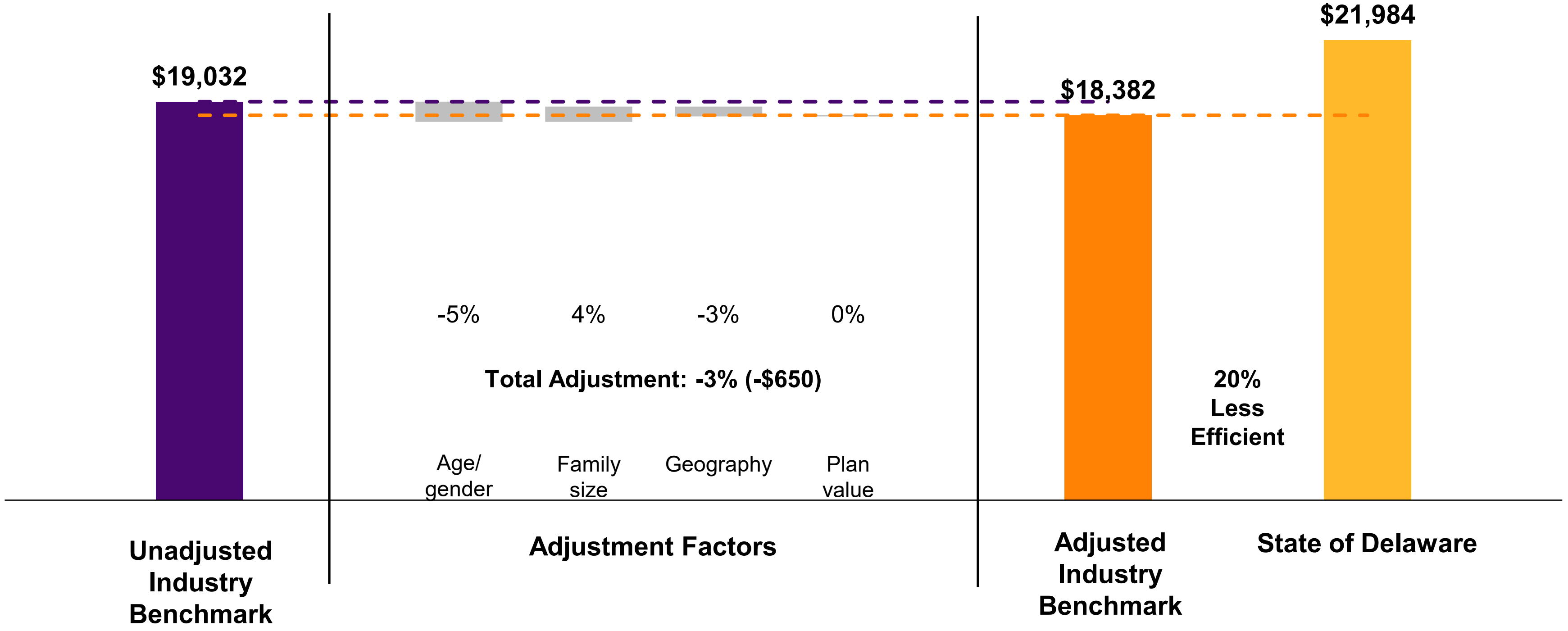
Medical cost benchmarks

CONSIDER:

- Are there opportunities to improve your cost efficiency for the next plan year?
- Is your plan efficiency an opportunity to highlight the strength of your program performance?

Program efficiency (versus industry benchmark)

? After adjustments, how efficient is your total plan compared to the Government / Public Sector / Education industry?



✓ Your total program is 20% less efficient than your industry, equating to $173.4 million of potential cost avoidance.

