

STATE EMPLOYEE BENEFITS COMMITTEE MEETING
REVISED AGENDA - December 19, 2022 – 2:00 pm
Statewide Benefits Office
97 Commerce Way, Suite 201
Large Conference Room
Dover, Delaware 19904

The State Employee Benefits Committee meeting will be conducted both in person and virtually. Members of the public may participate in person or virtually/by phone using the information provided. Meeting materials will be posted in advance on the [Public Meeting Calendar](#) and the [SEBC webpage](#).

Meeting number (access code): 2693 241 1424 Meeting Password: SEBC
or Join by Phone Toll Free: 1-866-205-5379 *Press (*6 to unmute if joining by phone)*
Meeting link address: [Cisco Webex Meetings - Meeting Detail](#)

1. Call to Order
2. Approval of November 21, 2022 SEBC meeting minutes*
3. Director's Report/Subcommittee Updates
4. Financials
 - a. October 2022 Fund Report
5. Update on CVS Commercial Plan Performance for FY22
6. Spousal Coordination of Benefits Policy Revisions Effective January 1, 2023*
7. GHIP Strategic Framework
8. FY24 Planning - Benefits Modernization Initiative/Employee Preferences Survey
9. Other Business
10. Public Comment
11. Adjournment

Visit the SEBC website at dhr.delaware.gov/benefits/sebc for further details. Meeting materials are posted after each meeting.

***Agenda items may require action and approval by the Committee.**

The Committee may move into Executive Session for the purpose of discussing confidential financial information and trade secrets or the content of documents excluded from the public record pursuant to 29 Del.C. §10004(b)(6), and to receive legal advice pursuant to 29 Del.C. §10004(b)(4) relating to pending or potential litigation. The Committee may move into Executive Session for one or more of these reasons.



**MINUTES FROM THE MEETING OF THE STATE EMPLOYEE BENEFITS COMMITTEE
November 21, 2022**

The State Employee Benefits Committee (the “Committee”) met at 2:00 p.m. on November 21, 2022. The meeting was held at 97 Commerce Way, Suite 201, in Dover; however, in the interests of protecting the citizens of this State from the public health threat caused by COVID-19, this meeting was presented via WebEx, and participants were encouraged to attend virtually.

Committee Members Represented or in Attendance:

Director Cerron Cade, Office of Management & Budget (“OMB”), SEBC Co-Chair
Secretary Claire DeMatteis, Department of Human Resources (“DHR”), SEBC Co-Chair
Secretary Molly Magarik, Department of Health & Social Services (“DHSS”)
Ms. Judy Anderson, Delaware State Education Association “DSEA” (Designee of Mr. Jeff Taschner, Executive Director, DSEA)
The Honorable Bethany Hall-Long, Office of the Lt. Governor
Controller General Ruth Ann Jones, Office of the Controller General (“OCG”)
Mr. Matthew Rosen, Senior Policy Advisor, Office of the State Treasurer “OST” (Designee of The Honorable Colleen Davis, State Treasurer, OST)
The Honorable Chief Justice Collins Seitz, Delaware Supreme Court
The Honorable Trinidad Navarro, Insurance Commissioner, Department of Insurance (“DOI”)

Others in Attendance

Deputy Director Leighann Hinkle, SBO, DHR	Ms. Katherine Impellizzeri, Aetna
Ms. Nina Figueroa, Health Policy Advisor, SBO, DHR	Ms. Julie Caynor, Aetna
Ms. Heather Johnson, DHR	Ms. Carrie Schiavo, Delta Dental
Ms. Adria Martinelli, Deputy Attorney General, Department of Justice, SEBC Legal Counsel	Mr. Walter Mateja, Merative
Mr. Chris Giovannello, Willis Towers Watson (“WTW”)	Ms. Sandy Hart, Merative
Ms. Gabby Costagliola, WTW	Ms. Christina Crooks Bryan, DEHA
Ms. Jaclyn Iglesias, WTW	Ms. Rebecca Byrd, ByrdGomes
Ms. Jeanette Hammon, Sr. Fiscal and Policy Analyst, OMB	Ms. Kristina Deakins, City of Dover
Mr. Robert Scoglietti, Deputy Controller General, OCG	Ms. Naomi Poole, City of Dover
Ms. Judi Schock, Deputy Principal Assistant, OMB	Ms. Mary Kate McLaughlin, Barnes & Thornburg
Mr. Steven Costantino, Director Health Care Reform, DHSS	Ms. Karen Peterson, Retired Senator
Ms. Ashley Tucker, Deputy State Court Administrator, Administrative Office of the Courts	Ms. Barbara Philbin, Pensioner
Ms. Kathy Nedelka, HRIS Specialist, PHRST, OMB	Mr. David Taylor, Pensioner
Ms. Michelle Carpenter, HRIS Manager, PHRST, OMB	Ms. Denise Schwartz, Pensioner
Ms. Wendy Beck, Highmark Delaware	Ms. Donna Dossett, Pensioner
Ms. Jeanie Carson, Highmark Delaware	Ms. Elisa Diller, Pensioner
Mr. Adam Knox, Highmark Delaware	Ms. Helene Diskau, Pensioner
Mr. Charles Simons, Highmark Delaware	Ms. Mae Gaskins, Pensioner
Ms. Charlene Hrivnak, CVS Health	Ms. Nancy Alteri, Pensioner
Ms. Sara Dunlevy, CVS Health	Ms. Rebecca Scarborough, Pensioner
Mr. Michael North, Aetna	Mr. Richard Phillips, Pensioner
	Mr. Robert Clarkin, Pensioner
	Mr. Steve LePage, Pensioner

STATE OF DELAWARE STATEWIDE BENEFITS OFFICE

Mr. Tom Pledgie, Pensioner
Ms. Wendy Strauss, Pensioner
Ms. Kathy Carter, Pensioner

Mr. Steve Carter, Pensioner
Ms. Carole Mick, SBO, DHR – Recorder, State Employee
Benefits Committee and Subcommittees

CALLED TO ORDER – SECRETARY DEMATTEIS, DHR

Secretary DeMatteis called the meeting to order at 2:04 p.m.

APPROVAL OF MINUTES – SECRETARY DEMATTEIS, DHR

A MOTION was made by Director Cade and seconded by Secretary Magarik to approve the minutes from the October 24, 2022, meeting of the State Employee Benefits Committee.

MOTION ADOPTED UNANIMOUSLY

DIRECTOR'S REPORT – DEPUTY DIRECTOR HINKLE, DHR, SBO

Senate Bill (SB) 309 mandates insurers to provide chiropractic care has been signed by the Governor with an effective date of January 1st, 2024. Fiscal impact to the GHIP for FY24 is estimated around \$35.5K and \$71K for FY25. SBO is working with Highmark and Aetna on compliance with this bill.

SB 316 mandates insurers to cap diabetic supplies, strips, and meters at \$35 per member per month. The GHIP has two separate vendor programs for medical and prescription benefits, compliance on this bill required a Senate Amendment to be included to address administrative concerns. This bill will be effective April 2023. Fiscal impact to the GHIP is estimated at \$15K annually.

The SEBC was provided a list of proposed meeting dates for CY23 with separate meeting times and dates for the Financial and Health Policy & Planning Subcommittees. Any combined Subcommittee meetings will occur in the 10:00 a.m. timeslot. Subcommittee meetings have been moved from Thursday to the Monday before the SEBC meeting. The new meeting dates will provide SBO and WTW a full week to gather and compile feedback from Subcommittee members before the full Committee meeting.

SBO would like the SEBC to discuss Agenda items for the Subcommittees on areas of focus such as health plan offerings and Active and pre-65 retiree premium rates for the FY24 plan year. Agenda items slated for the December SEBC meeting include: GHIP strategic framework goals and priorities and additional discussion on the Spousal Coordination of Benefits (SCOB) Policy. Any additional agenda items can be provided to SBO from Committee members.

The SCOB policy discussion is to address changes that would allow more flexibility for a pensioner's spouse to be covered by the State's Medicare health plan.

FINANCIAL UPDATE – MR. CHRIS GIOVANNELLO, WTW

September 2022 Fund Report

Premium contributions return to expected budget at \$76M. Claims continue to run high at \$10.7M above budget. The Fund is \$28.2M over budget for Q1. A deeper dive into the high claims experience will be addressed at a future meeting, however, utilization and cost are major factors.

Director Cade asked for a breakdown of the claims experience by group (actives, retirees, pre-65 retirees). Mr. Giovannello stated WTW has reached out to the State's vendor partners for information on claims experience. Utilization is exceeding pre-pandemic levels mainly due to delay in care from the pandemic.

The fund equity balance is \$123.5M with a variance to budget deficit of \$35.5M.

FY23 GHIP Budget Revised*

Mr. Giovannello reviewed the FY23 revised budget to reflect the change to maintain the Special Medicfill plan for CY23 instead of transitioning to the Medicare Advantage Plan. The GHIP budget is based on claims experience through June 2022 and the budget has not been updated to reflect recent claims experience. Net income for FY23 is estimated at a deficit of \$64.5M and the GHIP surplus after reserves is estimated at a deficit of \$2.7M.

Secretary DeMatteis commented that the total operating expenses are over \$1.1B for FY23. Chief Justice Seitz stated that we are spending down the surplus and will soon be in a deficit. Mr. Giovannello confirmed that the fund will soon go into a negative status minus reserves currently in the fund. The fund equity balance is estimated at \$92.7M with a claim liability of \$68.2M and a minimum reserve of \$27.2M leaving the Fund with a deficit of \$2.7M after reserves.

