

# The State of Delaware

Request-For-Proposal for Medical Insurance Third Party Administrator

## Background Section

### Organization Description

The SEBC is chaired by the Director of the Office of Management and Budget (OMB). The Committee is comprised of the Insurance Commissioner, the Chief Justice of the Supreme Court, the State Treasurer, the Director of the Office of Management and Budget, the Controller General, the Secretary of Finance, the Secretary of Health and Social Services, the Lieutenant Governor<sup>1</sup>, and the President of the Correctional Officers Association of Delaware or their designees. Meetings of the SEBC are public and minutes and materials from each meeting are available at <http://ben.omb.delaware.gov/sebc/index.shtml>.

The Statewide Benefits Office (SBO) is a division within the OMB. The SBO functions as the administrative arm of the SEBC responsible for the administration of all statewide benefit programs with the exception of pension and deferred compensation benefits. These programs include, but are not limited to, health, prescription, dental, vision, disability, life, flexible spending accounts, wellness and disease management programs, pre-tax commuter benefits, and supplemental benefits. Visit <http://ben.omb.delaware.gov> for information about the programs.

Since July 1, 2007, the SEBC has contracted with Blue Cross Blue Shield of Delaware, now operating as Highmark Delaware, and Aetna as the Plan's third party medical claims administrator. The SEBC is now issuing a bid for a third party medical claims administrator that can provide GHIP participants with improved care management and significant unit cost reduction without sacrificing the quality of care delivered for a contract award effective July 1, 2017. While the effective date is July 1, 2017, firms are encouraged to propose or illustrate creative delivery strategies that may not be market ready for 7/1/17 but may be within the terms of this agreement.

The State would like to take bolder actions that focus on mitigating the total cost of care for both the GHIP and its participants while driving improvements in the health of the GHIP population. Therefore, the third party medical claims administrator must be able to provide innovative cost containment features, including but not limited to centers of excellence, accountable care organizations and patient-centered medical homes, to mitigate the high growth rates in GHIP expenditures over the last several years. In addition, the third party administrator must also have robust quality management processes in place to ensure that the providers participating in any cost containment program must meet strict quality guidelines. It will be favorable if firms can provide meaningful trend and cost guarantees with their proposal.

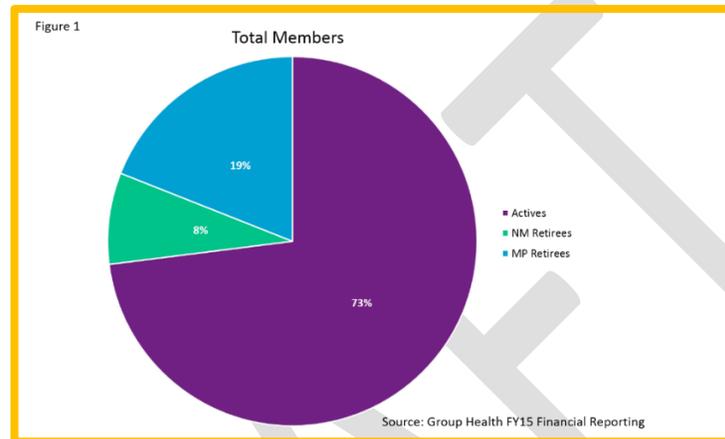
As the SEBC is looking for a third party administrator that can drive meaningful changes in the health and the cost of GHIP participants, **requiring targeted interventions and care delivery strategies that are materially different from traditional health management programs and fee-for-service pricing offered by most third party administrators**, this RFP represents a significant departure from the requested scope of services covered in the last procurement of a third party administrator for the GHIP in 2011.

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<sup>1</sup> The office of the Lieutenant Governor is currently vacant.

## GHIP Background Information

The State of Delaware Group Health Insurance Program (GHIP) provides medical and prescription benefit coverage to over 122,000 covered lives. This includes approximately 31,000 active employees, 5,900 non-Medicare retirees and 17,000 Medicare retirees whose benefits are extended to their spouses and dependents. Also, covered are approximately 18,000 employees, retirees and their dependents from groups that also participate in the GHIP as permitted through Delaware Code. As shown in Figure 1, active employees and dependents represent over 70% of the GHIP's population with retirees representing the remainder.