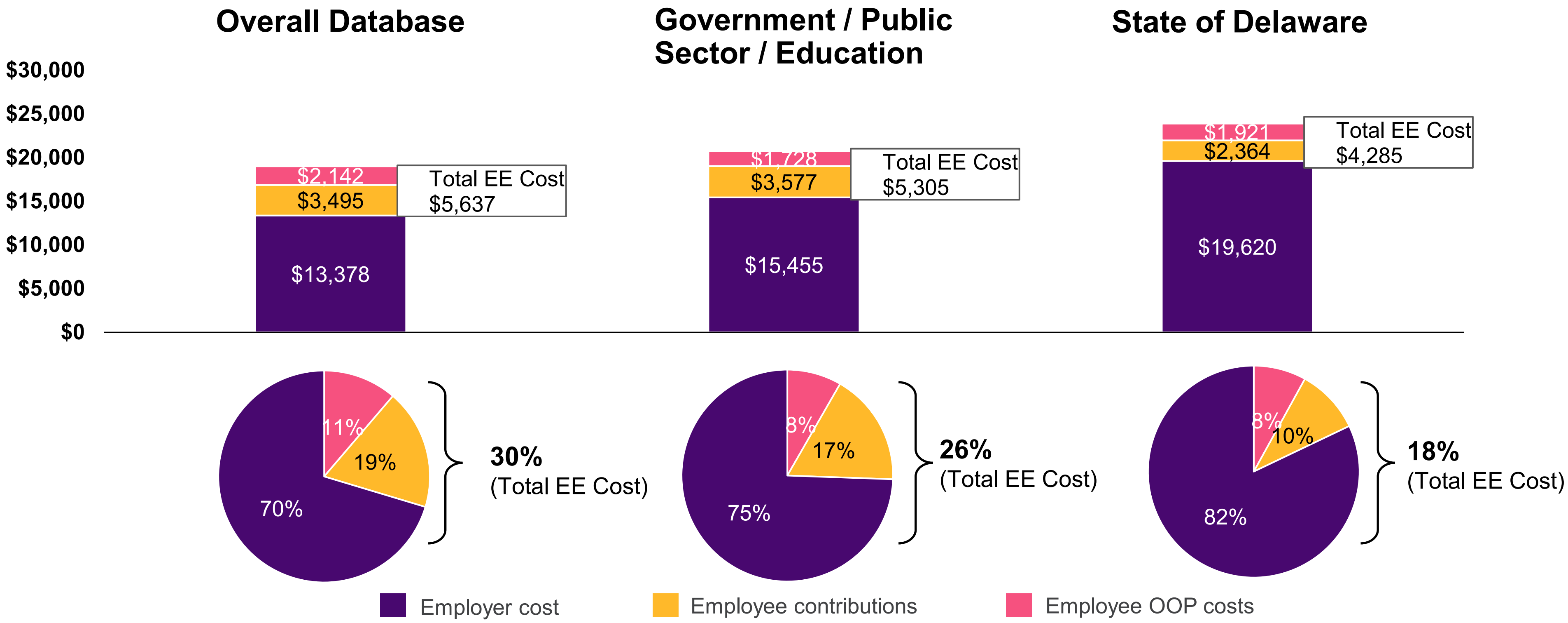
Medical cost benchmarks

CONSIDER:

- The competitiveness of your employee cost sharing is an important consideration when attracting and retaining talent
- Cost shifting is an important discussion each year in an effort to balance company cost management and employee affordability

Total cost and contributions

? How does your employees' share of total cost, including contributions and out-of-pocket expenses, compare to benchmarks?



✓ Compared to the overall database, your employee share of total costs is lower. Compared to others in your industry, your employee share of total costs is lower.

Medical plan design benchmarks

Medical plan design benchmarks

Account based plans with HRA

Medical* (single/family)	State of Delaware	Database	
	Aetna CDH Gold	All companies	Government / Public Sector / Education
Account funding	$1,250 / $2,500	$500 / $1,000	NA
Deductible	$1,500 / $3,000	$1,750 / $3,500	NA
Plan coinsurance	90%	80%	NA
Office visit (OV) copays**	NA	$25 / $50	NA
Inpatient (IP) copay	NA	$250	NA
Outpatient (OP) copay	NA	$100	NA
Virtual care copay	NA	$25	NA
Urgent care (UC) copay	NA	$50	NA
Emergency room (ER) copay	NA	$250	NA
Out-of-pocket maximum	$3,000 / $6,000	$2,250 / $4,600	NA

*In-network benefits
**Primary care physician/specialty care physician copays (if applicable)

Medical plan design benchmarks

Medical plan design benchmarks

PPO/POS plan designs

Medical* (single/family)	State of Delaware		Database	
	Highmark Comprehensive PPO	Highmark First State Basic	All companies	Government / Public Sector / Education
Deductible	NA	$500 / $1,000	$800 / $2,000	$600 / $1,500
Plan coinsurance	100%	90%	80%	90%
Office visit (OV) copays**	$20 / $30	NA	$25 / $40	$25 / $35
Inpatient (IP) copay	$150	NA	$250	$250
Outpatient (OP) copay	$50	NA	$125	$100
Virtual care copay	$20	NA	$25	$20
Urgent care (UC) copay	$20	$25	$50	$30
Emergency room (ER) copay	$200	NA	$200	$150
Out-of-pocket maximum	$4,500 / $9,000	$1,500 / $3,000	$2,500 / $5,000	$2,500 / $4,500