APPROVAL OF THE FY23 GHIP BUDGET REVISED

A MOTION was made by Secretary Magarik and seconded by Chief Justice Seitz to approve the FY23 Revised GHIP Budget.

MOTION FOR DISCUSSION

No Discussion.

MOTION ADOPTED UNANIMOUSLY.

The Honorable Bethany Hall-Long left the meeting.

FY23 Q1 Financial Reporting

The FY23 Q1 plan cost analysis determined that GHIP gross claims are up 19.7% from FY22 Q1. A review of FY23 Actuals to FY23 Revised Budget showed a variance in total program costs of 1.5% over budget and key observations for total GHIP population were noted.

Secretary Magarik asked if there was any data on how many members who visited the ER also have a PCP. Mr. Giovannello stated that WTW can provide data on members with PCPs.

FY24 GHIP Projections

Mr. Giovannello summarized long term health care cost projections with a projected deficit of \$143.5M by the end FY24 and displayed premium rate increase scenarios. A 17.2% rate increase effective July 1st, 2023, for actives and pre-65 retirees would be required to solve the projected FY24 deficit. To smooth the rate over 3 years would require a 9.8% annual rate increase per year in FY24, FY25, and FY26.

Ms. Iglesias provided commentary on SB 120 primary care bill and potential financial impact to the GHIP.

Chief Justice Seitz stated the rate increase for FY24 is required to solve for a \$0 deficit and continual rate increase of 5%-7% will be needed every year to keep up with the health care trend. A discussion continued with Committee members surrounding ways to reduce health care costs.

Premium rate increases for FY24 were displayed based on both premium rate increase scenarios.

COVID-19 NATIONAL PUBLIC HEALTH EMERGENCY UPDATE – MS. JACLYN IGLESIAS, WTW

Ms. Iglesias provided an update on the National Emergency Declaration and the Public Health Emergency (PHE) potential expiration dates and impact to the GHIP. COVID-19 benefit enhancements under the GHIP will expire at the end of the National Public Health Emergency period and members will be provided a 30-day advance notice. Ms. Iglesias provided extension options and cost to the GHIP to extend these benefits.

The PHE was issued by the U.S. Department of Health and Human Services and is issued in 90-day increments. It was most recently extended to January 11, 2023. The Federal government will provide states a 60-day notice prior to the expiration of the PHE.

Committee members had a discussion on incremental cost of COVID-19 vaccines, oral antivirals, and over-the-counter test kits following the end of the PHE. The SEBC would like more information on what other states are doing in terms of member cost sharing related to COVID-19 over-the-counter test kits.

FY24 PLANNING – MS. JACLYN IGLESIAS, WTW

Benefit Modernization Initiative

Ms. Iglesias reviewed the benefits modernization initiative that was brought to the SEBC in June 2022. This initiative will evaluate options for GHIP benefits modernization for active employees and non-Medicare retirees. An employee survey is slated for release in CY23 Q1 to solicit input from benefit eligible employees on benefit preferences and gaps for underserved populations.

SEBC Subcommittee Areas of Focus

Planning considerations for FY24 and later were analyzed to provide short-term and long-term cost savings measures to the GHIP. The WTW recommendation would be to have Subcommittee members focus on short-term items.

Secretary DeMatteis agreed with the WTW recommendation of focusing on short-term initiatives for Subcommittee discussion. WTW will have materials on short-term initiatives for the Subcommittees for the December meeting.

OTHER BUSINESS

No new business was presented.

PUBLIC COMMENT

Several state retirees provided comment on Medicare Advantage (MA) and their concerns with the State considering this type of plan. Additional concerns included the State's GHIP deficit, confusion over the financials presented at today's meeting, cost of healthcare and the inclusion of State pensioners in future meetings. Barbara Philbin, a State retiree, provided comment on Commissioner Navarro's article about MA Plans. Tom Pledge, a State retiree, provided comment on the SEBC and Subcommittee Agendas containing too much information and the priority of Agenda items.

Commissioner Navarro provided clarification on the article that was published about MA plans.

ADJOURNMENT

A MOTION was made by Director Cade and seconded by Secretary Magarik to adjourn the public session at 3:50 p.m. MOTION ADOPTED UNANIMOUSLY.

Respectfully submitted,

Carole Mick, Executive Secretary, Statewide Benefits Office, Department of Human Resources
Recorder, State Employee Benefits Committee, and Subcommittees

State of Delaware Health Fund Monthly Statement October 2022

OPERATING REVENUES	October		October Budget		Variance		YTD Actual		YTD Budget		Variance	
	\$	%	\$	%	\$	%	\$	%	\$	%	\$	%
Premium Contributions												
Highmark	\$ 59,651,438	70.62%	\$ 59,409,842	75.95%	\$ 241,596	0.41%	\$ 235,123,225	68.96%	\$ 237,639,369	69.42%	\$ (2,516,144)	-1.06%
Aetna	\$ 15,634,391	18.51%	\$ 16,527,891	21.13%	\$ (893,499)	-5.41%	\$ 61,955,881	18.17%	\$ 66,111,563	19.31%	\$ (4,155,682)	-6.29%
Total Premium Contributions	\$ 75,285,830	89.13%	\$ 75,937,733	97.08%	\$ (651,903)	-0.86%	\$ 297,079,106	87.13%	\$ 303,750,932	88.73%	\$ (6,671,826)	-2.20%
Other Revenues												
Medicare Retiree RX Prog. (EGWP) Direct Subsidy	\$ (112,081)	-0.13%	\$ (112,539)	-0.14%	\$ 458	-0.41%	\$ (225,725)	-0.07%	\$ (242,470)	-0.07%	\$ 16,745	-6.91%
Federal Reinsurance	\$ 1,863,867	2.21%	\$ 1,847,893	2.36%	\$ 15,974	0.86%	\$ 7,418,096	2.18%	\$ 7,377,798	2%	\$ 40,299	0.55%
Prescription Drug Rebates (Commercial)	\$ -	0.00%	\$ -	0.00%	\$ -	0.00%	\$ 16,325,655	4.79%	\$ 16,177,816	4.73%	\$ 147,839	0.91%
Prescription Drug Rebates (EGWP)	\$ -	0.00%	\$ -	0.00%	\$ -	0.00%	\$ 11,271,279	3.31%	\$ 13,062,611	3.82%	\$ (1,791,332)	-13.71%
Prescription True Up/Yr End Recon Pymts	\$ -	0.00%	\$ -	0.00%	\$ -	0.00%	\$ -	0.00%	\$ -	0.00%	\$ -	0.00%
Medicare Part D Coverage Gap Discount	\$ 6,815,197	8.07%	\$ -	0.00%	\$ 6,815,197	0.00%	\$ 6,815,197	2.00%	\$ -	0.00%	\$ 6,815,197	0.00%
Participating Group Fees	\$ 560,950	0.66%	\$ 548,979	0.70%	\$ 11,971	2.18%	\$ 2,152,233	0.63%	\$ 2,191,824	0.64%	\$ (39,591)	-1.81%
Other Revenues	\$ 51,513	0.06%	\$ -	0.00%	\$ 51,513	0.00%	\$ 137,192	0.04%	\$ -	0.00%	\$ 137,192	0.00%
Total Other Revenues	\$ 9,179,445	10.87%	\$ 2,284,333	2.92%	\$ 6,895,113	301.84%	\$ 43,893,927	12.87%	\$ 38,567,579	11.27%	\$ 5,326,348	13.81%
Total Operating Revenues	\$ 84,465,275		\$ 78,222,066		\$ 6,243,210	7.98%	\$ 340,973,033		\$ 342,318,511		\$ (1,345,478)	-0.39%
OPERATING EXPENSES												
Claims												
Highmark	\$ 43,159,557	47.93%	\$ 39,179,876	46.02%	\$ 3,979,680	10.16%	\$ 187,209,713	49.24%	\$ 162,152,212	46.68%	\$ 25,057,502	15.45%
Aetna	\$ 12,963,296	14.40%	\$ 12,825,994	15.07%	\$ 137,302	1.07%	\$ 55,009,729	14.47%	\$ 56,179,088	16.17%	\$ (1,169,359)	-2.08%
Express Scripts/CVS (non-Plan D)	\$ 15,948,248	17.71%	\$ 15,336,154	18.01%	\$ 612,094	3.99%	\$ 64,161,668	16.88%	\$ 59,237,239	17.05%	\$ 4,924,429	8.31%
Express Scripts/CVS (Plan D)	\$ 14,052,225	15.61%	\$ 14,022,477	16.47%	\$ 29,748	0.21%	\$ 57,491,476	15.12%	\$ 54,370,264	15.65%	\$ 3,121,212	5.74%
Surgery Plus	\$ 304,053	0.34%	\$ -	0.00%	\$ 304,053	0.00%	\$ 1,364,771	0.36%	\$ -	0.00%	\$ 1,364,771	0.00%
Total Claims	\$ 86,427,379	95.99%	\$ 81,364,502	95.57%	\$ 5,062,877	6.22%	\$ 365,237,358	96.06%	\$ 331,938,803	95.57%	\$ 33,298,555	10.03%
Other Expenses												
Program Fees and Costs (Vendor ASO Fees)	\$ 3,235,630	3.59%	\$ 3,271,591	3.84%	\$ (35,961)	-1.10%	\$ 12,877,696	3.39%	\$ 13,065,829	3.76%	\$ (188,134)	-1.44%
Office Expenses	\$ 204,898	0.23%	\$ 273,734	0.32%	\$ (68,836)	-25.15%	\$ 923,725	0.24%	\$ 1,094,936	0.32%	\$ (171,212)	-15.64%
Employee Assistance	\$ 34,426	0.04%	\$ 40,596	0.05%	\$ (6,170)	-15.20%	\$ 154,409	0.04%	\$ 162,383	0.05%	\$ (7,974)	-4.91%
Data Warehouse	\$ 39,125	0.04%	\$ 49,676	0.06%	\$ (10,551)	-21.24%	\$ 232,792	0.06%	\$ 198,704	0.06%	\$ 34,088	17.16%
Consultant Fees	\$ 86,948	0.10%	\$ 125,000	0.15%	\$ (38,052)	-30.44%	\$ 320,299	0.08%	\$ 500,000	0.14%	\$ (179,701)	-35.94%
COBRA Fees	\$ 12,119	0.01%	\$ 9,251	0.01%	\$ 2,868	31.00%	\$ 37,000	0.01%	\$ 37,004	0.01%	\$ (4)	-0.01%
ACA Fees	\$ -	0.00%	\$ -	0.00%	\$ -	0.00%	\$ 423,280	0.11%	\$ 342,211	0.10%	\$ 81,069	23.69%
Total Other Expenses	\$ 3,613,146	4.01%	\$ 3,769,847	4.43%	\$ (156,702)	-4.16%	\$ 14,969,200	3.94%	\$ 15,401,067	4.43%	\$ (431,868)	-2.80%
Total Operating Expenses	\$ 90,040,524		\$ 85,134,349		\$ 4,906,175	5.76%	\$ 380,206,558		\$ 347,339,870		\$ 32,866,687	9.46%
Net Income	\$ (5,575,249)		\$ (6,912,283)		\$ 1,337,034		\$ (39,233,524)		\$ (5,021,359)		\$ (34,212,165)	
Balance Forward	\$ 123,503,710		\$ 159,052,910				\$ 157,161,986		\$ 157,161,986			
Fund Equity Balance	\$ 117,928,462		\$ 152,140,627		\$ (34,212,165)	-22.49%	\$ 117,928,462		\$ 152,140,627		\$ (34,212,165)	-22.49%
Average Members	130,659		130,427		232	0.18%						

