The State of Delaware

Request for Proposals Summary and PRC Recommendation

Medical and Prescription Insurance Audit Services

May 30, 2025

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Contents

- Context for today’s discussion
- Summary of the background and process for the Medical and Prescription Insurance Audit Services requests for proposals (RFP)
- High level RFP objectives
- RFP timeline
- Review PRC Recommendation
- Next steps

Context for today's discussion

- The State of Delaware has engaged Willis Towers Watson to assist with a request for proposal (RFP) and evaluate vendors for an audit of the State's medical and prescription drug plans
- The SEBC conducts a procurement for each benefit program every 3-5 years (including professional services such as claims auditing), and the contract for medical and prescription insurance audit services was last marketed in 2020
- The Proposal Review Committee (PRC) consisting of SEBC members or their designees was established for this RFP; the PRC met several times in the last 2 months to discuss vendor proposals, interview and evaluate vendor finalists, score proposals on evaluation criteria, and formulate recommendations for the SEBC's consideration
- In preparation for today's presentation, the SEBC was asked to review the Proposal Review Committee's Summary and Findings and recommendation. The SEBC will be asked to vote to approve the recommendations today to begin contract negotiations.

Background

- The medical insurance audit will be conducted for the five medical plan options administered collectively by Highmark and Aetna, plus the services administered by Lantern (formerly known as Employer Direct Healthcare, administrator of the SurgeryPlus program)
- The prescription insurance audit will be conducted for the two plans administered by CVS: Commercial (non-Medicare) and Employer Group Waiver Plan (EGWP) (Medicare)
- The current contract for medical and prescription drug audit services for the State is with Claim Technologies Inc., a division of Brown & Brown Insurance Services (herein after referenced as “CTI”) and will terminate at the end of FY2025
  - CTI has conducted audits for the GHIP since FY2015 (following the 2015 RFP), which expired in FY2020 and was then awarded again in FY2020 (following the 2020 RFP)
- The RFP explored several considerations related to feedback on opportunities for improvement from the Statewide Benefits Office and/or employees, which will be explored further in the high level RFP objectives and additional scope requirements in the slides to follow

Current audit services contract

Medical insurance audit

- **Electronic Review of All Claims (100%)** processed within the contract compliance review period to explore claims system capabilities and the accuracy of plan set-up
- **Target Claims Selection** using a sample of 250 claims for review onsite at TPA[1] office to validate the electronic query results
- **Operational Review** of administrative policies, procedures, and internal quality control measures critical to minimizing financial loss and maintaining participant satisfaction levels. Includes review of the SOC-1 report[2] supplemented with a State-specific administration questionnaire. Takes place onsite at TPA office
- **Eligibility Screening of All Claims (100%)** against the State's source eligibility file to ensure true retroactive date of eligibility has been used, rather than date that the TPA received the eligibility file
- **Financial Comparison** of amount paid on the data file to amounts invoiced and paid by the State
- **Written report** of findings
- **Post-audit Support** for resolving open issues with the TPAs (8 hrs)

Prescription insurance audit[3]

- **Electronic Review of All Claims (100%)**
- **Operational Review**
- **Financial Comparison**
- **Rebate Review**
  - Involves the analysis of the contractual rebate agreements that exist between the PBM and drug manufacturers compared to the actual rebates processed
- **MAC[4] List Review** of top 50 drugs utilized
  - "Maximum Allowable Cost" defines the maximum amount that a PBM will reimburse for the cost of a drug
- **Written report** of findings
- **Post-audit Support** for resolving open issues with the PBM (4 hrs)

Plans included in each insurance audit:

- Medical insurance audit – PPO, HMO, CDH Gold and First State Basic plans, all on a fiscal year basis (Note: Medicare Supplement plan and Lantern program are excluded from this audit)
- Prescription insurance audit – Commercial (non-Medicare) on a fiscal year basis and Employer Group Waiver Plan (EGWP) (Medicare) on a calendar year basis

1. TPA = Third Party Administrator, i.e., Highmark Delaware and Aetna.
2. SOC-1 Report = System and Organization Controls Report; a report on entities' internal control over financial reporting.
3. Description of scope of services for PBM contract compliance review is consistent with the medical review unless otherwise noted above.
4. MAC = Maximum Allowable Cost.

