State Employee Benefits Committee
Friday, July 11, 2016 at 2:00 p.m.
Tatnall Building, Room 112
Dover, Delaware

The State Employee Benefits Committee met on July 11, 2016, at the Tatnall Building, Room 112, Dover, Delaware. The following Committee members and guests were present:

Committee Members:
Brian Maxwell, Director, Office of Management and Budget
Mike Morton, Controller General
Evelyn Nestlerode, Designee of Chief Justice
Ken Simpler, State Treasurer
Henry Smith, Designee of Secretary of Health and Social Services
Valerie Watson, Designee of Secretary of Finance
Karen Weldin Stewart, Insurance Commissioner

Guests:
Brenda Lakeman, Director, SBO
Faith Rentz, Deputy Director, SBO
Lisa Porter, SBO
Brian Baker, Cerner
Rebecca Byrd, The Byrd Group
Laurene Eheman, SBO
Jacqueline Faulcon, DRSPA
Karen Faulhaber, PHRST
Judith Grant, HMS
James Harrison, DSEA-R

Guests (cont'd):
Cheryl Heiks, Cozen O'Connor
Peter Henry, Cerner
Leighann Hinkle, SBO
Andrew Kerber, DOJ
Gisela McKenzie, Univ. of DE
Omar Masood, OST
Casey Oravez, OMB
Karol Powers-Case, DRSPA
Kimberly Reinagel-Nietubicz, CGO
Paula Roy, Roy Associates/DCSN
Wayne A. Smith, DHA
Jennifer Vaughn, DOI
Andrew Wilson, Morris James

Jennifer Mossman, Highmark
Walt Mateja, Truven Consulting
Kevin Fyock, Willis Towers Watson
Jaclyn Iglesias, Willis Towers Watson
James DiGuiseppe, Willis Towers Watson

Introductions/Sign In
Director Maxwell called the meeting to order at 2:01 p.m. Introductions were made.

Approval of Minutes - handout
Director Maxwell asked the committee to take a moment to review the minutes from the June 24th SEBC meeting and noted a minor change to these minutes under Motions (last page) as it stated the Director "made" a motion and should be changed to read the Director "requested" a motion. Controller General Morton made the motion to approve the minutes and Mr. Smith seconded the motion. Upon unanimous voice approval, the minutes were approved.

Health Insurance RFP – Development & Planning, Scorecard and Executive Summary – handout – Willis Towers Watson
Director Maxwell indicated this meeting is a continuation to discuss the upcoming Request for Proposal (RFP) for the third party administrators for the Health Insurance for the State of Delaware to be presented by Willis Towers Watson.

Kevin Fyock with Willis Towers Watson (WTW) informed the committee there are three documents in the packets with two to be reviewed at today's meeting. The focus of this discussion will be on the (PPT) presentation followed by the Scorecard discussion. The agenda included an update on the Health Insurance RFP, RFP Scoring and the next steps. WTW is working in conjunction with the Statewide Benefits Office (SBO) on developing the Health Insurance RFP and is working through the third draft of the RFP. A reminder of the structure of the RFP is as follows:

- RFP Introduction
- RFP Background
- Minimum Requirements
- Detailed Questionnaire, consisting of five sub-sections
  - Bidder Profile

  - Medical Plan Administration
  - Health Care Delivery
  - Member Support, Tools and Resources
  - Health Management
- Network Adequacy
- Financial Proposal

The RFP is being utilized as a tactic to address the State of Delaware's broader strategic framework (mission and goals) and will be developed over the next three to six months.

- As the RFP is broad in nature, covering both the State of Delaware's current plan options as well as potential modifications to maximize efficiency in cost, access and quality, it will support the future goals and mission within the State's broader strategic framework

Jaclyn Iglesias with Willis Towers Watson continued with the update in an outline of the key areas. As mentioned at the last meeting, this RFP will be materially different than the RFP previously released back in 2011. The RFP aims to gather details on what the market can offer through many areas, including both traditional aspects of plan administration, as well as emerging models aimed at maximizing plan efficiency. Examples of information that will be sought through this RFP process from bidders in review of both traditional models and emerging models were shown below.