	Target	YTD				End of Year			
		Budget	Actual	Variance		Budget	Forecast*	Variance	
				\$	%			\$	%
Fund Equity	\$ 85,300,000	\$ 152,140,627	\$ 117,928,462	\$ (34,212,165)	-22%	\$ 90,500,694	\$ 56,288,529	\$ (34,212,165)	-38%
Claim Liability	\$ 61,000,000	\$ 61,000,000	\$ 61,000,000	\$ -	0%	\$ 61,000,000	\$ 61,000,000	\$ -	0%
Minimum Reserve	\$ 24,300,000	\$ 24,300,000	\$ 24,300,000	\$ -	0%	\$ 24,300,000	\$ 24,300,000	\$ -	0%
Surplus/(Deficit)	\$ -	\$ 66,840,627	\$ 32,628,462	\$ (34,212,165)	-51%	\$ 5,200,694	\$ (29,011,471)	\$ (34,212,165)	-658%

*Forecast = Actual + Remaining Budget

The State of Delaware

Update on CVS Commercial Plan Performance for FY22

State Employee Benefits Committee

December 19, 2022

Disclaimer

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Update on CVS Commercial Plan Performance for FY22

- Pharmacy benefits management under the State Employee Group Health plan has been administered by CVS Health since July 1, 2021 for Commercial (non-Medicare) plan participants and since January 1, 2022 for EGWP (Medicare) plan participants
 - Change impacted every participant enrolled in the State Employee Group Health plan
- FY22 Commercial plan performance results are now available for:
 - Financial performance guarantees
 - Member satisfaction survey
- Performance results for the EGWP 2022 plan year (ending 12/31/2022) will not be available until mid-2023

CVS Commercial Plan Performance Guarantee Results, FY2022

- CVS met that majority of the performance guarantees (PGs) for the 2022 fiscal year (7/1/2021 – 6/30/2022)
- Two financial guarantees were missed related to specialty brand effective rate and specialty generic effective rate discount guarantees
 - PG sets targets for minimum level of discounts achieved for both brand and generic drugs dispensed through the plan
 - Actual measured discounts were less than target
 - Resulted in a penalty payment back to the State Group Health Plan in the amount of \$818,000
- Member satisfaction survey results are generally positive; highlights include:
 - Overall satisfaction with prescription benefit services: actual result of 96% vs. target of 90%
 - Further details are noted in the appendix

Appendix

CVS Commercial Plan Member Satisfaction Survey
Results, FY2022



State of Delaware

Results

Performance Guarantee (PG) Member Satisfaction

August 2022



State of Delaware

PERFORMANCE GUARANTEE (PG) REPORT CARD









Completes  145	Sample dates  04/01/22 – 06/30/22	Survey method  Phone	Survey type  CVS Standard	Fielding dates  07/18/22 – 07/29/22
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OVERALL EVALUATION

Overall Satisfaction With Prescription Benefit Services

RESULT	TARGET	RESULT VS. TARGET
96%	90%	+6%

SATISFACTION WITH CVS CAREMARK SERVICES

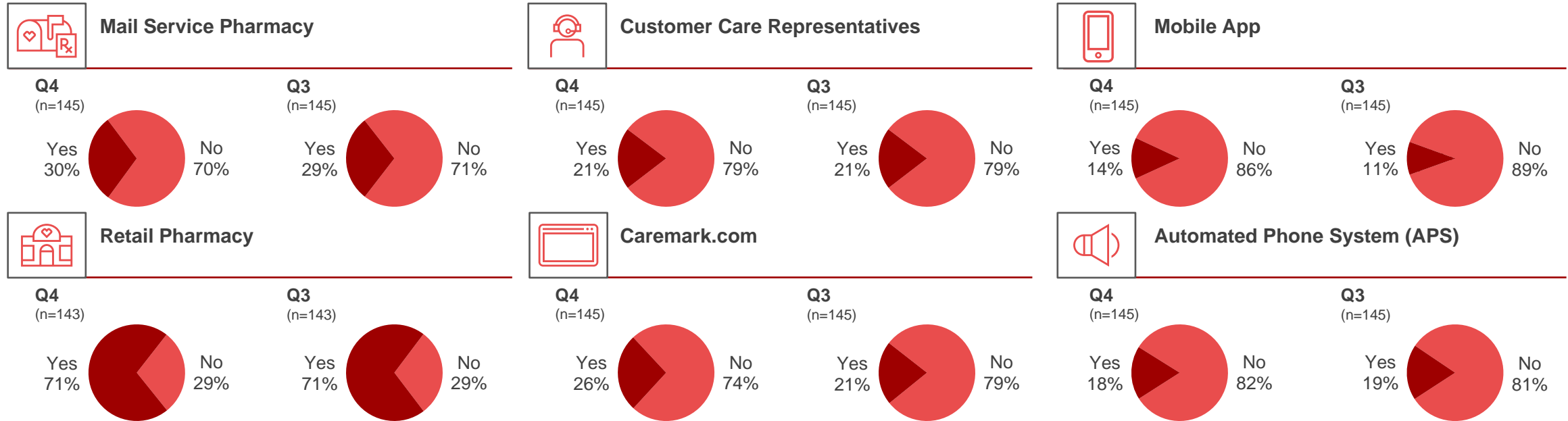
RESULT	RESULT	RESULT																												
 Mail Service Pharmacy Usage: 30% <table border="1"> <tr> <td>Overall satisfaction</td> <td>100%</td> </tr> <tr> <td>Ease of ordering medication</td> <td>98%</td> </tr> <tr> <td>Receiving by scheduled date</td> <td>100%</td> </tr> </table>	Overall satisfaction	100%	Ease of ordering medication	98%	Receiving by scheduled date	100%	 Customer Care Representatives Usage: 21% <table border="1"> <tr> <td>Overall satisfaction</td> <td>100%</td> </tr> <tr> <td>Effectively responding</td> <td>100%</td> </tr> <tr> <td>Understanding your concern/inquiry</td> <td>100%</td> </tr> </table>	Overall satisfaction	100%	Effectively responding	100%	Understanding your concern/inquiry	100%	 Automated Phone System (APS) Usage: 18% <table border="1"> <tr> <td>Overall satisfaction</td> <td>100%</td> </tr> <tr> <td>Resolution of request/question</td> <td>100%</td> </tr> </table>	Overall satisfaction	100%	Resolution of request/question	100%												
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Overall satisfaction	100%																													
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Understanding your concern/inquiry	100%																													
Overall satisfaction	100%																													
Resolution of request/question	100%																													
 Retail Pharmacy Usage: 71% <table border="1"> <tr> <td>Overall satisfaction</td> <td>92%</td> </tr> <tr> <td>Courtesy and professionalism</td> <td>96%</td> </tr> <tr> <td>Ability to use preferred pharmacy</td> <td>99%</td> </tr> <tr> <td>Convenience of location</td> <td>100%</td> </tr> </table>	Overall satisfaction	92%	Courtesy and professionalism	96%	Ability to use preferred pharmacy	99%	Convenience of location	100%	 Caremark.com Usage: 26% <table border="1"> <tr> <td>Overall satisfaction</td> <td>95%</td> </tr> <tr> <td>Right amount of information</td> <td>95%</td> </tr> <tr> <td>Locating prescription information</td> <td>95%</td> </tr> </table>	Overall satisfaction	95%	Right amount of information	95%	Locating prescription information	95%	 Member Communication <table border="1"> <tr> <td>Overall satisfaction</td> <td>94%</td> </tr> <tr> <td>Quality of communications</td> <td>93%</td> </tr> <tr> <td>Status updates and reminders</td> <td>91%</td> </tr> </table>	Overall satisfaction	94%	Quality of communications	93%	Status updates and reminders	91%								
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Courtesy and professionalism	96%																													
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Quality of communications	93%																													
Status updates and reminders	91%																													
Retail pharmacy most recently used (% indicating) <table border="1"> <tr> <td>CVS</td> <td>15%</td> </tr> <tr> <td>Walgreens</td> <td>47%</td> </tr> <tr> <td>Rite Aid</td> <td>22%</td> </tr> <tr> <td>Wal-Mart</td> <td>6%</td> </tr> <tr> <td>Target</td> <td>0%</td> </tr> <tr> <td>Kroger</td> <td>0%</td> </tr> <tr> <td>Other</td> <td>11%</td> </tr> </table>	CVS	15%	Walgreens	47%	Rite Aid	22%	Wal-Mart	6%	Target	0%	Kroger	0%	Other	11%	 Mobile App Usage: 14% <table border="1"> <tr> <td>Overall satisfaction</td> <td>95%</td> </tr> <tr> <td>Right amount of information</td> <td>95%</td> </tr> <tr> <td>Checking status of order</td> <td>94%[^]</td> </tr> </table>	Overall satisfaction	95%	Right amount of information	95%	Checking status of order	94% [^]	 Non-CVS Caremark Service: Drug Benefit Plan <table border="1"> <tr> <td>Overall satisfaction</td> <td>94%</td> </tr> <tr> <td>Medications covered</td> <td>92%</td> </tr> <tr> <td>Out-of-pocket costs</td> <td>92%</td> </tr> <tr> <td>Ability to get prescribed medications</td> <td>92%</td> </tr> </table>	Overall satisfaction	94%	Medications covered	92%	Out-of-pocket costs	92%	Ability to get prescribed medications	92%
CVS	15%																													
Walgreens	47%																													
Rite Aid	22%																													
Wal-Mart	6%																													
Target	0%																													
Kroger	0%																													
Other	11%																													
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State of Delaware

