The State of Delaware

Medical TPA Request for Proposals (RFP) – Scope of Work

State Employee Benefits Committee Meeting

November 25, 2025

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Background and context for today's discussion

- The State of Delaware provides medical benefits to approximately 124,780 members, including State employees, pensioners, and their covered spouses and dependent children enrolled in the State's medical plans currently administered by Aetna and Highmark
  - Eligible State employees include school district, charter school and higher education employees and their dependents
  - Non-State participating groups, including municipalities and fire companies, are also eligible for State medical benefits
- There are four medical plan options for active employees and non-Medicare pensioners, and one plan option for Medicare-eligible pensioners:
  - Highmark Delaware currently administers the Comprehensive PPO and First State Basic plans
  - Aetna currently administers the HMO and CDH Gold plans
  - The Special Medicfill Medicare Supplement plan is administered by Highmark Delaware
- The State's contracts for active employee plans with Aetna and Highmark will expire on June 30, 2027 for the non-Medicare plans, and December 31, 2027 for the Medicare Supplement plan
- The State's medical benefits are self-insured:
  - Aetna and Highmark adjudicate claims and maintain the provider networks
  - The State pays claims invoice and administration fees out of the GHIP fund
  - The State works with WTW to develop budget rates and determine employee contributions
- State employees and pensioners contribution amounts vary based on plan option and coverage tier as well as eligibility for state share.

Considerations for the next Medical TPA RFP scope of services

- Including an option to evaluate the addition of a HDHP (High-Deductible Health Plan) with HSA (Health Savings Account)
- Recommendations from the PRC during the Audit RFP
  - Ensuring RFP includes questions to further understand the ability of the Medical TPA contracts to include necessary language for timely and efficient audits to be conducted
  - Ensuring RFP includes questions to further understand any emerging capabilities of real-time, ongoing audits for medical and how the Medical TPAs can support
  - Ensuring RFP includes questions to further understand the Medical TPA capabilities for ongoing data exchanges with auditors
- Ability for the State to carve out Care Management services should the SEBC choose (this is not required, but something the State has discussed including in the contract)
- Requesting vendors to offer PGs (Performance Guarantees) versus requesting them to match the current PGs in place with the State

Considerations for the next Medical TPA RFP scope of services (continued)

- Ability to receive rebates on drugs through the medical plans
- Request information on the current air ambulance coverage that is within network and if not already included, the vendor's plan for getting inclusion of these services into their network
- Requesting details on how vendors manage a member's deductible if a member changes groups mid-plan year
- Requesting details of any benefit enhancements or programs offered to support members in their cancer journeys
- Ability for Medical TPAs to carve out the GHIP from their BOB when implementing federal, state or vendor mandated changes that provides the GHIP with flexibility to align effective date with a July 1 plan effective date
- Ability for Medical TPAs to share archived data with new SBO vendors (i.e. HDW) at no additional cost
- Ability for Medical TPAs to support MHPAEA testing requirements for both NQTL and QTL for internal audits (not DOL audits)
- Ability to send data to Lantern (the State's COE vendor), including eligibility, claims and prior authorizations
- Ability to automatically reverse claims when there is a retroactive termination due to member ineligibility
- Ability to comply with state legislation, specifically SB12 with SA1- PA Reform Act
- Ability to send lab data to the State's Health Data Warehouse
- Asking how the Medical TPA defines engagement for their care management programs and if there is flexibility

Proposed Medical TPA RFP objectives

Identify Medical TPA(s) that can:

Support GHIP Strategic Framework goals

Increase proportion of spend through advanced alternative payment models (APMs)

Reduce per-member cost for diabetic members, musculoskeletal conditions, and behavioral health

Limit total cost of care inflation

Offer and increase engagement in decision support tools

Offer additional support to future priorities of the SEBC as changes are made to the Strategic Framework

Provide competitive financial terms and performance guarantees

Competitive provider reimbursement rates and administrative fees

Service level guarantees including accountability for supporting the GHIP Strategic Framework goals

Offer solutions that uphold and support:

- Investments in primary care, and
- Affordability Targets of the Delaware Department of Insurance's Office of Value Based HealthCare Delivery

Support GHIP's programs and plan offerings

Administer current plans

Support plan provisions that optimize effectiveness of GHIP benefit offerings

Integrate with other programs and vendors supporting the GHIP

Maintain a provider network that meets current and future state goals of the GHIP

Provide supplemental coverage to Medicare eligible retirees and their Medicare-eligible dependents

Support introduction of an HSA qualified plan

Support other state-level health care initiatives

Deliver on core medical TPA functions

Member services: web portal for enrollment and account information

Program management: web portal for administrative services

Communications support: open enrollment, direct mailing, member ids, education, targeted communications, etc.

