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Correspondence Memorandum

**CONFIDENTIAL
UNTIL GIB VOTE ON
INTENT TO AWARD
CONTRACT**


Date: February 28, 2018
To: Group Insurance Board
From: Beth Bucaida, Procurement Lead
Bureau of Budget, Contract Administration and Procurement
Rachel Carabell, Senior Health Policy Advisor,
Office of Strategic Health Policy
Arlene Larson, Manager Federal Health Programs & Policy
Office of Strategic Health Policy
Subject: Request for Proposals for the State of Wisconsin Medicare Advantage Health Benefit Option: Results and Recommendation

ETF requests Group Insurance Board (Board) approval to award the Medicare Advantage (MA) contract to UnitedHealthcare (UHC) with prescription drug coverage offered by Navitus Health Solutions (Navitus). This MA contract would begin May 16, 2018, or a later date as directed by the Board following negotiations. This contract would extend through December 31, 2021, with options to renew for two additional two-year periods extending through December 31, 2025. ETF further recommends that the MA plan be provided in addition to current offerings with coverage effective January 1, 2019. If approved, ETF will begin negotiations with UHC in March. ETF will bring UHC’s final bid, negotiation updates and any technical contract changes to the Board at its May meeting.

Background

In developing its recommendation to the Board, ETF staff worked to meet the following goals:

- Expand Medicare offerings that have lower monthly premium costs than the current Medicare options
- Deliver high-quality, high-value services
- Offer an array of benefit packages
- Provide participant choice

Reviewed and approved by Eileen K Mallow, Deputy Director,
Office of Strategic Health Policy
 Electronically Signed 3/8/18

Board	Mtg Date	Item #
GIB	3.21.18	4

In late 2017, staff worked with the University of Wisconsin Survey Center to survey state and local group health insurance participants to learn about their preferences for Medicare-coordinated health benefits administered by ETF. The results of the survey are being shared with the Board in a memorandum under Agenda Item 4.

MA plans include elements that may surpass other Medicare offerings. These are:

CMS Oversight

A significant advantage for offering an MA plan is that the Centers for Medicare and Medicaid Services (CMS) provide extensive oversight of group MA plans, including:

- Setting network access requirements
- Quality improvement programs and star ratings
- Grievance and appeal procedures
- Fiscal soundness requirements
- Claims processing procedures
- Audits and penalties
- Other administrative requirements

Quality

CMS incentivizes group MA plans to improve quality by providing higher payments to higher-quality plans. The results are conveyed in Star Ratings, where 5 Stars is the highest standard.

Cost

Group MA plans are often priced lower than other Medicare coverage options. The plans receive payments from CMS, which contribute to the lower costs.

Less Complexity

Group MA plans provide a more seamless experience than plans that pay secondary to Medicare. For example, members covered by a group MA plan will receive just one explanation of benefits and one invoice for a service, versus multiple statements they may receive with another plan.

Additional Benefits

Group MA plans are able to provide additional benefits at no cost to members such as fitness center membership discounts.

ETF's Request for Proposal (RFP) for Medicare Advantage Plans for Medicare-Enrolled Participants in the State of Wisconsin Group Health Insurance and Wisconsin Public Employer Programs was issued October 17, 2017. Five vendors submitted proposals by the due date of November 28, 2017. Vendors could choose to offer a regional Wisconsin plan as well as a statewide/nationwide passive Preferred Provider Organization (PPO) plan. A list of the proposers is included in Table 1 below.

Table 1. RFP Proposers

Health Plan Name	Finalist?	HMO	Nationwide Passive PPO
Dean Heath Plan (Dean)	✓	✓	N/A
Humana	No, disqualified	-	-
Security Health Plan (Security)	No, withdrew	-	-
Quartz	No, disqualified	-	-
UnitedHealthcare (UHC)	✓	N/A	✓

Proposal Scoring

Proposers were required to respond to general and technical questions in the RFP and provide a cost proposal. A summary of the categories covered in the RFP follows in Table 2; the full RFP and questions are publicly available at:

<https://etfonline.wi.gov/etf/internet/RFP/MedAdvPlan/index.html> .