The GHIP is self-insured and pays the actual claims (expenditures) incurred by the GHIP participants for services received under the health and prescription plans. Claim expenses represent approximately 96% of the GHIP's total expenditures. The SEBC is responsible for design of the plans available to the GHIP's participants and setting premium rates that can support the projected expenses of the GHIP. The percentage of employee and employer share of the premium rates is established in Delaware Code as are the actual plan offerings available to employees and retirees.<sup>2</sup>

Due to restrictions placed on the GHIP by the Delaware Code, the SEBC cannot employ one of the more traditional levers to manage cost, i.e., shifting additional cost to plan participants through higher premium cost sharing (see chart below). Further, while increased cost sharing through plan design continues to be an option available to the SEBC, there has been limited support for increasing member out-of-pocket costs at the point of care, particularly in the absence of sufficient resources that would allow members to make an informed decision about their costs. The SEBC's efforts to promote additional health care consumerism has also been stymied by the low enrollment in the GHIP consumer directed plan option (i.e., <5% of the covered population). Therefore, one of the goals of this RFP process is to identify a third party administrator with a robust set of health care cost and quality transparency tools that would supply plan participants with the information needed to make informed decisions about their health care.

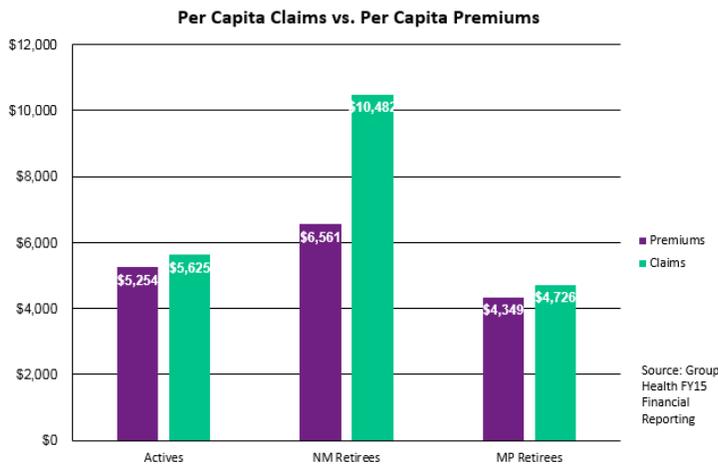
<sup>2</sup> Delaware Code, Title 29, Chapter 52 Web Address: <http://delcode.delaware.gov/title29/c052/index.shtml>

	Actives	Non Medicare	Medicare Primary
Premium Cost Share Percentage Split	State/Employee	State/Retiree	State/Retiree
Highmark Comprehensive PPO	86.75%/13.25%	86.75%/13.25%	
Highmark & Aetna HMO	93.5%/6.5%	93.5%/6.5%	
Highmark & Aetna Consumer Directed	95.0%/5.0%	95.0%/5.0%	
Highmark First State Basic	96.0%/4.0%	96.0%/4.0%	
Highmark Special Medicfill Supplement			100%/0%* 95.0%/5.0%**

\*Retirees with full state share who retired before July 1, 2012

\*\*Retirees with full state share who retired after July 1, 2012

The active and non-Medicare populations have always paid the same premium rates for each plan; however, the actual claims (expenditures) of the non-Medicare retiree population are significantly higher than the active population as illustrated in the chart below. The Medicare population receives secondary medical coverage through the GHIP as well as prescription drug benefits through an Employer Group Waiver Medicare Part D plan implemented in calendar year 2013. The premium rates for the Medicare population are more closely aligned with the actual claims (expenditures) of the population.



The following table outlines the actuarial value of each plan based upon in-network benefits as compared to a few sample plan designs available through the Marketplace. The State funds on average, 91.4% of the total premium of the plans.

