

The State of Delaware

GHIP Strategic Framework FY2026 – FY2029

State Employee Benefits Committee Meeting

Approved April 20, 2026

Overview of the FY2026-2029 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

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

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

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 (2)

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 - Embed Centers of Excellence (COE) utilization targets in Medical TPA RFP - Evaluate implementing a modern provider search tool to increase cost transparency and support site of care decisions - 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.)	- The richer a plan design, the less incentive patients have to evaluate prices and provider quality when making healthcare decisions. - SBO/SEBC reliance on TPAs to conduct targeted interventions - Current availability of cost transparency tools that are specific to GHIP members may be limited - Implementation of a modern provider search tool would come at a cost
Measures: Site of Care Steerage Report, Centers of Excellence 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 (1)

Strategy 1: Optimize benefit design to promote cost-effective, high-value care	
Tactic	Considerations
• Offer consumer-driven plan options • 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 • 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 (2)

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), Centers 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 or other third-party vendors 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 - Partner with legislature and departments where possible to support hospital price controls or other state-wide cost-management legislative initiatives	- Optimizing vendor contracts may be constrained by administrative process timelines (e.g., procurement and contracting cycles) - Cost management tactics to be considered in partnership with state-wide/legislative initiatives include: reference based pricing; reverse auctions; direct contracting with providers or drug manufacturers; investment in primary care access and utilization

Measures: Audits, payment integrity algorithms, provide any recommendations to General Assembly annually in the fall of each year

Goal 3: Manage healthcare costs for GHIP and members (3)

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 • The richer a plan design, the less incentive patients have to evaluate prices and provider quality when making healthcare decisions. • 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

Strategy 6: Use demographic and actuarial insights to manage cost trends

Tactic	Considerations
• Conduct demographic and experience analyses for specific member cohorts to identify cost drivers, emerging risks, and variations to the Fund by group • Evaluate predictive retirement trends and model long-term impacts on enrollment, plan costs, and the health fund	• Experience by group can change over time and making changes to rating methodology can cause volatility and create challenges to forecasting

Measures: Cost studies, OPEB/retiree medical valuations

Goal 4: Ensure **transparency and continuous improvement** toward achieving goals by monitoring, measuring and reporting progress (1)

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	
Measures: Development of KPIs and implementation plans	
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
Measures: Evaluation and possible implementation of evolving data analytics capabilities	

Goal 4: Ensure **transparency and continuous improvement** toward achieving goals by monitoring, measuring and reporting progress (2)

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
Measures: Annual refinement and confirmation of GHIP Strategic Framework	
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	
Measures: Dashboards and annual results report	

Appendix

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	GHIP members have access to healthcare services that are priced fairly and competitively relative to comparable regions/states. 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.