Table 2. RFP Sections

RFP Section and Title	Description
Section 6 General Questionnaire	
Experience	Location, types of clients and MA insurance business
CMS Approval and Oversight	Approval from CMS to offer group Medicare Advantage or application to do so and results of CMS audits for 5 years
Staff Qualifications	Account management and key staff
Customer Service	Policies to meet contractual requirements and increase health literacy
Implementation	Submission of implementation plan with detail and key dates
Enrollment and Communication	Submission of detailed strategy to educate members on program including information on enrollment with Medicare Parts A and B

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Data Security	Security of hosting environment, application architecture, account and identity management and vulnerability assessment
Section 7 Technical Questionnaire	
Provider Management	Provider steerage, engagement and feedback on initiatives such as evidence-based practices and behavioral health care
Provider Reimbursement	Experience in administering various provider reimbursement methods
Medical Management and Quality of Care	Case and disease management, including advanced care planning, palliative care and CMS Star Ratings
Total Health Management and Wellness	Experience in administering and facilitating wellness programs, financial rewards and member tools
Pharmacy Programs	If offered, experience in administering a pharmacy benefit program
Data Integration and Collaboration	Integration of electronic medical records and data sharing with the warehouse
Plan Design	Identification of ability to administer Uniform Benefits including any limitations
Section 8 Network Submission Requirements, Alternative Benefit Design and Cost Proposal	
Network Submission	Identification of whether the vendor is bidding on an HMO or Passive PPO model and network detail
Alternative Benefit Designs (not scored)	Submission of two alternatives for consideration
Cost Proposal	Submission of preliminary bid
Implementation Credits	Identification if willing to offer a one-time allowance to ETF

Performance Guarantees	Identification of agreement with performance standards
Final Premium Bid	If selected by the Board, agree to submit bid on April 30, 2018

Vendors could score a maximum of 1,000 points for responses to the RFP, with general questions receiving a maximum of 300 points, technical questions receiving a maximum of 500 points, and the cost proposal receiving a maximum of 200 points. An additional 500 points were available for vendor presentations to the evaluation committee. Three separate teams evaluated the RFP responses. The general and technical answers, with the exception of section 6.7 Data Security, were scored by an evaluation committee of four members. Section 6.7 was scored by a subcommittee of three ETF IT subject matter experts. These two committees were assisted by ETF procurement staff. Cost proposals were scored by the Board’s consulting actuary, Segal Consulting (Segal).

Point Scoring and Analysis

ETF received five responses to the RFP; only four were scored. Subsequently, one of the four proposers withdrew and two were disqualified, as described below. The two finalists and their scores are detailed in Table 3.

Table 3. RFP Scores

Health Plan	Sections 6 and 7	Section 8 (Cost)	Vendor Presentation	Total out of 1,500 Points
Dean	491	0	371	862
UHC	610	200	435	1,245

All proposers included some assumptions and exceptions in their proposals. Some violated the RFP instructions that no assumptions and exceptions were allowed for specific sections of the RFP and some exhibits. ETF provided an opportunity for proposers who violated the instructions to recant those assumptions and exceptions.

- Humana submitted an extensive list of assumptions and exceptions and indicated that they were unable to recant them. The evaluation committee, in consultation with ETF’s Office of Legal Services, rejected Humana’s proposal, and therefore did not score it.
- After their technical proposal had been scored, it was noted that Quartz had submitted several assumptions and exceptions within their cost proposal, including five related to performance guarantees. Quartz refused to recant those assumptions and exceptions and was disqualified.

Security Health Plan submitted a proposal, which was scored by the evaluation committee, then asked ETF if the group MA plan would completely replace the current Medicare offerings. The RFP had informed proposers that there was a possibility the

plan could be a full replacement, and proposers were encouraged to provide full replacement plan pricing as well as pricing for a plan that would be a component of the overall ETF program strategy. All four vendors were informed by email that MA would be offered in addition to current offerings for 2019, with the possibility of a Medicare program option redesign in a future year. Subsequently, Security withdrew its proposal.

Cost Proposals

Proposers were required to submit preliminary Per Member Per Month (PMPM) rates for three years for Group Health Insurance Program (GHIP) retired Medicare eligible members. Each proposer could bid either group MA only, or add MA with prescription drug coverage (MAPD). Cost proposals were based upon current CMS rate information. Every year in April CMS issues rates for the following year. As such, RFP finalists are required to submit a final bid to ETF by April 30, 2018. This information will be brought to the Board at the May meeting.