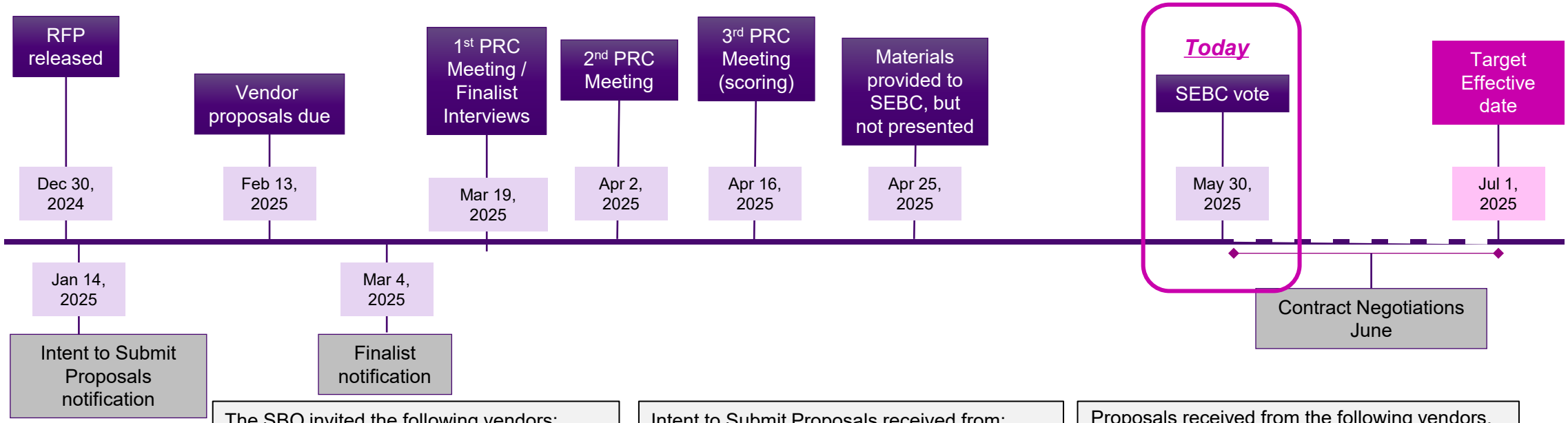
High level RFP objectives

- Provide competitive administrative fees and financial guarantees
- Ability to conduct a medical and PBM contract compliance review including sampling methodology and statistical control measures to review Aetna, Highmark, Lantern, and CVS' operational policies, procedures, and internal control measures
- Manage timelines associated with the requested scope of services that reflect minimal involvement with the SBO in the review process with comprehensive reporting capabilities
- Demonstration of extensive experience in administering the requested scope of services for clients of comparable size in auditing of Aetna, Highmark, Lantern, and CVS with outstanding references that demonstrate an ability to meet the State's needs
- Attention to compliance with the submission requirements of the bid including format, clarity, conformity, realistic responses, and completeness, as well as responsiveness during the evaluation process
- Explore traditional versus real time approach

Additional scope requirements included in the 2025 Audit RFP

- Inclusion of the Medicare Supplement plan in the medical audit scope of services
- Additional description of audit services to cover medical and prescription drug services administered by third parties such as Lantern and PrudentRx
- Clarification that the requested prescription drug audit services will include reviews of the Commercial and EGWP plans
- Additional description of audit services required to validate CVS is upholding the PBM requirements under House Bill 219 of the 151st General Assembly, including the requirement for brand drug claims processed in the State of Delaware to use National Average Drug Acquisition Cost (NADAC) pricing
- Notation of certain audit services that will be requested as buy-up options for the State's consideration, such as the purchase of additional hours of post-audit support that the auditor will incur to support the State in addressing audit findings with the TPAs and PBM

RFP timeline



The SBO invited the following vendors:

- ✓ 4C Health Solutions dba 4C Digital Health (4C Health)
- ✓ Claim Technologies, Inc. (CTI)
- ✓ Healthcare Horizons
- ✓ Healthcare Management Systems (HMS)
- ✓ Myers and Stauffer
- ✓ Tiber Creek (Rx)
- ✓ Truveris
- ✓ Sagebrush

Intent to Submit Proposals received from:

- ✓ 4C Health
- ✓ CTI
- ✓ Entrepreneurial Consulting LLC
- ✓ Myers and Stauffer
- ✓ Sagebrush
- ✓ Truveris

Proposals received from the following vendors, which are all finalists:

- ✓ 4C Health
- ✓ CTI
- ✓ Sagebrush
- ✓ Truveris

Next steps

- SEBC to vote on approval of the PRC recommendation

Appendix

After a provider submits a medical claim, what happens next?

Major steps involved for a third-party administrator to process a medical claim

Elements of risk in medical claim processing

- Data entry
- Duplicate review
- Administrator business rules (e.g., Current Procedural Terminology (CPT) code edits)
- Member eligibility
- Interpretation of benefits
- Authorization
- Provider status and pricing
- Accumulators; deductible, out-of-pocket, benefit maximums/limitations
- Reasonableness of processing turnaround time
- Coordination of benefits (COB) / Third-party liability (TPL)

Prescription drug claims processing follows a similar process

1. Coordination of Benefits (COB)
2. Third Party Liability (TPL)

Every organization should have a documented audit plan to verify that benefits are being administered as intended

Why audit self-insured plans?

Significant cost to employers An employer with a self-funded plan is handing off their "checkbook," it is a prudent business practice to periodically assess the administrator's performance	**Compliance requirements** Increased regulation (ERISA, Sarbanes-Oxley, HIPAA, ACA) has heightened the importance of documenting proactive vendor management; audits can help a fiduciary meet its duty to monitor service partners	**Assess accuracy and quality** Ensures claims are processed consistently and accurately in accordance with plan designs and benefit provisions, and validates the accuracy of administrator self-reported claim processing performance guarantees
Cost control Helps identify and prevent inaccurate payments, billing errors and potential fraud such as provider or member billing schemes	**Financial** Potential recovery for past errors; prevention of future errors can be significant, especially for programming errors (industry average for auto-adjudicated claims is about 85%)	**Continuous improvement** Audits provide insights into the accuracy of administration and identify areas for improvement

Emerging capabilities among audit vendors

- Traditionally, medical and prescription drug claim audit services have focused on **retrospective** reviews of plan experience
  - Often have been challenges in obtaining more real-time access to claims data for various reasons including technology limitations, data sharing agreements and usual claim processing timelines
  - Allows for typical claim processing activities to take place before claims are audited, such as claim resubmissions, coordination of benefits and overpayment recoveries
  - Current audit services contract based on retrospective claim reviews
- Recently, a limited number of vendors have entered the market claiming the capability to provide **real-time, ongoing** administrative claims and fee reviews for medical and pharmacy benefit programs, such as 4C Health Solutions and Truveris
- Throughout the vendor's responses, it was not always clear whether they were speaking to their capabilities and experience of retrospective or real-time audits. Therefore, WTW and the PRC tried to ask further information during the vendor interviews for vendor's to highlight that differentiation.

Emerging capabilities among audit vendors (continued)

- Vendor marketplace for real-time, ongoing audits (i.e., administrative claims and fee reviews) is very small
- “Real-time” audits often happen after claims are paid
- There is no overlap in the scope of services with the “traditional” audit capabilities characteristic of retrospective claim reviews
- WTW has few clients who have partnered with these types of audit vendors; limited data exists on client outcomes
- WTW’s point of view is that these types of claim reviews would not replace the traditional, retrospective audits procured through past Audit RFPs
  - Real-time claim reviews would not necessarily account for typical claim processing activities that may skew audit results when viewed on an ongoing basis vs. retrospectively, such as accounting for the medical carrier’s post-claim payment activities such as recovery of overpayments that occurs during the normal course of claims processing