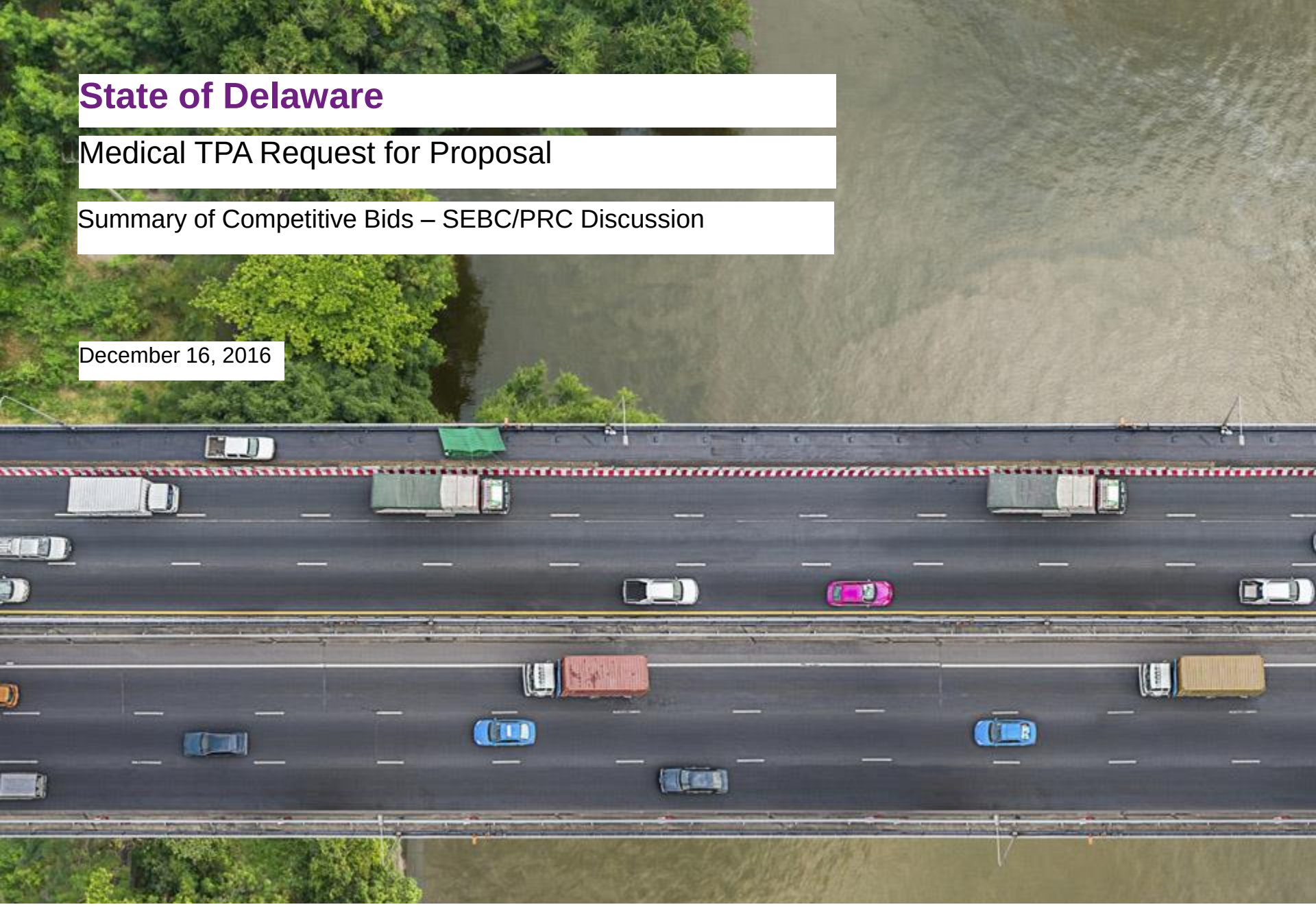

# State of Delaware

## Medical TPA Request for Proposal

Summary of Competitive Bids – SEBC/PRC Discussion

December 16, 2016



Willis Towers Watson

# Today's Discussion

- Process Overview
  - Summary of vendor bidders
  - Evaluation and scoring

- Executive Summary – Key Findings
  - Overall summary
  - Funding arrangements
  - Alternative provider contracting arrangements