Providing excellent account management to the SBO for implementation and ongoing, reporting

Claims administration

Provide excellent customer service to participants

Capability to accept electronic transfer of enrollment according to the State's existing schedule

Care management

Care navigation support

Reporting

Participation in the DHIN

Coordination with Delaware community health resources and State agencies

Proposed Medical TPA RFP objectives (continued)

- ***Compliant*** with the minimum submission requirements set forth in the RFP document;
- Have a ***strong reputation*** and ***historical experience*** in the medical insurance market;
- Possible integration with new Enterprise Resource Planning (ERP) system: The State is conducting a separate RFP for an ERP system and it is possible that this will result in a change to the State's ERP system, which would be announced in 2026. It is anticipated that there would be a multi-year implementation process following that announcement. The State would like to understand how bidders have dealt with a system change like this with other clients as the implementation of the new ERP would occur after the initial start date of the TPA contract.
- Have ***experience*** working with plan sponsors of ***similar size*** and ***complexity*** to the State; and
- ***Be responsive*** to changes in the program and requests of the SEBC and the SBO.

Next steps

- SBO and WTW will incorporate feedback from the SEBC on the scope of services and into the Medical TPA RFP as it is developed
- SEBC will review the Medical TPA RFP at the March 23, 2026 SEBC discussion and provide feedback on the full RFP document
- SBO and WTW will incorporate feedback from the SEBC into the final version of the RFP for the SEBC's approval
- SEBC will vote on the Medical TPA RFP for approval at the April 20, 2026 SEBC meeting

Appendix

State of Delaware medical plan options – effective July 1, 2025

Plan Options	Highmark Delaware First State Basic Plan		Aetna CDH Gold Plan		Aetna HMO Plan		Highmark Delaware Comprehensive PPO Plan	
Plan Type	Preferred Provider Organization (PPO)		Preferred Provider Organization (PPO)		Health Maintenance Organization (HMO)		Preferred Provider Organization (PPO)	
Primary Care Provider (PCP) Selection	Recommended		Recommended		Required		Recommended	
Coverage Options/ Premiums (Rates)	Total Monthly Premium (Rate)*	You Pay Monthly (Bi-Weekly) *State pays difference*	Total Monthly Premium (Rate)*	You Pay Monthly (Bi-Weekly) *State pays difference*	Total Monthly Premium (Rate)*	You Pay Monthly (Bi-Weekly) *State pays difference*	Total Monthly Premium (Rate)*	You Pay Monthly (Bi-Weekly) *State pays difference*
Employee	$1,093.66	$43.74 ($21.87)	$1,131.92	$56.60 ($28.30)	$1,141.76	$74.22 ($37.11)	$1,248.56	$165.44 ($82.72)
Employee & Spouse	$2,262.74	$90.50 ($45.25)	$2,346.96	$117.34 ($58.67)	$2,407.30	$156.48 ($78.24)	$2,590.92	$343.30 ($171.65)
Employee & Child(ren)	$1,662.46	$66.50 ($33.25)	$1,729.38	$86.46 ($43.23)	$1,746.60	$113.52 ($56.76)	$1,924.26	$254.96 ($127.48)
Family	$2,828.52	$113.14 ($56.57)	$2,981.60	$149.08 ($74.54)	$3,003.76	$195.24 ($97.62)	$3,239.00	$429.16 ($214.58)
Plan Feature	In-Network[1,2,3]	Out-of-Network[1,2,3]	In-Network[1,2,3]	Out-of-Network[1,2,3]	In-Network[1,2,3]	Out-of-Network[1,2,3]	In-Network[1,2,3]	Out-of-Network[1,2,3]
Preventive Care/ Screening/Immunization (age, gender and risk parameters may apply)	100% covered, not subject to deductible	30% coinsurance, not subject to deductible	100% covered, not subject to deductible	30% coinsurance after deductible	100% covered	Not covered	100% covered	20% coinsurance after deductible
Deductible (per plan year)	$500 per individual/ $1,000 per family	$1,000 per individual/ $2,000 per family	$1,500 per individual/ $3,000 per family	$1,500 per individual/ $3,000 per family	N/A	N/A	N/A	$300 per individual/ $600 per family
Health Reimbursement Account (HRA)	N/A	N/A	$1,250 per individual/ $2,500 family	$1,250 per individual/ $2,500 family	N/A	N/A	N/A	N/A
Out-of-Pocket Maximum (including copays and deductibles)	$2,000 per individual/ $4,000 per family	$4,000 per individual/ $8,000 per family	$4,500 per individual/ $9,000 per family	$7,500 per individual/ $15,000 per family	$4,500 per individual/ $9,000 per family	N/A	$4,500 per individual/ $9,000 per family	$7,500 per individual/ $15,000 per family
Prenatal and Postnatal Care	10% coinsurance after deductible	30% coinsurance after deductible	10% coinsurance after deductible	30% coinsurance after deductible	100% covered after $25 initial copay (inpatient room and board copays do apply to hospital deliveries/ birthing centers)	Not covered	100% covered (inpatient room and board copays do apply to hospital deliveries/birthing centers)	20% coinsurance after deductible