Various Payment Models	Consumer Awareness	Disease Management Options	Other Potential Initiatives
- Traditional Fee-for-Service (including % of billed charges, DRGS & APCs) - Accountable Care Organizations (ACOs) - Patient-Centered Medical Homes (PCMHs) - Centers of Excellence (COEs) - High Performing Networks	- Provider data transparency - Member self-service: technology and portals - Decision support tools - Additional programs that can aid in providing awareness and education to members	- Health Management programs (Disease Management, Care Management) - Care coordination - Gaps in care technology - Alternative Health	- Coordination with On-site Health Centers - Telemedicine - Additional options such as Health Savings Accounts (HSAs) and Medicare Advantage Plans - Coordination with Statewide Initiatives (such as the all claims payer database)

Commissioner Stewart commented that along with the DE Health Care Commission, we are looking at Fee for Value (FFV) and this is not listed. Ms. Iglesias responded the intent is to look for FFV and is a characteristic of a concept that will be tapped into here as well. The models listed here might not be characterized exactly the same way but essentially the intent of these models is to price based on value and believe we are working on a similar concept.

Treasurer Simpler stated to echo the Commissioner's comment, the one thing that is so perplexing about this industry is the use of terms that mean the same thing but sometimes sound a lot different so where WTW can help educate this committee on terms it would be helpful.

Ms. Iglesias continued with Consumer Awareness. Member self-service and what tools are in place for the GHIP whether it is a mobile App or something other than a desktop computer or telephone number; what are the varieties of ways that a member could tap into supporting their health when they need to seek care. Provider transparency will be looked at as to how the third party administrators (TPA's) are helping the GHIP population understand what the true costs of health care really are and drive the individuals to be more educated.

Treasurer Simpler commented that we did get a little bit of this going on with our TPAs and our care providers saying if we only had the information they had, we could do the X, Y and Z. Will this be reconciled with the new TPAs where we can as a body hold one person responsible or make sure the data is available as opposed to having data in one lock box or in another lock box. Mr. Fyock said this is one area that has come long way since 2011 and we are hopeful that when evaluating the bidders we will see a differentiation in what is provided in the marketplace and a more positive ability for members to access information on a mobile basis.

Commissioner Stewart inquired on the impact that the All Payer Claims Database (APCD) legislation that was passed at the end of the General Assembly. Mr. Fyock responded it is similar and as part of the RFP presented at the last SEBC meeting, we are asking the bidders to participate in the all payer claims database. This is similar but will look for specific tools offered by the TPA or insurer that give the member the ability to go in and query how much it would cost. Ms. Lakeman commented the legislation that was passed mandates the GHIP to participate in the APCD with the Delaware Health Information Network (DHIN) being used as a framework for this new database. The APCD will lead to more transparency for organizations like ACOs that need this data to manage their population. The APCD includes the GHIP, Medicaid and the Marketplace populations and other entities that voluntarily wish to participate.

Ms. Iglesias reviewed another key area in the Health and Disease Management with a list of programs in place to help people who are catastrophically or chronically ill. How will bidders assist GHIP members who need and are identified in one of these conditions through claims data to navigate the member through the system and find the care needed. Most of the larger TPAs do offer these services and this will be an area to evaluate.

In addition and new for the 2016, this RFP will be taking a closer look at some of the capabilities to coordinate care with different providers in the community as a greater emphasis on how the TPAs might look to help members navigate the system in more detail, particularly as to the Pay Per Value models which will be evaluated as part of the process. Technology capabilities that the vendors have to help identify GHIP participants that may have an acute health care need connected to the Gaps in Care Technology as it monitors claims data, member's health and could potentially help identify a variety of urgent health situations that may arise like medication interaction. Other potential initiatives were reviewed.

Treasurer Simpler asked if we are looking for one party to do all of this and is this the goal of the RFP. Mr. Fyock stated the goal of the RFP is not for a single partner but part of the intention of casting such a wide net is to leave it open as to who are the best partners to help the State move forward. Ms. Iglesias mentioned that more will be covered in the RFP Scorecard but we are looking to evaluate each of the bidders on the particular plan options that they are submitting for, potentially there could be different bidders offering one plan versus another. Treasurer Simpler asked if the nature of the different types of bidders is going to be very different or does WTW think bidders would be similar to the TPAs that we have now. Mr. Fyock responded that they think it will be a mix and are hopeful to have some non-traditional players.

Ms. Iglesias finished up on the RFP status and referenced slide 5 of the high level timeline and noted we are still in the top row in developing and finalizing the RFP, looking at a formal launch of August 15th to be released to bidders.

The scorecard used from the prior 2011 RFP was modified with sections and weighting for consideration as shown in the additional handout and below with detailed breakdown of sections.