*In-network benefits
**Primary care physician/specialty care physician copays (if applicable)

Medical plan design benchmarks

Medical plan design benchmarks

HMO plan designs

Medical* (single/family)	State of Delaware	Database	
	Aetna HMO	All companies	Government / Public Sector / Education
Deductible	NA	$750 / $1,600	$600 / $1,400
Office visit (OV) copays**	$15 / $25	$20 / $35	$25 / $35
Inpatient (IP) copay	$150	$250	$250
Outpatient (OP) copay	$50	$75	$100
Virtual care copay	$15	$20	$20
Urgent care (UC) copay	$15	$30	$30
Emergency room (ER) copay	$200	$150	$150
Out-of-pocket maximum	$4,500 / $9,000	$2,500 / $5,000	$2,500 / $5,200

*In-network benefits
**Primary care physician/specialty care physician copays (if applicable)

Medical plan design benchmarks

Account based plans with HSA

Delaware does not offer an HSA compliant plan today but may consider in the future.

Medical* (single/family)	Database	
	All companies	Government / Public Sector / Education
Account funding	$500 / $1,000	$500 / $1,000
Deductible	$2,025 / $4,306	$2,000 / $4,000
Plan coinsurance	80%	86%
Office visit (OV) copays**	$25 / $50	$30 / $60
Inpatient (IP) copay	$250	$100
Outpatient (OP) copay	$150	NA
Virtual care copay	$45	$49
Urgent care (UC) copay	$45	$75
Emergency room (ER) copay	$200	$200
Out-of-pocket maximum	$2,000 / $4,000	$2,000 / $4,000

*In-network benefits
**Primary care physician/specialty care physician copays (if applicable)

Medical plan design benchmarks

Appendix: Cost Management Tactics

4 categories of levers to lower healthcare spending

Participation

Fewer plan members lowers total medical spending

Plan design and cost sharing

Shifting costs and tweaking plan design can lower employer costs and utilization

Population Health programs

Improving health and navigation can lower costs but takes effort and savings are lagged

Carrier and PBM accountability

PBMs and carriers impact unit cost and utilization

Legend for subsequent pages

++	**Most favorable**
+	**Favorable**
	Neutral or not applicable
–	**Not favorable**
– –	**Very unfavorable**
★	**Current GHIP tactic/strategy**

Categories of assessment

- Amount of savings
- Timing of savings
- Administrative effort required
- Member perception
- Impact on quality
- Prevalence in the market
- Applicable to midmarket and large market clients

Legend for subsequent pages

Category	Rating system									
Potential savings – relative to total plan cost	+ +	1%+ TME	+	Up to 1% TME		Cost neutral	– –	Increases TME		
Timing for savings	+ +	<1 year	+	1-3 years		> 3 years				
Administrative effort	+ +	Minimal	+	Small		Medium	–	Large	– –	Very high
Member perception	+ +	High satisfaction	+	Moderate satisfaction		Neutral or not applicable	–	Mild dissatisfaction	– –	High dissatisfaction
Impact on quality of care	+ +	Much improved	+	Improved		Neutral or not applicable	–	Worse	– –	Much worse
Prevalence in market		Under a quarter		Quarter to half		Half to 3 quarters		Over 3 quarters		

Notes on savings
- TME = Total medical expense
- Savings depend upon starting point and details of the initiative
- Most clients will need to have multiple initiatives to reach their savings goals

Participation

Fewer plan members lowers total medical spending

	Savings potential	Savings Timing	Admin effort	Member perception	Quality	Prevalence	Med/Rx	Comments
Eliminate spousal coverage	+	+	++	−−	−		Both	Can adversely impact recruitment/retention
Eliminate part-time coverage	+	+	++	−			Both	Many part-time employees have been able to obtain marketplace plans with subsidies
Dependent audits	+	++	+	−			Both	
Spousal surcharge	+	+	++	−			Both	
Spousal incentive plan		+	−	−	−		Both	Often has high administrative costs and modest savings, and client should check with counsel
Medicare coordination	+	++	−	−			Both	Transitioning those eligible to primary Medicare responsibility lowers employer costs
Eliminate domestic partner coverage	+	+	+	−			Both	About two-thirds of companies in Benefit Data Source cover domestic partners
Increase waiting period	+	+	+	−			Both	Members can delay non-urgent expenses until waiting period is over

Plan design and cost sharing (1/3)