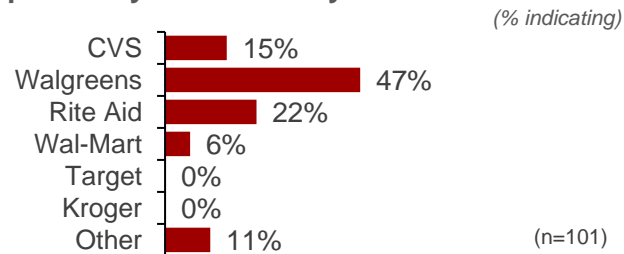
Completes  145	Sample dates  04/01/22 – 06/30/22	Survey method  Phone	Survey type  CVS Standard	Fielding dates  07/18/22 – 07/29/22
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Q4 VS. Q3 RESULTS

USAGE



Retail pharmacy most recently used



State of Delaware

Q4 VS. Q3 RESULTS



Overall Evaluation

Completes



145

Sample dates



04/01/22 – 06/30/22

Survey method



Phone

Survey type



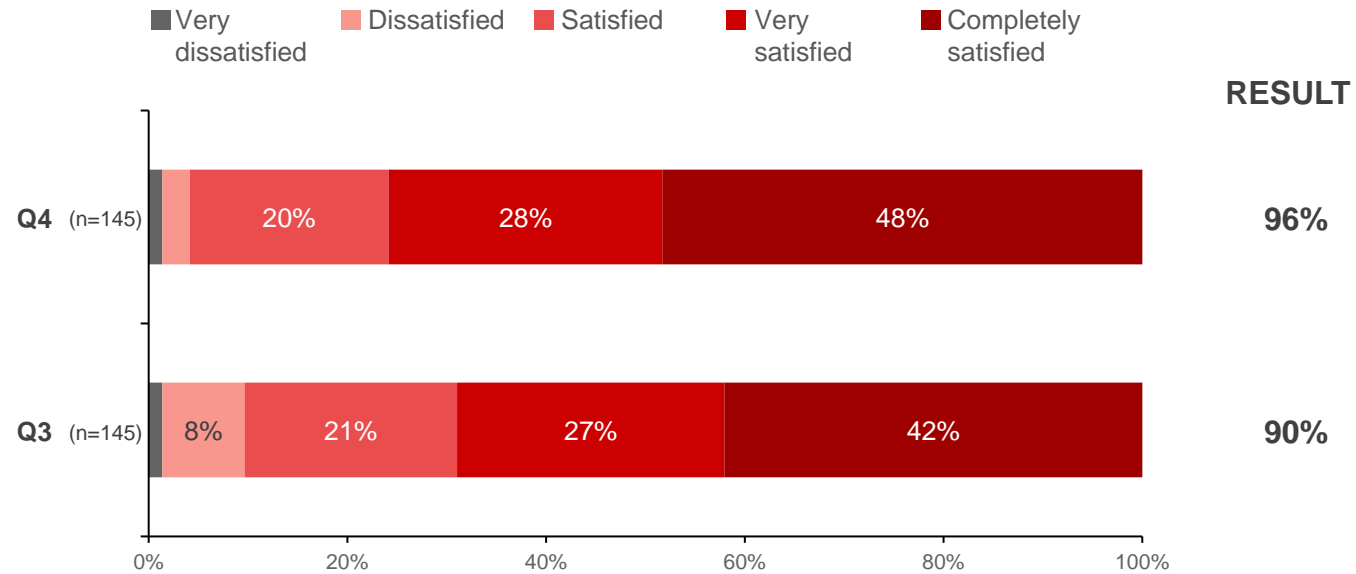
CVS Standard

Fielding dates



07/18/22 – 07/29/22

Overall Satisfaction With Prescription Benefit Services



RESULT Overall satisfaction. Percent of satisfied or better on a 5 point scale.

↑↓ Indicates that the Q4 result is significantly higher or lower than the Q3 result.

SPOUSAL COORDINATION OF BENEFITS POLICY

This policy became effective with the State of Delaware on January 1, 1993 for a spouse who is eligible for health care coverage through the spouse's own employer. Effective July 1, 2011, the Spousal Coordination of Benefits Policy became applicable to retiree health care coverage available to a spouse through the spouse's employer from whom the spouse is collecting a pension benefit. The intention of this policy is to ensure fiscal responsibility for the State of Delaware Group Health Insurance Plan fund where other employers are offering health care benefits to their employees and retirees.

This section describes how this policy effects payment of health care benefits for spouses. In order to certify that an Employee or Pensioner's spouse is or is not covered by a health care plan where the spouse works or where the spouse is collecting a pension benefit, all Employees or Pensioners who enroll a spouse **MUST** complete the Spousal Coordination of Benefits Form to accompany submission of the enrollment application, each year during open enrollment and anytime throughout the year if your spouse's employment or insurance status changes. The Spousal Coordination of Benefits Form is used to determine the spouse's eligibility for primary or secondary coverage in a State of Delaware Group Health Insurance plan.

IT IS THE EMPLOYEE OR PENSIONER'S RESPONSIBILITY TO UPDATE SPOUSAL INFORMATION WITHIN 30 DAYS AFTER THE SPOUSE LOSES OR GAINS COVERAGE AND EACH YEAR DURING OPEN ENROLLMENT.

How Payment of Benefits for Spouses is Affected

The following describes how the policy effects the benefits payment for spouses:

- If the Employee or Pensioner's spouse **is eligible for and not enrolled** in the health care plan offered by the spouse's own employer as an active employee or non-Medicare retiree, or is eligible for a cash benefit in lieu of a health plan and is not enrolled in a health plan, the State will pay 20% of allowable charges for services covered under the State's health care plan. See next section for enrollment requirements.
- If the Employee or Pensioner's spouse **is eligible for and enrolled** in the health care plan offered by the spouse's own employer as an active employee or non-Medicare retiree, or is eligible for a cash benefit in lieu of a health plan and is enrolled in a health plan, the State will pay for benefits provided under the State's health care plan after the spouse's health care plan pays. Payment from both plans combined will not exceed 100% of covered charges.
- If the Employee or Pensioner's spouse **is not eligible for and, therefore, is not enrolled** in the health care plan where the spouse works or is collecting a pension benefit, or any other health care plan, and is not receiving a cash benefit in lieu of health care from the employer or former employer, the State will pay for benefits as provided under the Employee or Pensioner's selected State health care plan.
- If the Pensioner's spouse is **eligible for and enrolled** in the health care plan offered by the spouse's employer or former employer as a Medicare eligible retiree, or is eligible for a cash benefit in lieu of a health care plan and enrolled in a health plan, the State will terminate coverage under the State's Medicare Advantage Plan. See next section for enrollment requirements.