State of Delaware
Health Insurance RFP Scorecard

Draft #4 - 7/7/2016

Category	2011 Health Ins RFP - Final Scoring	Market Practice	2016 Health Ins RFP - WTW Recommendations* Non-Medicare Plans	2016 Health Ins RFP - WTW Recommendations* Medicare Plan Only**
Plan Administration	15%	X	15%	20%
Claim Administration				
Eligibility / Enrollment Processing				
Customer Service				
Implementation Timeline *(new plan designs, new networks)*				
Plan Design Capabilities and Services	15%	X	13%	18%
Accommodate Existing *and/or Future* Designs				
Medical Management				
Open Enrollment Support *(including communications)*				
Account Management *(dedicated team, experience and PGs)*				
Reporting / *Measurement (for value-based contracting models)*				
Adequate Network Access*	15%	X	20%	n/a
Adequate Network Access *(i.e., >90% EEs within GeoAccess standards)*				
Network Management				
Member Disruption				
Future Network Optimization Opportunities				
Financial Terms	35%	X	30%	35%
Administrative Fees				
Discounts *(inclusive of value-based contracting models)*				
Financial Guarantees *(beyond min requirements, e.g., fees at risk, ROI)*				
Experience and References	10%	X	10%	15%
References & Financial Ratings				
Ability to Address the State's Needs (experience, proposed solutions)				
Future Growth Plans within Delaware (network, value-based contracting models)				
Performance Guarantees	10%	X	0%	n/a
Removed as its own category - now part of minimum requirements				
Responsiveness	0%	Sometimes	2%	2%
Compliance with Bid Requirements and Responsiveness to Follow-ups				
Tools & Technology	n/a	X	5%	5%
Online Member Portal Content / Accessibility (e.g., mobile, app)				
Provider Cost / Transparency Tool				
Account Management Tools (to be demo'ed during finalist mtg)				
Integration	n/a	X	5%	5%
With Other State of Delaware Benefits / Vendors				
With Other Community Resources (e.g., onsite clinics)				
TOTAL	**100%**	**n/a**	**100%**	**100%**

Italics/items highlighted in blue = New categories added by WTW

*Scoring will be expanded for all plans so that each vendor will be evaluated on each type of plan included in their proposal (i.e., both current plans such as the HMO, PPO, First State Basic, Consumer-Driven Plan, Medicare Supplement, and future plans not in place today, such as a value-based care network or a Medicare Advantage plan).

**For the Medicare Supplemental plan, the 20% weighting reflected under Adequate Network Access will be redistributed in 5% increments to Plan Administration, Plan Design Capabilities and Services, Financial Terms and Experience and References.

Director Maxwell questioned the Market Practice column with an X appearing and would prefer to know how other states have weighted these categories (10-15% or 20-30%) versus an X. Mr. Fyock said the issue with understanding the potential range is dependent on how many categories the organizations had in their evaluation; we could throw out 10 to 15% for Plan Administration but if it was Plan Administration and two other categories, the percentages could be higher. Based on both public and private organizations that our team has worked with, this spread is appropriate when it comes to evaluating the different bidders but each organization would have a materially different scorecard that could be separated into three to five categories or twelve different categories and may tend to dilute the percentages. We could take that back and try to find a common denominator of organizations that have some type of range and try to split it up.

Ms. Iglesias explained where italicized text is shown on the scorecard and blue shaded areas are additions that WTW has proposed for the 2016 scorecard. The only notable subtraction from the scorecard between 2011 and 2016 would be the performance guarantees (PGs) category. The reason why this is being removed is it is now a minimum requirement. The bidders will need to confirm their ability to administer the set of PGs that exist today. There are some regarding additional performance or financial guarantees that the bidders would be willing to propose to the State in addition to the minimum, and these will be evaluated under the category of Financial Terms within the subcategory of Financial Guarantees. Mr. Fyock stated this allows us to help differentiate among the bidders, those who really stand out by way of PGs and using where we are today as the threshold and baseline.

Ms. Nestlerode asked to go back to the expectation of three to five bids, is that typical across the board in other regions, other markets or unique to the State. Mr. Fyock responded that this range of bids is typical.

Director Maxwell questioned under Plan Design Capabilities and Services where in Account Management it states dedicated team, experience and PGs – is this Performance Guarantees also. Ms. Iglesias confirmed it is and the willingness of the bidders to guarantee either additional resources or a dedicated team as opposed to a designated team that services other accounts or organizations and to bring a degree of commitment that the bidder will put forth for the State.

Treasurer Simpler inquired in the current draft, are the PGs now a minimum threshold you actually changed or will stick with what we have and improve on it. Ms. Iglesias stated WTW has looked at the PGs in place today and bumped them up against typically seen best in class in the market, and have made recommendations where there are opportunities to enhance the PGs, and have had ongoing dialog with SBO regarding where that falls into a request for the bidders to propose.

Treasurer Simpler asked what is at the heart of the PGs. Mr. Fyock responded that on a traditional basis this includes average speed to answer, customer service, how the account management team performs and then there are more non-traditional PGs like clinical metrics.