Shifting costs and tweaking plan design can lower employer costs and utilization

	Savings potential	Savings Timing	Admin effort	Member perception	Quality	Prevalence	Med/Rx	Comments
Increase Member premium share	++	++	++	−−	●	◐	Both	Members may be less sensitive to premium increases as they are a small portion of total paycheck
Increase out-of-pocket cost sharing	++	++	++	−−	−	◐	Both	Increased point-of-service cost sharing decreases utilization of low- and high-value care
Most restrictive formulary	+	++	+	−−	−	◔	Rx	Restrictive formularies can lead to nonadherence
★ Rx copay maximizer or accumulator	+	++	+	−	●	◐	Rx	**Currently offering PrudentRx and Cost Saver copay assistance programs with CVS**
★ Eliminate GLP-1 for obesity	++	++	+	−−	−−	◔	Rx	**Currently under consideration.** Members will not gain clinical benefits. Might adversely effect recruitment and retention
Narrow network for obesity Rx	+	++	+	−	−	◔	Rx	Narrow network is preferable to employees than noncoverage. Can cause loss of rebates
Restrict site of service	+	+	−	−	+	◔	Both	High-leverage providers and hospital site of service have higher prices and often don't provide additional value
Limit preventive drug list to required meds	+	++	+	−	−	◐	Rx	Those with diabetes will face higher cost sharing

Plan design and cost sharing (2/3)

Shifting costs and tweaking plan design can lower employer costs and utilization

	Savings potential	Savings Timing	Admin effort	Member perception	Quality	Prevalence	Med/Rx	Comments
Reconfigure wellbeing incentives	+	+ +	–	–			Med	Accounting method can mean eliminating incentives increases employer cost
Offer only narrow network plans	+ +	+ +	–	– –	+ +		Med	Requires substantial communication and disrupts many clinical relationships
Narrow network (alongside other offerings)	+	+ +	+	+	+		Med	Positive selection of limited network plans can give false sense of savings
Narrow Rx network	+	+ +	–		+		Rx	
Virtual first health plan	+	+ +	–	+			Med	Positive selection of new plan designs can give false sense of savings. Extra choice can make members happy
Decrease or eliminate out-of-network (OON) payment	+	+ +	–	– –			Med	**Aetna HMO provides In-Network coverage only**. Can lead to balance billing for services not covered by the No Surprises Act.
No payment for low-value services	+	+ +	–	– –	+ +		Med	Some services are "low value" for only a portion of the population but high value for others

Plan design and cost sharing (3/3)

Shifting costs and tweaking plan design can lower employer costs and utilization

	Savings potential	Savings Timing	Admin effort	Member perception	Quality	Prevalence	Med/Rx	Comments
Mandatory center of excellence (COE)	+	+	●	−	++	◔	Medical	Many carriers object, and most clients choose voluntary COE. Substantial communications necessary. Savings depend on portion of total cost included.
Voluntary COE	●	++	●	+	+	◑	Medical	**COE model in place with Lantern. Utilization savings are offset by cash incentives**
Reference-based pricing plan	+	++	−	−−	−	◔	Medical	Members can receive large balance bills; some plans provide legal assistance. Rare outside of small companies
Offer a limited benefit plan	++	++	−	−−	−	◔		Could violate antidiscrimination rules and could
Require primary care physician (PCP) gatekeeper	●	NA	−	−	●	◔	Medical	**Aetna HMO option requires a PCP to manage access/referrals**
Prohibit OON elective dialysis	+	+	●	−	●	◔	Medical	Can decrease OOP costs. Modest savings. Requires change of plan documents
Decrease or eliminate spouse / dependent subsidy	+	+	−	−	●	◔	Both	Increases family premiums substantially
Offer different benefits to different populations	+	+	−	−	●	◔	Both	If richer plan offered to highly compensated employees, could cause non-discrimination concerns. Can do forecast testing to evaluate.

