The State of Delaware

Medical TPA Request for Proposals (RFP)

State Employee Benefits Committee Meeting

December 16, 2025

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Context for today's discussion

- The SBO and WTW have been working together to draft the medical TPA scope of services and prepare for the upcoming medical TPA RFP
- During the November 25, 2025 SEBC meeting, the SEBC discussed the draft scope of services for the upcoming medical TPA RFP, requested updates to that scope, and posed follow-up questions for WTW and the SBO
- The feedback requested from the SEBC and incorporated as agreed into the draft RFP was incorporated into the medical TPA scope of services and the follow-up items were reviewed, will be discussed today
- In preparation for today's discussion, the SEBC was provided the updated medical TPA scope of services
- Today's discussion will focus on reviewing follow-ups from the SEBC members that will be considered and incorporated into the medical TPA RFP draft

Background

- 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

SEBC follow ups from November SEBC meeting

- What changes have happened in the marketplace since the last TPA procurement
  - There have been few significant changes to the medical TPA marketplace in Delaware since the last procurement. It continues to be one of the most consolidated markets across the country on the provider side. This limits choice and ability for carriers/TPAs to negotiate on price.
  - Labor shortages and supply chain disruption are priced in as provider contracts are negotiated
  - The rise in GLP-1 utilization and associated costs increase budget pressures across the spectrum of plan sponsors
  - High-cost trends encourage focus on alternate plan designs and value-based provider contracting
  - Start-ups and disruptive models continue to yield new approaches to program management and care delivery; innovations in the market create pressure for traditional vendors to replicate results
  - Telehealth normalization: Pandemic-era telehealth has become a permanent fixture in care models
  - Employer health benefits: Rising costs pushed employers to explore innovative benefit designs, including wellness programs and alternative insurance models
  - Public health focus: State laws and initiatives emphasized cost transparency, preventive care, and equitable access

SEBC follow ups from November SEBC meeting (continued)

- Inclusion of “retirees” within the scope of services document
  - This has been updated on page 3 under the bullet “Deliver on the core administrative functions of a medical TPA”
- Plan design changes/member cost shift to steer members to lower cost facilities
  - WTW can model revised plan designs for SEBC consideration in the RFP to address steerage concerns
- A Committee member was interested in opportunities to explore direct contracting with medical providers and health care systems.
  - Propose adding, “Confirm your ability to support the State in claims adjudication should direct contracting be implemented.” to the RFP questionnaire.
  - Direct contracting with medical providers/health care systems would require substantial State funding and staffing to support the development of a nationwide network.
- What are Patient Centered Medical Homes (PCMH)? Is there an opportunity to engage GHIP members with PCMHs?
  - PCMHs were a concept originally integrated into accountable care organizations (ACOs). ACOs would provide primary care services via a team-based approach, with the intent being that better coordination of comprehensive care would result in better health outcomes and lower costs. PCMHs, in the commercial market, are now generally referred to as Advanced Primary Care and routinely included in ACO models.

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 continue to 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

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

Plan Options	Highmark Delaware First State Basic Plan		Aetna CDH Gold Plan		Aetna HMO Plan		Highmark Delaware Comprehensive PPO Plan	
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