How to Determine When Spouse is NOT required to Enroll in Their Own Employer's Active or Retiree Health Plan or Marketplace Coverage

Generally, the Employee or Pensioner's Spouse does not need to be enrolled in the health care plan where the spouse works or is collecting a pension benefit, or in an individual health plan through the Health Insurance Marketplace, if ONE of the following are applicable:

- The Employee or Pensioner's spouse does not work full-time or is not collecting a pension benefit; **or**
- The Employee or Pensioner's spouse is not eligible for benefits under the employer's health care plan because the spouse has not satisfied their employer's requirements as to the number of hours worked or has not satisfied their employer's requirements to be eligible for retiree health benefits; **or**
- The Employee or Pensioner's spouse's employer requires a contribution from the employee or former employee of more than 50% of the premium for the lowest active or retiree health benefit plan available through their own employer; **or**
- The Employee or Pensioner's spouse's employer does not offer active or retiree health coverage or a cash benefit in lieu of health coverage; **or**
- The Pensioner's spouse does not work full-time **and** collects a pension benefit **and** is eligible for Medicare **and** the spouse's former employer does not offer a cash benefit in lieu of health coverage **and** only offers a Medicare Advantage plan.

How to Determine if a Spouse Works Full-time

Based on the State Group Health Insurance Plan Eligibility and Enrollment Rule regarding full-time status, *Full-time* means that an individual is regularly scheduled to work 30 or more hours per week or 130 or more hours per month.

However, if a spouse works less than the full-time hours required by the spouse's employer **and** such spouse receives less than the full-time contribution towards health care coverage, then the spouse is considered part-time even though the spouse works 30 or more hours per week required by the State Group Health Insurance Plan Eligibility and Enrollment Rules. Under these circumstances, the spouse is not required to obtain coverage through the spouse's employer.

For example:

A State employee's spouse works for an employer who requires 40 hours per week to be considered a full-time employee and employer contributes \$200 towards health care coverage for each full-time employee. The spouse only works 32 hours per week and the spouse's employer contributes \$160 towards the spouse's health care coverage. Since the spouse works less than the required number of hours and receives less than the full-time employer contribution, the spouse is considered part-time.

How to Determine the 50% Contribution Requirement

When determining contributions made by the spouse towards the spouse's health care coverage, all flexible benefit dollars, cash in lieu of health benefits, and/or credits available to the spouse are counted as contributions provided by the spouse's employer.

If the spouse's contribution is 50% or less for the lowest individual only plan available through the spouse's employer or former employer, it is necessary for the spouse to enroll in the spouse's own plan.

In the case of cash in lieu of benefits:

- If the non-Medicare spouse is receiving contributions that are equal to 50% or more of the premium of the State of Delaware Group Health Insurance Plan's lowest individual only plan for active and non-Medicare retirees, it is necessary for the spouse to enroll in the spouse's own plan. If the spouse is receiving contributions that are less than 50% of the premium of the State of Delaware Group Health Insurance Plan's lowest individual only plan for active and non-Medicare retirees, it is not necessary for the spouse to enroll in their own employer or former employer plan, or an individual health care plan.
- If the Medicare eligible spouse is receiving contributions that are equal to 50% or more of the premium of the State of Delaware Group Health Insurance Plan's premium of the Medicare supplement plan for Medicare eligible spouses, it is necessary for the spouse to enroll in the spouse's own plan. If the spouse is receiving contributions that are less than 50% of the premium of the premium of the State of Delaware Group Health Insurance Plan's Medicare supplement plan for Medicare eligible spouses, it is not necessary for the spouse to enroll in their own employer or former employer plan, or an individual health care plan.

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What Happens When There is no Open Enrollment Period for the Spouse

Sometimes a spouse may be unable to enroll in the spouse's own employer or former employer health care plan because there will be no Open Enrollment Period consistent with a new enrollment. In such cases, health care benefits will be provided under the Employee or Pensioner's selected State plan until the next Open Enrollment Period for the spouse's employer or former employer plan.

If the spouse is not enrolled in the spouse's own employer or former employer health care plan by the effective date associated with the employer or former employer plan's next Open Enrollment period, the State Plan will pay benefits at 20% of the allowable charges for services covered under the Employee's selected State health care plan, until such time that the spouse obtains employer or former employer coverage.

What Happens When the Spouse's Employer Only Offers an HMO Plan

Some employers may only offer an HMO plan and the HMO plan service area is not directly accessible to the spouse. In such instances, it is not necessary that the spouse enroll under the spouse's own employer's plan. However, the State Plan will evaluate the spouse's enrollment under the employer's health care plan on an annual basis. If, in the judgment of the State, the spouse's employer offers only an HMO plan to avoid covering spouses of State of Delaware employees, then the State reserves the right to pay benefits at 20% of the allowable charge for services covered under the Employee's selected State health care plan.

What Happens When the Spouse is Considered a Partner, Owner, or Principal in a Law Firm, Accounting Firm or Any Other Type of Business, Company, Corporation or Firm

If the spouse is considered a partner, owner, or principal in a law firm, accounting firm or any other type of business, company, corporation or firm, the spousal determination will be based on the spouse's corporation's or company's offering of health insurance, or any type of credits, contributions or fringe benefits for **full-time employees and/or retirees that do not have ownership in the company** to use toward the cost of medical and prescription drug coverage or a cash amount in lieu of medical and prescription drug benefits.

What Happens When the Spouse's Employer Only Offers a High Deductible Health Plan with Health Savings Account

Some employers may only offer a High Deductible Health plan with Health Savings Account. In such instances, the spouse must still enroll in the employer's health care plan when required by the Spousal Coordination of Benefits Policy and should carefully review IRS Revenue-Ruling 2005-25 regarding enrollment in any other health plan and the impact on Health Savings Account contributions and taxation.

What Happens When a Spouse who is Retired, with or without Retiree Health Care from their Former Employer, Returns to Full-Time Employment

As active employee coverage is generally primary to retiree coverage, when a spouse who is retired from an employer, other than the State, returns to the workforce as a full-time employee, the spouse should obtain health care coverage through the full-time employer if the employee contributes 50% or less to the premium of the lowest employee only health care plan. Please note: the spouse must also maintain any available retiree health care coverage from their former employer for the period when the employee is retired and/or the spouse leaves full-time employment.

What Happens When the Pensioner's Spouse's Former Employer offers only a Medicare Advantage Plan for Medicare Eligible Retirees

If the Pensioner's spouse's former employer offers only a Medicare Advantage Plan for its Medicare retirees, the spouse ~~must~~ may enroll in either that plan or the [State of Delaware Medicare supplement State of Delaware Group Health Insurance Medicare Advantage](#) plan. Medicare Advantage plans do not coordinate with [other Medicare supplement plans](#); therefore, the spouse cannot also be enrolled in the [State's Medicare supplement plan](#). ~~other Medicare Advantage plans. The Centers for Medicare and Medicaid Services (CMS) only allows enrollment in one qualified Medicare Advantage plan.~~ If the former employer's retiree plan should change from a Medicare Advantage plan to a Medicare supplement plan, the Pensioner's spouse must enroll in the supplement coverage with their former employer if the spouse's contribution is 50% or less for the premium for the supplement plan. At that time, the pensioner should contact the Office of Pensions ~~to disenroll the spouse in the State's Medicare Advantage plan.~~

What Happens When the Spouse is a Participating Group Employee

Participating Groups are organizations with employees who are not State of Delaware employees, but who are eligible to receive health care coverage under the State of Delaware Group Health Insurance Plan.

When a benefit eligible Participating Group employee is married to a State of Delaware employee enrolled in the State Plan, the spouse must elect coverage through the Participating Group employer. Neither member can be enrolled in more than one State Group Health Insurance plan. Both members must enroll in separate coverage with their own employer.

What Happens When the Spouse is a Participating Group Retiree

Employees who retire from a Participating Group may be eligible for a pension benefit under the State of Delaware County and Municipal Pension Plan. Pensioners receiving a pension benefit under the State County and Municipal Pension Plan are eligible for health care through the State of Delaware Group Health Insurance Plan.

When the spouse is retired from a Participating Group and receiving a pension benefit under the State County and Municipal Pension Plan and is married to a State of Delaware employee or pensioner enrolled in the State Group Health Insurance Plan, the spouse may be enrolled under the State of Delaware employee or pensioner's State Group Health Insurance plan if the spouse is receiving contributions that are less than 50% of the premium of the State of Delaware Group Health Insurance Plan's lowest individual only plan.

NOTE:

You may access <https://de.gov/statewidebenefits> for examples that will help you determine when a spouse should be enrolled in the spouse's own employer or former employer health care plan.

Policy Effective Date 1/1/93

Policy Modified Effective 7/1/11

Policy Modified Effective 5/1/15

Policy Modified Effective 5/1/16

Policy Modified Effective 5/1/18

Policy Modified Effective 1/1/23

Proposed Spousal Coordination of Benefits (SCOB) Policy Changes Effective January 1, 2023

Executive Summary of Proposed Changes for SEBC Vote on December 19, 2022

On July 25, 2022, the SEBC reviewed and voted on changes to the SCOB Policy to be effective January 1, 2023. With the exception of the following modifications, all changes approved on July 25, 2022, will remain in full force and effect on January 1, 2023.

1. Propose **removing** the following language that describes how the policy effects the benefits payment for spouses as the State Group Health Insurance Plan will not offer a Medicare Advantage plan to Medicare pensioners and spouses effective January 1, 2023:

If the Pensioner's spouse is **eligible for and enrolled** in the health care plan offered by the spouse's employer or former employer as a Medicare eligible retiree, or is eligible for a cash benefit in lieu of a health care plan and enrolled in a health plan, the State will terminate coverage under the State's Medicare Advantage Plan. See next section for enrollment requirements.