Ms. Nestlerode inquired if Tools & Technology would be evaluated as to how much the bidder has available to us or evaluating based on what the bidder is promising to develop and are there incentives or things beyond that to create tools. Mr. Fyock agreed absolutely and for many of these sections, we will let the bidders talk about their plans to improve the State of Delaware's health care, to improve upon the current offerings by way of a Value Based Contract or a movement away from fee for service (FFS).

Treasurer Simpler asked what the TPAs incentive is whether a fixed price, pay on volume and to what extent is their interest in alignment with the State at the compensation level of controlling costs in the Plan. Mr. Fyock responded depending on what model it is, generally likely to see the provider has the same amount of stake or similar to the organization. TPA or Insurers that have negotiated different discounts with certain providers or have demonstrated a desire to push people to higher performing facilities is something that sets them apart from their peers. These examples might not provide direct compensation to the TPA; however, result in savings to the GHIP.

Commissioner Stewart inquired that we are not asking these TPAs to turn people down from having procedures done to save money so the TPA receives a portion or percentage of bringing the cost down which could lend itself to some people having a hard time to get approval to have procedures done. Mr. Fyock stated the search for a TPA to aid in moving the State forward, will not include strategies that discourage people from getting services, yet ones that steer members to the most efficient providers and ones that are going to have a better patient outcomes. Mr. DiGuiseppe stated that we are looking for providers to administer the GHIP plans accurately, timely and with financial accuracy and provide top rate customer service. In addition, what are the bidders willing to do to guarantee a tempered trend, lowering costs and how will that be measured and what caveats are in place. This is where a lot of time will be spent to see where the TPAs can work with their providers to steer people to the most effective, lowest total cost of care.

Ms. Iglesias summarized the scorecard and footnotes related to the Network Access section and drawing out that Future Network Optimization Opportunities under this section is intended to acknowledge and value the availability of the different Fee for Value or Pay for Performance models that will be part of the bidders' purpose.

Treasurer Simpler asked WTW which categories will serve to distinguish the bidders. Mr. Fyock responded that with greater than 50% confidence, the vendors will differentiate in the areas of Network Access, Tools & Technologies and Financial Terms with the traditional and change in payment methodologies offered.

WTW is looking at TPA's that would be able to administer the plans that are in place today as a starting point so there does need to be a broad network or already established network in place. WTW is also evaluating the ability of the TPA's to either have in place today these Fee for Value models or to have these models implemented within a certain period of time and allow the bidders to present viable options. Many of the larger traditional TPA's do have these models or are actively developing them. WTW is confident that there will be several models to compare.

Director Maxwell asked WTW that since the three categories (highlighted in blue) were added, to talk about why they were added, the value in these categories, and specifically describe the Integration category. Ms. Iglesias explained that Responsiveness was added in response to a change in the State procurement requirements that there does need to be some weighting on each bidder's ability to respond to the RFP, ability to follow directions, ability to provide responses in a timely way. This requirement did not exist in 2011.

Tools & Technology was added due to the evolution in the marketplace with the non-paper based resources that the TPAs offer to plan participants such as a desktop, tablet, mobile phone as there is a variety of electronic and telephone options to support services that were not as evolved in 2011. There is a lot of opportunity to leverage this technology to add value to the overall goals of the GHIP. Director Maxwell asked if the EOB (explanation of benefits) members receive in the mail and they are not sure if it is a bill, not a bill or don't understand would be an example of how technology could improve member experience and understanding. Ms. Iglesias responded that for example, there may be a tool or explanation online in the member portal to help members understand what their EOB means, how to read it, and understand the costs. Or maybe help find a provider that is now in network that was not before, or maybe how much a procedure may cost at one facility versus another. The Account Management Tools is a subcategory to get a better understanding of what the TPAs tools are for their own internal teams to help them do the most effective job possible at supporting the State in administering the services and WTW expects bidders to demonstrate during the finalist meeting for that capability. Mr. Fyock added Tools & Technology will not only evaluate the bidders ability to provide benefit information from a portal, but also compare each vendor's capabilities to provide other tools through their portal that could include the members ability to look up providers, utilize transparency tools to indicate costs or even quality. WTW will want to compare how vendors can differentiate themselves based on engaging members and making members more accountable based using technology like cell phones utilized by virtually every GHIP member.