Population Health programs (1 of 2)

Improving health and navigation can lower costs but takes effort and savings are lagged

	Savings potential	Savings Timing	Admin effort	Member perception	Quality	Prevalence	Med/Rx	Comments
Rebid, consolidate or eliminate low-performing point solutions	+	●	–	●	●	◑	Both	Better programs can engage and help members.
Increase prior authorization (PA)	++	++	–	– –	●	◔	Both	PA programs are hated by members and providers but lower total medical expense. Rx programs already have substantial PA
★ Telemedicine	+	++	++	++	●	○	Medical	**Currently offered via Teledoc Health.** Telemedicine can increase costs if it does not substitute for in-person care
Onsite/Near-site	+	●	–	++	++	◔	Medical	Limited by employee concentration.
Genetic testing management	●	++	+	●	++	◔	Both	Likely to increase in importance
Expert medical opinion (EMO)	+	++	+	++	++	◔	Medical	EMO often bundled into larger offering
★ Navigation/Concierge	●	NA	+	++	++	◔	Medical	**Currently offering Aetna One Advisor and CCMU (Highmark)** Steerage savings do not always offset program cost; in particular, stand alone/overlay vendors may be cost-prohibitive
Pharmacy navigation	+	++	+	++	++	◔	Rx	Wide spectrum of vendors, effort and savings variable

Population Health programs (2 of 2)

Improving health and navigation can lower costs but takes effort and savings are lagged

	Savings potential	Savings Timing	Admin effort	Member perception	Quality	Prevalence	Med/Rx	Comments
★ Point solutions (oncology/metabolic/ musculoskeletal/ mental health)	+	++	+	+	++	◔	Both	**Currently offering Hinge, Aetna Enhanced Maternity, Transform Diabetes/Livongo/YMCA**
Promote FIT over colonoscopy	+	++	+	+	●	◔	Medical	Can increase effectiveness if more are screened for colorectal cancer
Promote pediatric vaccinations	+	++	+	●	++	◑	Both	Pediatric vaccinations are the rare medical service that is cost saving
Cell and gene therapy program (i.e., carrier programs, stop loss, etc.)	+	++	+	++	++	◔	Both	
★ More intensive clinical management (like CCMU)	+	++	+	++	++	◑	Both	**CCMU program in place with Highmark; Aetna One**

PBM and carrier accountability

PBMs and carriers have impact on both unit cost and utilization

	Savings potential	Savings Timing	Admin effort	Member perception	Quality	Prevalence	Med/Rx	Comments
Reprocurement of medical carrier and/or PBM	++	+					Both	**PBM and Medical TPA RFPs underway or scheduled for 2027 PY**. Regular rebidding is key to demonstrating fiduciary responsibility
Direct provider or pharma contracts	++	+					Medical	Generally limited to large companies with substantial geographic concentration (med) and HR resources (both)
Consider PBMs with different price models	+	+					Both	**PBM RFP will include alternative pricing models**
Payment integrity audits or vendor	++	++	+	–	–		Both	**SBO retained incumbent CTI after RFP in 2025**
Pharmacy market checks	+	++	++	+	+		Rx	**SBO/WTW perform routine market checks and will negotiate ability to market check in new PBM contract**
International pharmacy sourcing	+	+	––		+		Rx	High admin costs has so far limited demand
Employer coalition for Rx or Rx + Med	++	+	–				Both	Can lower member cost sharing

Risk management

These initiatives can mitigate risk but are not designed specifically to lower costs

	Savings potential	Savings Timing	Admin effort	Member perception	Quality	Prevalence	Med/Rx	Comments
Individual coverage health reimbursement arrangement	Varies	+	− −	− −	−		Both	Rarely used, and likely to be less attractive with increased marketplace premiums in 2026 and beyond. Cost savings from decreased subsidization
Stop loss	Varies	+	++				Both	Can help protect coverage for rare disease treatments; generally not efficient for large groups like GHIP population
Captives	Varies	+	− −				Both	Some companies productizing captives for smaller companies. Self-insurance can avoid reinsurance premiums
Cell and gene therapy reinsurance or pooling	Varies	++		+	+		Both	Some products are likely to have very low loss ratios.

Initiatives unlikely to lower total medical expense

Some might provide value to plan members, but will not lower total medical expense (TME)

Program	Comment or references
Traditional wellbeing programs	Can provide value on investment but not shown to lower TME.
Add cost-effective drugs to preventive list and waive cost sharing	Cost **effective** drugs don't lower TME. Only cost-**saving** interventions lower TME
Price transparency tools	Studies do not show that members are effective at "shopping" for care
Fertility programs	Can lower multiple births, but will raise TME
Direct primary care	No well-designed studies showing cost savings
Executive physicals	Likely to raise costs
Genetic testing for cancer susceptibility or multi-cancer early detection tests	Not shown to lower cost or decrease premature mortality.
Full body MRI scans	Likely to raise costs
Prenatal testing	Can detect rare diseases early but no evidence of lower TME
Stem cell/Platelet rich plasma for musculoskeletal	Randomized trials suggest little clinical benefit.
Broad coverage of GLP-1 medications for obesity	Excellent evidence of clinical benefit, but will raise TME