2. Propose further **clarification** with regards to the 50% contribution requirement when the spouse is receiving cash in lieu of benefits both when the spouse is non-Medicare eligible and when the spouse is Medicare eligible. These clarifications are necessary due to the State Group Health Plan offering a Medicare supplement plan in calendar year 2023. The clarifications are reflected below in red:
 - If the **non-Medicare** spouse is receiving contributions that are equal to 50% or more of the premium of the State of Delaware Group Health Insurance Plan's lowest individual only plan for active and non-Medicare retirees, it is necessary for the spouse to enroll in the spouse's own plan. If the spouse is receiving contributions that are less than 50% of the premium of the State of Delaware Group Health Insurance Plan's lowest individual only plan for active and non-Medicare retirees, it is not necessary for the spouse to enroll in their own employer or former employer plan, or an individual health care plan.
 - If the Medicare eligible spouse is receiving contributions that are equal to 50% or more of the premium of the State of Delaware Group Health Insurance Plan's Medicare supplement plan for Medicare eligible spouses, it is necessary for the spouse to enroll in the spouse's own plan. If the spouse is receiving contributions that are less than 50% of the premium of the premium of the State of Delaware Group Health Insurance Plan's Medicare supplement plan for Medicare eligible spouses, it is not necessary for the spouse to enroll in their own employer or former employer plan, or an individual health care plan.

3. Propose **corrections** to the section of the SCOB Policy which clarifies what happens when the pensioner's spouse's former employer offers only a Medicare Advantage plan for Medicare eligible retirees. These corrections are necessary due to the State Group Health Insurance Plan offering a Medicare supplement plan in calendar year 2023. The changes are reflected below in red:

If the Pensioner's spouse's former employer offers only a Medicare Advantage Plan for its Medicare retirees, the spouse ~~must~~ **may** enroll in either that plan or the **State of Delaware Medicare supplement** ~~State of Delaware Medicare Advantage~~ plan. Medicare Advantage plans do not coordinate with other Medicare supplement plans; therefore, the spouse cannot also be **enrolled in the State's Medicare supplement plan** ~~other Medicare Advantage plans~~. The Centers for Medicare and Medicaid Services (CMS) only allows enrollment in one qualified Medicare Advantage plan. If the former employer's retiree plan should change from a Medicare Advantage plan to a Medicare supplement plan, the Pensioner's spouse must enroll in the supplement coverage with their former employer if the spouse's contribution is 50% or less for the premium for the supplement plan. At that time, the pensioner should contact the Office of Pensions ~~to disenroll the spouse in the State's Medicare Advantage plan~~.

The State of Delaware

GHIP Strategic Framework

State Employee Benefits Committee

December 19, 2022

Disclaimer

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Overview of the GHIP Strategic Framework

- The State Employee Benefits Committee has adopted the **Group Health Insurance Plan (GHIP) Strategic Framework** to outline GHIP goals and guiding principles
- Framework includes:
 - **Mission statement** – unchanged since originally adopted in December 2016
 - **Goals** – last updated in February 2020, uses FY21 as baseline for measurement
 - **Strategies** – last updated in February 2020, based on goals
 - **Tactics** – last updated in February 2020, based on strategies
- Four-part format of the Framework reflects preferences of SEBC members from 2016; to date, SEBC has not opted to streamline this format
- Most recent update for SEBC on progress towards goals was provided in April 2022¹

¹ Source: <https://dhr.delaware.gov/benefits/sebc/documents/2022/0425-fy22-strategic-plan.pdf>.

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*** highlights core concepts embedded in the mission statement
- Definitions of all core concepts have been previously documented for the SEBC¹

¹ Source: <https://dhr.delaware.gov/benefits/sebc/documents/2016/1216-health-strategic-planning.pdf>.

Goals (effective February 2020)

Big Picture:

Increase proportion of medical spend to providers who are compensated for the quality, not quantity, of care delivered

Reduce cost for plan participants with diabetes

Limit health care cost inflation through targeted reduction in high cost, low value services and providers

Offer and increase engagement in tools that help plan participants use their health care benefits effectively

“Fine Print”:

Defines “pay-for-quality” using the same language as other Delaware agencies, workgroups and policy committees – i.e., defined within the **Alternative Payment Model (APM) Framework**.

Uses FY2021 medical spend as a baseline and FY23 as measurement period.

Goal establishes targets for increasing the proportion of future medical spend through two types of provider payment models, both focused on “pay-for-value (quality).”

Expectation: Meeting this goal produces a shift in provider compensation away from “pay-for-quantity” (fee-for-service) and towards “pay-for-value.”

Defines “cost” as the State’s share of medical and Rx expenses.

Uses FY2021 medical and Rx spend as a baseline and FY23 as measurement period.

Reduction measured as a percent of total cost per member per month.

Expectation: Meeting this goal will also result in a reduction of plan participants’ share of medical and Rx expenses.

Limits health care cost inflation (referred to as “total cost of care inflation”) to the same level as the Delaware Health Care Spending Benchmark.

Uses FY2021 medical and Rx spend as a baseline and FY23 as measurement period.

Targets specific types of services that are known to be expensive due to the types of providers used or due to high unit costs, including: inpatient and outpatient facility costs, drug costs.

The State employee health plan includes tools that help members select a medical plan and price out medical services and drugs.

Pre-2016, utilization of these tools had been low; though steady increases have been observed in recent years as a result of robust communication and education campaigns led by SBO in partnership with other State organizations.

Expectation: Over time, plan participant demographics will continue to skew towards more “technology native” members that will prefer to access the online version of these tools.

Goals (effective February 2020) – continued

Big Picture:

	Increase proportion of medical spend to providers who are compensated for the quality, not quantity, of care delivered	Reduce cost for plan participants with diabetes	Limit health care cost inflation through targeted reduction in high cost, low value services and providers	Offer and increase engagement in tools that help plan participants use their health care benefits effectively
Goal language approved by SEBC in Feb 2020*:	<p>Using the Alternative Payment Model (APM) Framework and FY2021 medical spend as a baseline¹, increase GHIP spend through advanced APMs² to be at least the following by the end of FY2023 (as % of total spend):</p> <ul style="list-style-type: none"> ▪ Category 3: 40% ▪ Category 4: 10% 	<p>Reduction of GHIP diabetic cost per-member-per-month (PMPM) by 8% by the end of FY2023³, using FY2021 spend as a baseline</p>	<p>Limit total cost of care inflation for GHIP participants at a level commensurate with the Health Care Spending Benchmark⁴ by the end of FY2023 by focusing on specific components, which are inclusive of, but not limited to:</p> <ul style="list-style-type: none"> ▪ Outpatient facility costs ▪ Inpatient facility costs ▪ Pharmaceutical costs 	<p>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 tool⁵ by at least 5% annually</p>

* Final Strategic Framework approved by the SEBC is available online: <https://dhr.delaware.gov/benefits/sebc/documents/strategic-framework.pdf?ver=0802>

1 Approximate FY21 baseline medical spend in advanced APMs: Category 3 – 48%, Category 4 – 1%. Based on GHIP-specific data provided by Highmark and Aetna. See following link for further details: <https://dhr.delaware.gov/benefits/sebc/documents/2022/0425-fy22-strategic-plan.pdf>.

2 Defined by the APM Framework as Category 3 and Category 4 models.

3 As a baseline, the FY2021 spend is \$1,584 PMPM for diabetics. The FY2023 target of \$1,741 PMPM for diabetics is based on an 8% overall reduction in projected FY2023 PMPM costs with an annual inflationary trend of 9.2% for combined medical and drug claims included.

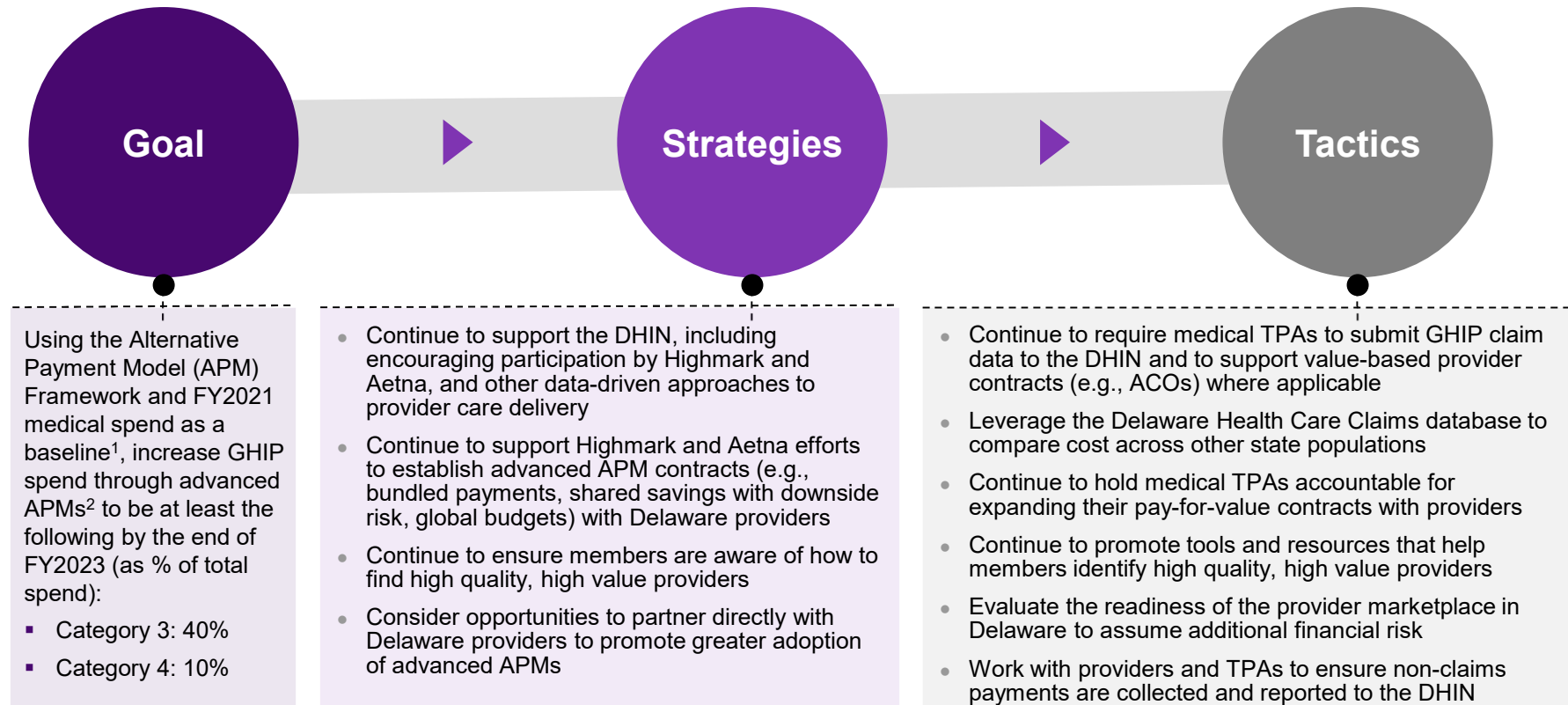
4 Currently pegged at 3.0% for CY2022 and 3.1% for CY2023.