	Sample Gold Plan**	Highmark First State Basic Plan	Highmark & Aetna CDHP (with HRA)	Sample Platinum Plan**	Highmark PPO	Highmark & Aetna HMO
Actuarial Value	80%	86.1%	87.0%	90%	90.3%	90.6%
Deductible (Single/Family)	\$900/\$1,800	\$500/\$1,000	\$1,500/\$3,000 +1,250/2,500 HRA	None	\$0/\$0	\$0/\$0
Out of Pocket Maximum	\$4,500/\$9,000	\$2,000/\$4,000	\$4,500/\$9,000	\$4,500/\$9,000	\$4,500/\$9,000	\$4,500/\$9,000

(Single/Family) Medical Only						
In-Network Coinsurance	25%	10% Coinsurance	10% Coinsurance	10%	0%	0%
Primary Care	\$30	10% Coinsurance	10% Coinsurance	\$20	\$20	\$15
Specialist	\$50	10% Coinsurance	10% Coinsurance	\$40	\$30	\$25
Inpatient Facility	25% Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	\$200	\$150	\$150
Emergency Room	\$300	Deductible & Coinsurance	Deductible & Coinsurance	\$200	\$150	\$150
Out-of-Network Coinsurance	40%	30%	30%	30%	20%	N/A
<b>Prescription Drug Benefit</b>						
30-day Retail	\$10/\$40/\$80	\$8/\$28/\$50	\$8/\$28/\$50	\$5/\$20/\$50	\$8/\$28/\$50	\$8/\$28/\$50
90-day Retail & Mail	\$25/\$100/\$200	\$16/\$56/\$100	\$16/\$56/\$100	\$10/\$50/\$125	\$16/\$56/\$100	\$16/\$56/\$100
Out-of-Pocket Maximum (Single/Family)	\$2,100/\$4,200	\$2,100/\$4,200	\$2,100/\$4,200	\$2,100/\$4,200	\$2,100/\$4,200	\$2,100/\$4,200
<b>Current Enrollment (as of 2016)</b>						
As % of total	n/a	2%	3%	n/a	47.5%	47.5%

\*Actuarial Value based on in-network benefits only, out-of-network feature increases value slightly.

\*\*Sample Plan designs with split out of pocket maximums, medical and drug, and not specific to Delaware marketplace

## GHIP Historical Review

Important to note is the passage of House Bill 81 during the 146th General Assembly<sup>3</sup> in 2011. This legislation marked the first and only significant change in State employee and retiree benefits since the onset of rising healthcare costs experienced nationally at the turn of the century. It represented the collective work of the administration, legislature and unions representing the majority of State employees, all of whom recognized the changing landscape and financial hardships being faced by public sector employers with regards to controlling costs and preserving health and pension benefits. The impetus behind House Bill 81 was the \$80M deficit and contentious FY11 GHIP budget process. The cost sharing structure outlined previously was one of many outcomes of the legislation. Other changes included:

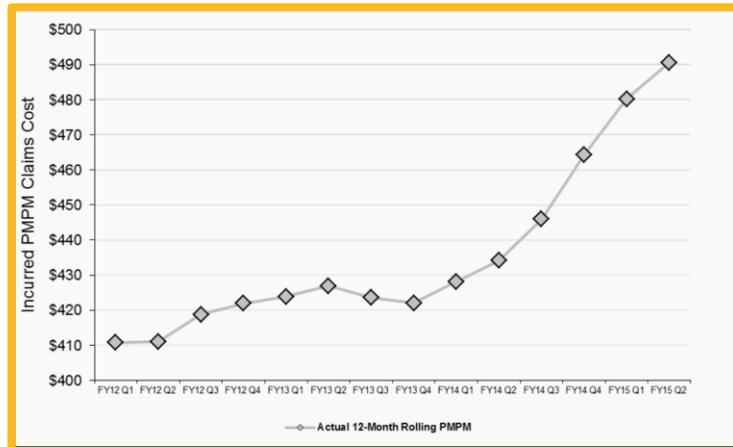
- Elimination of a free health plan replaced with a 4% cost share for employees and non-Medicare retirees enrolled in the First State Basic plan;
- A 5% cost share for Medicare retirees enrolled in the Medicare supplement plan who retired after July 1, 2012;
- Slight increases in the number of service years required to vest for specific percentage of the State share for retiree health benefits; and
- The elimination of Double State Share for new employees as well as a flat \$25 per month per contract for employees who remained eligible for Double State Share.<sup>4</sup>
- Prior to the passage of House Bill 81, the SEBC's authority and responsibilities were the same; however, the absence of a set employee/retiree cost share left the SEBC with the added responsibility of balancing the GHIP budget through either plan design changes or increases in the employee/retiree share of the total premium rates.