Segal scored the preliminary cost proposals. The PMPM preliminary bids appear in Table 4. For MA-only bids, the Navitus cost for 2019 will be added and the total premium will be presented to the Board at the August meeting. For a few points of reference, the 2018 post-buy down single Medicare premium for Navitus coverage is \$169.12. The 2018 single Medicare total rate without dental for Dean is \$420.00 and for It's Your Choice (IYC) Medicare Plus is \$366.10.

Table 4. PMPM Rate Bid

Health Plan Name	2019 MA only	2020 MA only	2021 MA only	2019 MAPD	2020 MAPD	2021 MAPD
Dean ¹	\$236.12	\$252.68	\$267.85	N/A	N/A	N/A
UHC	\$170.00	\$170.00	Variable cap based on CMS payment	\$349.00	\$354.00	Variable cap based on CMS payment

¹ It is important to note that Dean's 2019 rates are comparable to the rates currently offered for non-MA plans in our program.

Vendor Options for Group MA

1. Offer One Nationwide Passive PPO plan

UHC was the only scored proposer offering a nationwide passive PPO. Key benefits and risks associated with offering only a nationwide passive PPO MA plan to members include:

Benefits

- Extensive experience: UHC has offered group MA plans for more than 13 years (UHC currently offers group MA to several state retiree groups).

- Competitive rates: UHC will offer Uniform Benefits with Silver Sneakers, a wellness program including discounts for gym memberships. The proposed cost for Silver Sneakers is \$2.37 PMPM (this is included in the pricing listed in Table 4 above).
- High quality: In 2018 CMS awarded UHC's group MA plans 4.5 stars out of 5 for clinical quality and customer satisfaction.
- Face-to-face Outreach: UHC offers an extensive statewide outreach campaign including face-to-face meetings to educate retirees on group MA plans.
- Innovative member engagement through its HouseCalls program, a voluntary in-home assessment program where UHC nurse practitioners visit members in their homes. The goal is to identify gaps in care, increase adherence to care plans, prevent complications and collaborate with the member's primary care physician.
- National provider network: UHC has a robust national provider network, which is highly valued by many retiree participants, according to the recent retiree survey.
- Demonstrated expertise with Medicare populations: UHC demonstrated the most expertise serving the Medicare population, including having dedicated outreach and customer service units, specifically trained and focused on serving group MA plans.
- Ability to offer Uniform Benefits: with a comprehensive, nationwide, integrated Medicare provider network.

Risks

- Split contracts (contracts where some members in a family are on Medicare and some are not): UHC does not offer insurance to non-Medicare members in our program. Thus, for any split contract families where one or more members are not enrolled in Medicare, they could not enroll in UHC with family coverage. ETF is investigating a system change and policy adjustments for 2020 to permit the non-Medicare family members to select a different health plan while the Medicare member would have UHC. Due to the retirement of ETF's legacy systems, this change is not feasible for 2019.

2. Offer One Nationwide Passive PPO and One Regional HMO

Under this option, the UHC passive PPO would be available on a statewide/nationwide basis and Dean's group MA HMO plan would be offered in its CMS approved service area.

Key benefits and risks associated with this option, in addition to Option 1 above, include:

Benefits

- Experience and quality: Dean received a 5-star CMS rating for clinical quality and satisfaction for their individual MA product in their first rating year of 2018.
- Split contracts: Dean can accommodate split contracts, limited to their service area.
- Uniform Benefits and wellness benefits: Dean will offer Uniform Benefits and Silver & Fit, a wellness program including discounts for gym memberships for an additional fee of \$2.26 PMPM, which is not included in Dean's pricing listed Table 4.

Risks

- Approval from CMS to offer a group MA plan for 2019: Dean is approved to offer group MA programs in a seven-county service area. They have filed a Notice of Intent to Apply (NOIA) to expand into five more counties. As of 2018, Dean has not marketed nor sold any group MA products.
- Limited HMO Network areas: The CMS-approved service area for a Dean group MA plan is smaller than the Dean plan offered to non-Medicare members in our program. Thus, for members in a split contract or aging into Medicare, the MA members would have fewer provider choices under a Dean MA plan than non-Medicare members if they wanted to remain with Dean. Table 5 illustrates the county differences offered to MA versus non-MA members.