5 Through FY2021, this tool continued to be administered under the purview of the SBO. Post-FY2021, selection of a specific engagement platform / consumerism tool is at the discretion of the SEBC.

Strategies and tactics – examples

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 within mission statement highlights core concepts primarily supported by this goal.

¹ Approximate FY21 baseline medical spend in advanced APMs: Category 3 – 48%, Category 4 – 1%. Based on GHIP-specific data provided by Highmark and Aetna. See following link for further details:

<https://dhr.delaware.gov/benefits/sebc/documents/2022/0425-fy22-strategic-plan.pdf>

² Defined by the APM Framework as Category 3 and Category 4 models.

Request for input from the SEBC

Does the Committee have a preference for:

- Retaining the same goals that have been in place since February 2020, but updating the measurement period beyond FY2023
- Revising the goals to reflect the Committee's current areas of focus

Big Picture:

Increase proportion of medical spend to providers who are compensated for the quality, not quantity, of care delivered

Reduce cost for plan participants with diabetes

Limit health care cost inflation through targeted reduction in high cost, low value services and providers

Offer and increase engagement in tools that help plan participants use their health care benefits effectively

Goal language approved by SEBC in February 2020:

Using the Alternative Payment Model (APM) Framework and FY2021 medical spend as a baseline, increase GHIP spend through advanced APMs to be at least the following by the end of FY2023 (as % of total spend):

- Category 3: 40%
- Category 4: 10%

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

Limit total cost of care inflation for GHIP participants at a level commensurate with the Health Care Spending Benchmark by the end of FY2023 by focusing on specific components, which are inclusive of, but not limited to:

- Outpatient facility costs
- Inpatient facility costs
- Pharmaceutical costs

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

Next steps

- WTW and SBO will continue to evaluate the progress of the goals compared to FY22 results
- Additional reporting on FY23 results will be available in late CY2023
- Based on the Committee's feedback on future goals of the GHIP Strategic Framework, a refreshed set of draft goals will be presented for the Committee's review and consideration at the January 2023 SEBC meeting
 - Will also include an initial discussion of long-term planning opportunities (originally raised at the November 2022 SEBC meeting) as potential new strategies for inclusion with the revised goals

Long-term opportunities: FY25 or later

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

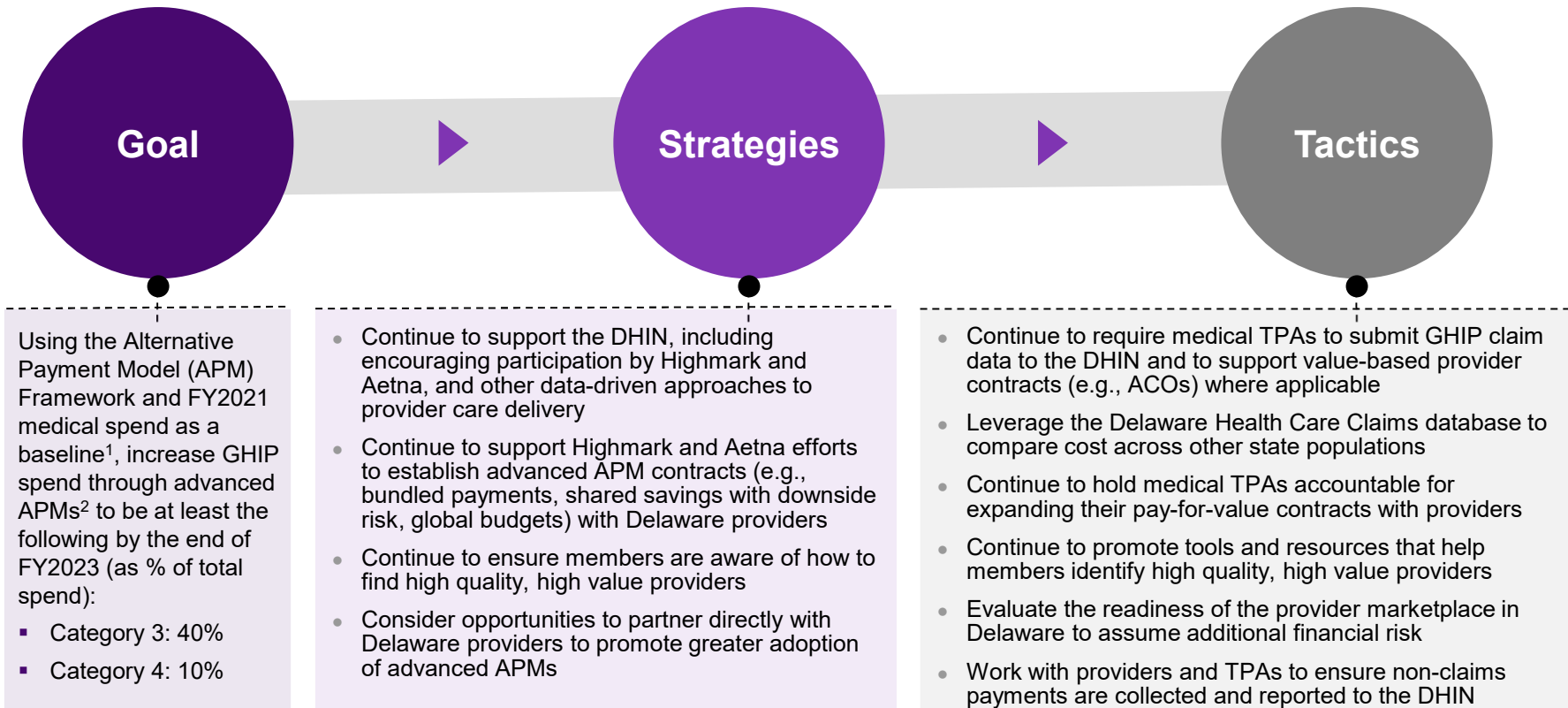
Appendix

GHIP Strategic Framework: Strategies and Tactics

GHIP goal #1

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.*



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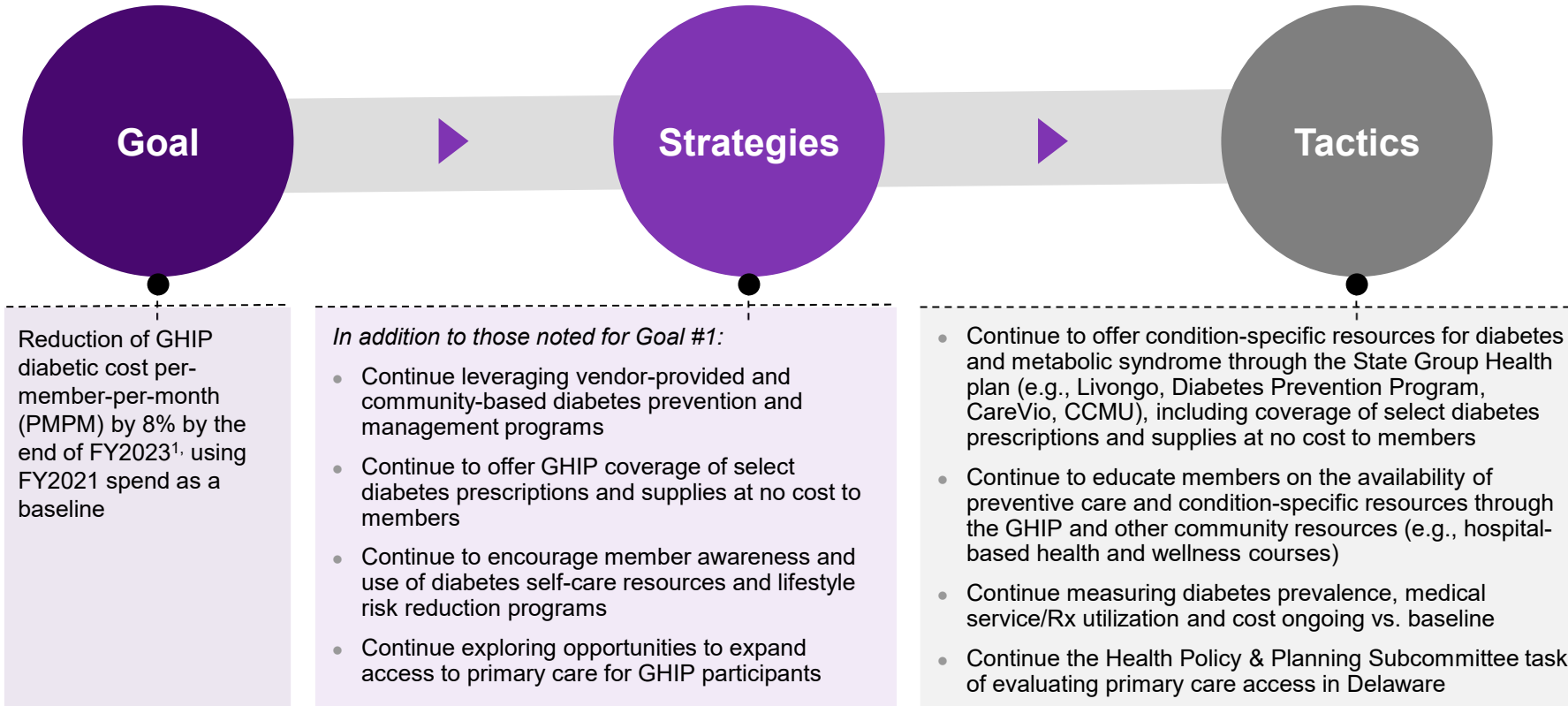
<https://dhr.delaware.gov/benefits/sebc/documents/2022/0425-fy22-strategic-plan.pdf>