# Medical TPA RFP process overview

## Introduction

- A Request for Proposal (RFP) for medical third party administrators (TPAs) to serve the State's Group Health Insurance Program (GHIP), effective July 1, 2017, was released on August 15, 2016
- The following vendors submitted responses to the RFP:
  - Aetna, Cigna, Highmark of Delaware (Highmark) and UnitedHealthcare (UHC)
  - Humana initially submitted an intent to bid but later withdrew the intent to bid
- Vendor responses were reviewed from both a qualitative and quantitative perspective, with a focus on the following objectives:
  - *Financial:* Reduce total cost of care for GHIP participants and the State; reduce program expenses through improved contractual and financial terms; support financial rewards for providers that meet certain cost and quality standards
  - *Access to high quality providers and to information on provider cost/quality:* Facilitate consumer choice of providers who deliver higher quality care at a lower total cost; provide GHIP participants with the tools and resources that will promote transparency in provider cost and quality and encourage participants to make informed decisions about their health
  - *Care and disease management:* Promote consumerism and health management through member tools and resources; provide care management programs that are effective at engaging members and steering them to the most effective care at the right time with the right providers
  - *Improved operational efficiency:* Streamline the number of vendors administering each medical plan offering, administer core account management functions with an eye toward administrative ease and simplicity
- The RFP is being utilized as a tactic to address the State's broader strategic framework; as the RFP is broad in nature, covering both current plan options and potential future modifications, **it will support the goals and mission within the State's broader strategic framework**

# Medical TPA RFP process overview

## Summary of vendor bidders

| | Aetna | Cigna | Highmark DE | UHC |
|---|---|---|---|---|
| **Self-Funded Products** | | | | |
| PPO/POS | ✓ | ✓ | ✓ | ✓ |
| CDHP – HRA | ✓ | ✓ | ✓ | ✓ |
| CDHP – HSA | ✓ | ✓ | ✓ | ✓ |
| HMO | ✓ (gated) | | ✓ (open access) | ✓ (open access) |
| Medicare Supplement | ✓ | | ✓ | ✓ |
| **Fully-Insured Products** | | | | |
| PPO/POS | | | ✓ | ✓ |
| CDHP – HRA | | | ✓ | ✓ |
| CDHP – HSA | | | ✓ | ✓ |
| HMO | | | ✓ | ✓ |
| Medicare Supplement | | | ✓ | |
| Group Medicare Advantage | ✓ | | | |

✓ Provided quote for product

Note: for all products, pharmacy will remain carved out to ESI (commercial and EGWP)

All products have a 7/1/2017 effective date, except Medicare Supplement and Medicare Advantage which have a 1/1/2018 effective date

# Medical TPA RFP process overview

## Evaluation and scoring

- Willis Towers Watson worked in conjunction with the Statewide Benefits Office (SBO) and the SEBC on developing the scorecard to evaluate responses to the medical TPA RFP
- Below is a high-level summary of the major sections and weightings

| Category | Active/Non-Medicare Eligible plans, plus Medicare Advantage | Medicare Supplemental Plan only* |
|---|---|---|
| **Traditional TPA Criteria** | **Weighted 75% of overall total** | |
| Plan Administration | 15% | 20% |
| Plan Design Capabilities and Services | 13% | 18% |
| Adequate Network Access* | 20% | n/a |
| Financial Terms | 30% | 35% |
| Experience and References | 10% | 15% |
| Responsiveness | 2% | 2% |
| Tools & Technology | 5% | 5% |
| Integration | 5% | 5% |
| **Subtotal – Traditional TPA Criteria** | **100%** | **100%** |
| **Value-based Care Delivery (VBCD) Criteria** | **Weighted 25% of overall total** | |
| **Subtotal – VBCD Criteria** | **100%** | **100%** |
| **Grand Total** | **100%** | **100%** |

*For the Medicare Supplemental plan only, 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.