Table 5. Network Access / Counties

Health Plan Name	# MA Counties	# Non-MA Counties	MA Counties list	Non-MA Counties list
Dean (combination of Dean Health Plan and Dean Prevea 360)	12	25	Brown ¹ , Columbia, Dane, Dodge, Fond du Lac, Green, Iowa, Jefferson, Kewaunee ¹ , Oconto ¹ , Rock, and Sauk	Adams, Brown ¹ , Columbia, Dane, Dodge, Door ¹ , Fond du Lac, Grant, Green, Green Lake, Iowa, Jefferson, Juneau, Kewaunee ¹ , Lafayette, Manitowoc ¹ , Marquette, Menominee ¹ , Oconto ¹ , Richland, Rock, Sauk, Sheboygan ¹ , Walworth and Waukesha
UHC	All 72 ² and nationwide	None	Statewide ² / nationwide	None

¹ Dean Prevea 360 counties.

² UHC bid a passive PPO and easily passed CMS' requirement that 51% of members be within their network (currently 96%) to operate nationally. However, UHC passed the GHIP's network access qualification test in only 56 of 72 counties.

- Minimal coverage outside service area: Unlike the current It's Your Choice Medicare plans, under the Dean MA HMO plan, medical care provided out-of-network that is not emergency, urgent or prior authorized will not be covered by Medicare Part A and/or B. This is a significant difference from the current coverage and will represent a financial risk to members who receive non-emergency services when traveling or residing outside the HMO's service area.

Options for Other Medicare Offerings

1. Maintain Current Program Offerings with UHC's new Medicare Advantage Offering

Currently, Medicare-eligible retirees have several options available to them for coverage under the GHIP: the IYC Health Plan or IYC Medicare Plus, a Medicare supplement. The current plan offerings wrap around Medicare Parts A and B fee-for-service benefits. These plan offerings are available through the same health plans available to non-Medicare members. Key benefits and risks associated with this option include:

Benefits

- Offers a new benefit choice to Medicare retirees at a lower premium without taking away existing choices.
- Restores an MA offering with a national provider network.
- Provides program choices in line with participant feedback received through a recent survey.
- Maintains a competitive insurer environment and member choice.

Risks

- Complex communication of helping members understand the difference between the three plan options: IYC Health Plan – Medicare, IYC Medicare Plus and IYC Medicare Advantage.

2. Discontinue Other Medicare Offerings (Medicare Advantage Complete Replacement)

The evaluation committee and staff considered the option to completely replace the current Medicare offerings with only the group MA plan, but determined, due to the benefits and risks listed above, that this should not be considered for 2019. There was another risk that affected the committee's decision, as follows.

Out-of-country retirees

A group MA plan does not offer coverage to residents outside of the United States and its territories. Thus, retirees who travel for extended periods or live outside of the U.S. and its territories would have no coverage except for certain emergency care. Currently, most of these members are enrolled in IYC Medicare Plus, as it offers a foreign travel rider.

3. Pharmacy Benefits

Staff explored the option to offer a group MA plan integrated with prescription drug benefits with internal program and technology staff. Staff found it is not feasible for 2019, due to ETF's current technology limitations. There may be opportunities to provide this option in the future if there is interest from Board members.

2019 Recommendations

ETF recommends the Board enter into a contract with UHC for an MA passive PPO plan (not including a UHC pharmacy benefit) subject to the conditions stated in the introduction. UHC's proposal scored significantly higher than the other proposals. UHC's experience with group MA plans is extensive and they can provide statewide and nationwide access. UHC has committed to administering the current Uniform Benefit plan and has demonstrated experience doing so. If approved, staff will enter into negotiations with UHC to administer the group MA plan starting in 2019.

In the event UHC is unable to administer a group MA plan to meet (or very closely meet) the current GHIP Medicare benefit offering or ETF and UHC cannot come to agreeable terms during contract negotiations, ETF will bring a recommendation to the May Board meeting that the Board consider not awarding a contract at this time and revisit its MA strategy in 2019.

Timeline

Below is an approximate timeline of next steps. If the Board approves the recommendation, much of the timeline will be dictated by CMS.

March 2018	ETF enters negotiations with UHC to administer group MA plan offerings
April 2018	CMS announces MA 2019 reimbursement rates
April 30, 2018	UHC submits a revised cost proposal to ETF
May 16, 2018	ETF presents to the Board an update on Medicare offerings and final contract recommendations for 2019
August 2018	CMS finalizes MA 2019 reimbursement rates

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August 22, 2018 Board approves all 2019 rates

October 2018 Open enrollment begins; members can select an MA plan

Staff will be at the Board meeting to answer any questions.