² Defined by the APM Framework as Category 3 and Category 4 models.

GHIP goal #2

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 within mission statement highlights core concepts primarily supported by this goal.

¹ As a baseline, the FY2021 spend is \$1,584 PMPM for diabetics. The FY2023 target of \$1,741 PMPM for diabetics is based on an 8% overall reduction in projected FY2023 PMPM costs with an annual inflationary trend of 9.2% for combined medical and drug claims included.

GHIP goal #3

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.



Goal

Strategies

Tactics

Limit total cost of care inflation for GHIP participants at a level commensurate with the Health Care Spending Benchmark¹ by the end of FY2023 by focusing on specific components, which are inclusive of, but not limited to:

- Outpatient facility costs
- Inpatient facility costs
- Pharmaceutical costs

In addition to those noted for Goal #1:

- Continue managing medical TPA(s) and GHIP coverage provisions
- Continue to offer and promote resources that will support member efforts to improve and maintain their health
- Continue to monitor GHIP claims experience to identify areas of unnecessary utilization

- Evaluate competitiveness of State Group Health medical and Rx vendors' pricing for covered services and drugs against their competitors
- Continue 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)
- Continue to educate GHIP members on lower cost alternatives to the emergency room for non-emergency care (e.g., telemedicine, urgent care centers, retail clinics)
- Continue to educate members on the availability of GHIP care management and risk reduction programs
- Continue to monitor utilization of the SurgeryPlus benefit and drive engagement through additional member education and ongoing review of incentives

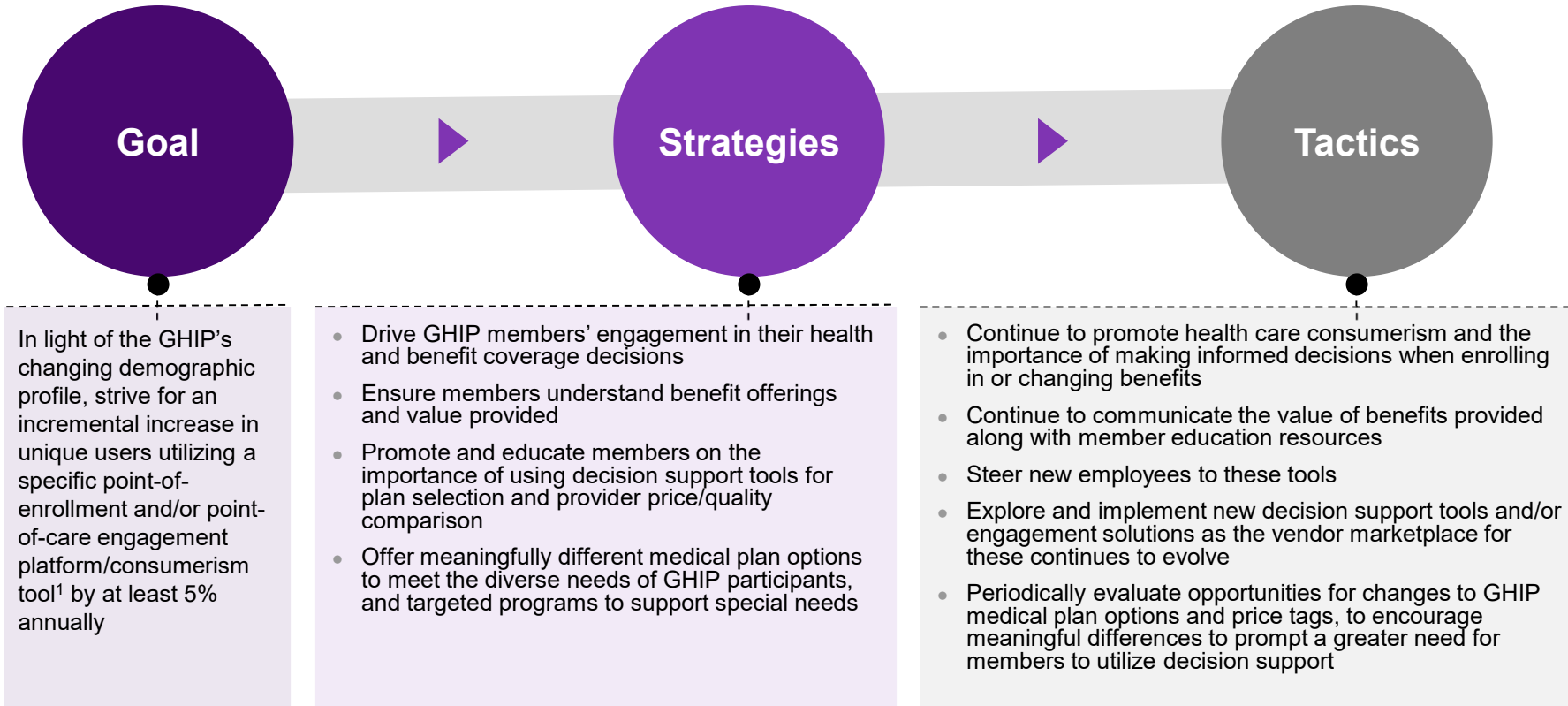
Purple text within mission statement highlights core concepts primarily supported by this goal.

¹ Currently pegged at 3.0% for CY2022 and 3.1% for CY2023.

GHIP goal #4

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 within mission statement highlights core concepts primarily supported by this goal.

¹ Through FY2021, this tool continued to be administered under the purview of the SBO. Post-FY2021, selection of a specific engagement platform / consumerism tool is at the discretion of the SEBC.

The State of Delaware

Benefits Modernization Initiative:
Employee Survey Update

State Employee Benefits Committee

December 19, 2022

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Modernizing benefits initiative

Overview

- At the November 2022 SEBC meeting, an update on the status of this project was provided to the Committee
 - Included overview of the project's foundation and goals, work completed to date and next steps, which included providing further details on survey components and more specific timing to the SEBC and the Subcommittees in December
 - At last Thursday's combined Subcommittee meeting, Subcommittee members were briefed on the material presented at the November SEBC meeting
- Today's discussion will focus on an overview of the topics for inclusion in the survey and a high-level timeline

Employee survey content

- Survey will focus on benefit preferences and the perceived value of benefits offered by the State
- Survey will include questions on the following topics:

Compensation	Medical / Rx Coverage	Retirement (Deferred Comp)	Flexibility in work location and schedule	Professional Development	Recognition	Other Benefits
Base pay increases	Premiums	Savings matching plan (457(b))	For employee segments where this is feasible	Formalized career plans	Methods that resonate with employees	Lifestyle spending accounts
	Plan design features			Training		Health savings accounts
	Total out-of-pocket costs			Tuition reimbursement (where offered)		Other voluntary / employee-pay-all insurance (identity theft, auto/home, pet, long-term care)
	Eligibility for coverage upon retirement*					Caregiving and family support
	Wellness					Student loan repayment

*Will include questions that cover recommendations of the Retirement Benefits Study Committee from March 2022.

Employee survey timeline

- Target launch of employee survey: February 2023
- Preliminary results shared with the SEBC: March 2023
- Detailed analysis of survey results: Q2 CY2023
- Results of detailed analysis shared with the SEBC: Q3 CY2023

- Preliminary results may inform some of the SEBC's decisions for the FY24 plan year, which are needed by March 2023 in order to implement in time for the start of FY24 (7/1/2023)
- Results of detailed survey analysis will likely be available for consideration towards changes in FY25 or later

Next steps

- Survey work group continues to meet weekly to develop survey content, work through technical details related to survey administration and establish an employee communication plan
 - This includes discussing alternatives for employees without ready access to computers and email
- Additional information about the employee communication plan will be shared as it becomes available in advance of the survey launch