While House Bill 81 did make changes and accomplished the intended objective of bringing the State employee and retiree health benefits in line with what was more common in the public sector environment, the growth rates experienced by the GHIP have continued to far exceed the State Operating budget growth

<sup>3</sup> The legislature meets on a part-time basis from January through June each year.

<sup>4</sup> See 29 Del. C. § 5202(d) for complete details at <http://delcode.delaware.gov/title29/c052/index.shtml>

and without additional change, appear to be unsustainable. Expenditures accelerated in FY14 after two years of relatively stable per member costs; however, this was not confirmed until updated expenditure projections became available in early February 2015 and as the SEBC began to deliberate over options to balance the FY16 GHIP budget. The following table was used during discussions with the SEBC and exemplifies the dramatic uptick in per member per month (PMPM) costs.



Source: Group Health FY15 Financial Reporting

As the projected deficit rose to \$116.3M, the increase provided in the Governor's 2016 recommended budget for FY16 fell \$60M short of the amount needed to fund the premium rates at a level equal to the expected GHIP expenditures. A similar scenario to that which the SEBC experienced during the FY11 GHIP budget process emerged and it was not until additional money was appropriated by the Joint Finance Committee and approved by the legislature as part of the State Operating Budget process that the SEBC was able to approve a balanced budget for FY16.

### **Employee and retiree healthcare was the largest cost driver in the State Operating Budget for the current year.**

Applying the most recent two years of GHIP costs in future trend projections, the estimated GHIP deficit for FY17 is significant. If expenditures continue to rise at the recent pace, without the implementation of changes in plan design or other options to slow down the increase in expenditures, GHIP costs will rise by another 41% over the next five years and exceed \$1 billion by fiscal year 2020 (FY20)<sup>5</sup>. These costs include only medical and prescription drug costs and do not take into account any other ancillary lines (*the scope of this RFP includes only medical coverage*).

Included in epilogue in the FY16 Operating Budget bill was language requiring the formation of the State Employees Health Plan Task Force to study the State Group Health Plan with the purpose of finding cost savings and efficiencies. The Task Force met through the fall of CY2015 and issued a report to the Governor and General Assembly on December 16, 2015. Minutes and meeting materials from the seven meetings of the Task Force as well as the final Task Force Report are available for review at <http://ben.omb.delaware.gov/hptf/index.shtml>.

<sup>5</sup> The State's fiscal year is July 1 through June 30 with the year identified as the year that falls on June 30th.

The report focuses on several short-and-long term actions for considerations, which are segmented by the following categories:

1. **Bending the cost curve**
2. Exploring opportunities to realign **provider payments**
3. **Benchmarking** GHIP plans and costs on a comparable basis
4. **Improving the health of the population**

According to the report<sup>6</sup>, the State of Delaware's health risk in 2014 was higher than the nationwide average, indicating a higher than average illness burden in the State of Delaware population<sup>7</sup>. Additionally, the risk score of the population increased 20% for 2014 versus 2013. Another concerning finding from this report indicated that the State's prevalence for key chronic conditions such as diabetes and hypertension were approximately 10% greater in the GHIP population compared to the state benchmark. The presentation of the Delaware Center for Health Innovation (DCHI) also commented that the health of the entire state demographics contribute to the issue. As a result, a key recommendation of this report was that the State should leverage the significant contribution the GHIP makes to Delaware hospitals' revenue to support quicker adoption of changes including provider incentives such as pay for performance and/or bundled or episodic payments that balance lower costs with improving quality of care and patient outcomes, and that any exploration should recognize and coordinate with findings of the DCHI.