The Integration category was included and represents how the TPAs will leverage all of the resources available to the TPA to help manage the GHIP participants who may have an acute or chronic need. There are opportunities to integrate with other benefits and vendors that the State provides to plan participants such as EAP if mental health or work/life need or leveraging Express Scripts pharmacy if for example there is a high cost medication that a participant is taking and member has questions. Making sure the TPA has been able to effectively demonstrate their ability to leverage those outside resources that the State offers and also integrating with other community resources, like potentially on-site health clinics and how the TPA can help coordinate care for participants with on-site centers, coordinate care through Telehealth and with the participants' primary care physician. There is a lot of opportunity for the TPAs to demonstrate their abilities and their experience with integrating with a variety of different players within the health care space, and not just limited to the provider network that they might be proposing for the State.

Mr. Fyock wrapped up the presentation with the Next Steps that include the RFP finalization and posting for public response on August 15, 2016. Strategy development roadmap to be reviewed and discussed at the next SEBC meeting on July 25, 2016. Plan is to develop over the next three to six months, a three to five year strategy. The RFP will be a tactic for that overarching strategy.

It is noted that the next SEBC meeting on July 25th is a regular meeting but we should be able to allocate some time to the RFP. The RFP finalist voting is scheduled for November, about four months away. Treasurer Simpler commented WTW is going to try to use the three to six months for the strategic framework and it would be helpful to have at least enough of the strategic plan or roadmap flushed out so that we understand how the proposals of the RFP finalists fit with that larger strategic framework. He encouraged WTW to have the strategic framework far enough along to enable the SEBC to make sense of the RFP recommendations that will be presented to the committee.

Public Comments
Ms. Karol Powers-Case had a question if the next 2 hour meeting is open to the public (July 25th). Response was that all meetings of the SEBC are public.

Other
Treasurer Simpler asked if the SEBC was done with the extra meetings and expressed concerned about the amount time remaining. He asked WTW to consider if the committee had adequate time to understand the strategic framework that WTW will be developing. Ms. Lakeman confirmed that today's meeting is the last extra meeting to specifically discuss the Health RFP. We have meetings once a month from now through end of the year. Director Maxwell stated that if there are discussion points that come up and members feel that we are not making enough progress, we can always schedule another meeting(s) if needed. Treasurer Simpler asked that WTW give some consideration to the three to six months of learning and work ahead to develop an initial three to five year plan with only four meetings left before the RFP award recommendation and if dedicating a portion of each meeting is sufficient.

Director Maxwell stated the only other piece of business which was talked about briefly at the last meeting was the release of the RFP to this committee and does this committee want to see the full draft of the RFP before it is released as finalized or if they are comfortable with the Executive Summary.

Treasurer Simpler thanked OMB for their efforts to have WTW reach out to SEBC members to obtain individual input and feedback and that it has been very worthwhile to talk with WTW. He further explained that he felt comfortable that WTW is not drafting the RFP in a manner that would exclude the SEBC from considering any strategies as part of the strategic framework process and that the RFP will not limit or exclude potential bidders responding to the RFP with non-traditional proposals. These two points give him great comfort that there is no need for the committee to micro-manage the technical process but simply understand the overall intent of the RFP and as well allow opportunity for the public to be aware.

As the consultants do not feel like we are truncating any of the options we have to explore related to the strategic planning process and that the Health Fund Task Force laid out the options, the only question the Treasurer repeatedly asks is would the manner the RFP has been drafted either one, exclude significant strategies that we would be foreclosed from exploring and the answer has been no and or would it exclude significant or different players coming to the table to have a possibility of bidding and the answer has been we are seeking to explore non-traditional to meet some minimal requirements. Those are the two points that give him great comfort that the committee is not trying to micro-manage the process but look into the details and important for the public and for the committee to know.

Clarification was provided to Ms. Nestlerode around the question before the committee as to their interest in seeing a full draft of the RFP or only the Executive Summary.

Ms. Watson asked if there are any unintended consequences in releasing the RFP in draft and inviting comments. Director Maxwell responded that the only unintended consequence would be those (vendors) that did not attend these meetings would not be aware of these discussions which is why posting the draft RFP on My Market Place is appropriate but may run the risk of people getting a head start or result in an increase of phone calls from vendors even though the RFP has not yet been officially advertised as final.

Ms. Nestlerode stated the Executive Summary should be efficient and will follow up if needed.

Treasurer Simpler would like some discussion on the request made previously on the format for the budget.
Ms. Rentz responded this is an intended agenda item for the next meeting. Revised financial reporting formats will be presented at the next SEBC meeting on Monday, July 25, 2016.

Motion
Director Maxwell requested a motion to adjourn the meeting. Controller General Morton made the motion and Commissioner Stewart seconded the motion. Upon unanimous voice approval, the meeting was adjourned at 3:07 p.m.

Respectfully submitted,

Lisa Porter
Executive Secretary
Statewide Benefits Office