- Medicfill coverage

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Plan Feature	In-Network[1,2,3]	Out-of-Network[1,2,3]	In-Network[1,2,3]	Out-of-Network[1,2,3]	In-Network[1,2,3]	Out-of-Network[1,2,3]	In-Network[1,2,3]	Out-of-Network[1,2,3]
24/7 Nurse Line	Yes, no cost		Yes, no cost		Yes, no cost		Yes, no cost	
Primary Care Visit to treat an injury or illness (In-person or virtual)	10% coinsurance after deductible	30% coinsurance after deductible	10% coinsurance after deductible	30% coinsurance after deductible	$15 copay per visit	Not covered	$20 copay per visit	20% coinsurance after deductible
Telemedicine (Virtual Doctor Visits with Teledoc (Aetna) or Amwell (Highmark)	10% coinsurance after deductible	Not covered	10% coinsurance after deductible	Not covered	$0 copay per visit for acute issues and behavioral health visits $25 for dermatology visits	Not covered	$0 copay per visit for acute issues and behavioral health visits	Not covered
Urgent Care Visit	100% covered after $25 copay per visit	100% covered after $25 copay per visit	10% coinsurance after deductible	30% coinsurance after deductible	$15 copay per visit	Not covered	$20 copay per visit	20% coinsurance after deductible
Emergency Room	10% coinsurance after deductible	10% coinsurance after deductible	10% coinsurance after deductible	10% coinsurance after deductible	$200 copay per visit (waived if admitted)	$200 copay per visit (waived if admitted)	$200 copay per visit (waived if admitted)	$200 copay per visit (waived if admitted)
Chiropractic Care (Requires medical necessity **Note: No visit maximum for treatment of back pain**	10% coinsurance after deductible for up to 30 visits per plan year	25% coinsurance after deductible for up to 30 visits per plan year	10% coinsurance after deductible for up to 30 visits per plan year	25% coinsurance after deductible for up to 30 visits per plan year	Lesser of $15 copay or 20% coinsurance (Referrals required through PCP)	Not covered	15% coinsurance for up to 30 visits per plan year 0% coinsurance for behavioral health and substance abuse disorder diagnosis	20% coinsurance after deductible for up to 30 visits per plan year
Physical Therapy/ Occupational Therapy/ Speech Therapy (Requires medical necessity) **Note: No visit maximum for physical therapy for treatment of back pain**	10% coinsurance after deductible	30% coinsurance after deductible	10% coinsurance after deductible No visit limit or medical necessity review for behavioral health and substance abuse disorder diagnosis	30% coinsurance after deductible No visit limit or medical necessity review for behavioral health and substance abuse disorder diagnosis	20% coinsurance for up to 45 visits per illness/injury (Referrals required through PCP) No visit limit and lesser of $15 copay or 20% coinsurance for behavioral health and substance abuse disorder diagnosis	Not covered	15% coinsurance 0% coinsurance for behavioral health and substance abuse disorder diagnosis	20% coinsurance after deductible
Specialist Visit (In-person or virtual)	10% coinsurance after deductible	30% coinsurance after deductible	10% coinsurance after deductible	30% coinsurance after deductible	$25 copay per visit (Referrals required for certain services through PCP)	Not covered	$30 copay per visit	20% coinsurance after deductible