The DCHI was created to develop, facilitate and oversee the implementation of collaborative efforts aimed at transforming the delivery of health care services in the State of Delaware. This includes the development of Delaware's State Health Care Innovation Plan catalyzed by the State Innovation Models (SIM) initiative, a national grant program administered by the Center for Medicare & Medicaid Innovation (CMMI). The goal of the SIM initiative is to support states to move toward value-based payment models and to improve population health.

In February of 2013, CMMI awarded Delaware a "design" grant, which funded the development of the State Health Care Innovation Plan. The State applied for a SIM "testing" grant in July of 2014 to support the implementation and testing of the plan. The goal is the "Triple Aim" - improving the health of Delawareans, improving the patient experience of care, and reducing health care costs. Through the SIM initiative, Delaware is planning to build upon a strong local foundation for innovation in order to achieve this through a system-level transformative healthcare plan that can serve as a scalable model for the nation. The State aspires to develop and implement a plan for broad-based health system transformation, including new payment and delivery models, which will achieve the Triple Aim.

The health transformation approach is organized in six workstreams:

- Delivery system
- Population health
- Payment model
- Data and analytics
- Workforce
- Policy

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<sup>6</sup> Final Report of the State Employees Health Plan Task Force, December 15, 2015.

<http://ben.omb.delaware.gov/hptf/documents/task-force-report.pdf>. Accessed June 18, 2016.

<sup>7</sup> Data reported by Truven Health Analytics the data warehouse to the GHIP.

Two workstreams dovetail most closely with the goals of this RFP: delivery system transformation, and payment model reform. **These workstreams have the goal of improving the delivery system to encourage “smarter” consumption and production of care and to change the focus of the State of Delaware from sickness to wellness.** The State Health Care Innovation Plan describes each workstream in further detail and can be read in its entirety here: <http://dhss.delaware.gov/dhcc/cmmi/files/choosehealthplan.pdf>.

According to the Health Care Innovation Plan:

*Delivery system transformation will focus on care coordination for high risk individuals (adults/elderly and children) who represent the 5-15% of the population in greatest need for intensive care coordination, with a particular emphasis on ensuring the integration of behavioral and medical care. Delaware will also concentrate its delivery system transformation on more effective diagnosis and treatment for episodic care– in particular, reducing unwarranted variation in care – for all population segments. This dual focus is important because while a small portion of Delawareans with chronic and behavioral health conditions represent nearly half of spending in the system, it is important to also address the other half of costs spread across the population.*

*In order to deliver care that better addresses these areas of focus, Delaware needs a system that is more person-centered, team-based, coordinated, and integrated than it is today. Delaware’s plan calls for a simple, common scorecard of performance and outcomes measures (both quality and cost) to ensure a common focus on care delivered consistently with these principles. Delaware also recognizes that many providers in the system today lack the scale and experience needed to transform their practices to deliver this type of care, so a set of shared services and resources will be developed to support providers in their transition (including a shared tool for stratification of care coordination needs, identifying care gaps, common clinical guidelines and protocols, support in identifying care coordinators, practice transformation support, and learning collaboratives).*

*Preliminary categories for the clinical guidelines needed to focus on more effective diagnosis and treatment have already been identified. Delaware will transition to outcomes-based payment models across all payers, achieving the goal of 80% of the state’s population receiving care through value-based payment and service delivery models within five years. While the ultimate goal is for nearly all Delawareans to receive care from providers whose incentives are linked to outcomes, the transition paths will vary to account for differences in starting point experience with taking accountability for quality and cost outcomes. Delaware envisions two prototypical payment models for Medicaid and Medicare that vary in the amount of savings shared and amount of risk taken by providers for delivering high quality and better managing costs. Commercial payers may consider these models for their outcomes-based payment models as well. In order to maximize provider participation in these new payment models, providers can participate through flexible structures which support clinical integration and accountability for outcomes-based payment, with a preference for formal structures (e.g., Accountable Care Organizations) as the vehicle for change. Payers also will fund practice investment in care coordination.*

The SEBC expects that the third party administrator selected from this RFP will be an active participant in these efforts, including participating in the Delaware Health Information Exchange (DHIN) to create a single interface for providers and patients to access health information that supports care coordination, performance reviews and patient engagement.