# Executive summary

## Key findings

- All the vendors are well positioned to effectively administer the State's current plan options; while there are some differentiators among the vendors, they are not significant enough to warrant elimination of any vendor from further consideration on that basis alone
- Overall, Highmark offered the strongest financial proposal and least member disruption on a full-replacement basis (Actives and Retirees)
  - Moving to Aetna would potentially increase the State's costs slightly, with a more significant increase in cost moving to UHC on a full-replacement basis
  - Cigna did not quote on all products and therefore is not a single vendor option; for the plans quoted, Cigna ranks 3rd on financials behind Highmark and Aetna
  - Discounts and projected claim costs may vary based on actual GHIP utilization mix
- All single-vendor and multi-vendor options present an opportunity to reduce "fixed dollar costs" through reduction in ASO fees and credit offsets
  - Cigna has the most competitive ASO fees for products quoted, but did not quote on all products
  - Aetna offered the strongest performance guarantees and the most credits
- Network access is favorable for all of the vendors' broad network offerings
  - Some member disruption (in particular with physicians) if the State were to move to Cigna or UHC

# Executive summary

## Key findings – funding arrangements

- Only two vendors, Highmark and UHC, quoted fully-insured arrangements for the Active and Pre-65 Retiree populations
  - Fully-insured quotes do not yield any savings and would increase the State's health care costs over current FY2017 budget rates
- Highmark was the only carrier to provide a quote for a fully-insured arrangement for the Post-65 Retiree population
  - Highmark's proposed 2018 fully-insured Medicfill rate is an increase from the FY2017 self-funded budget rates
- Highmark and UHC fully-insured premiums are guaranteed for 1 year only
- Timing for fully-insured renewals is typically 4-6 months before the start of a plan year (e.g., January – March for the State's July 1 plan year), which poses a challenge with respect to the State's budget cycle given that initial budget projections for the following year are required 6-9 months in advance
- Aetna was the only bidder to quote on a group Medicare Advantage (MA) plan
  - Group MA plans are always fully-insured, and Aetna's proposed MA plan mirrors the current Medicfill plan design
  - Aetna's proposed MA plan is projected to increase medical spend for the Medicare eligible population compared to estimated FY2018 claims and fees for the self-funded Medicfill plan

# Executive summary

## Key findings – alternative provider contracting arrangements

- All four vendors' proposals included at least one alternative health care delivery model
- Many of those solutions are still emerging, and may not yet be available to the full GHIP population
  - *High performing provider networks* – While these are available through all four vendors on 7/1/17, they do not provide equivalent access to high performing providers for all GHIP participants
  - *Accountable Care Organization (ACO)* – Highmark was the only vendor to include in its proposal
    - Highmark's closest ACO is in Lancaster County, PA, which is not viable for the majority of the GHIP population; Highmark is planning 1-3 additional ACOs in the Delaware market, expected to be available 7/1/17 (during this process Highmark has shared additional information related to ongoing negotiations to form Delaware ACOs)
  - *Advanced primary care* – currently available to GHIP population through alternative contracting models embedded in Aetna and Highmark's broad PPO networks and would continue as of 7/1/17
  - Additional care management and primary care coordination ("Care Link") in partnership with Christiana Care Health System (CCHS) is available through Aetna, Highmark and Cigna as of 7/1/17, but only Aetna has established a risk-sharing arrangement with CCHS ("AIM")
- AIM ("Alternative Innovation Model") is a customized HMO plan created through a collaboration between CCHS and Aetna in which CCHS assumes upside and downside financial risk for managing the HMO population
  - Leverages a team of CCHS clinicians supported by shared electronic medical records ("Care Link") to deliver telephonic and in-person care management at CCHS facilities
  - Additional fees apply for Care Link
  - AIM uses the standard Aetna HMO network