

REQUEST FOR INFORMATION (RFI)

BY THE
STATE OF TENNESSEE
DEPARTMENT OF FINANCE & ADMINISTRATION
Release 2 12/17/09

A. STATEMENT OF INTENT

The State of Tennessee, Department of Finance & Administration issues this Request for Information (RFI) as part of its effort to develop the scope of services for wellness and health management services for the public sector plans. In addition, the Department seeks to identify qualified organizations capable of providing such services for members enrolled in the public sector plans.

B. BACKGROUND

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Given the falling revenue collections, the State budget may not support more than a 3% annual increase in premiums--or approximately \$25 million in additional state dollars each year. Reducing premium increases to 3% when we expect medical costs to increase at 7-8% would require us to shift substantial costs to employees. In the absence of other plan changes, Aon, the plan's actuaries, warn that we would need to more than quadruple the deductibles in the current PPO in three years (e.g., the deductible for families in the PPO would grow from \$875 in 2010 to over \$3,750 in 2013). This increase in member cost would still not address the cost-drivers in our plans. (Note: For additional information in this regard, please see **Attachment A.**)

We have two simple options to contain costs:

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Please see **Attachment B** for a complete list of questions detailing the information sought by the State in this RFI. Parties may respond to all questions, or only those pertinent to their organization’s capabilities. Tightly organized and succinctly expressed responses are appreciated.

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Tennessee Department of Finance & Administration
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D. INSTRUCTIONS FOR RESPONDING

We would appreciate responses on standard 8 ½ x 11 inch paper, single-spaced, single-sided, with at least ¾"-inch margins, and with text no smaller than 11-point font (although oversize attachments departing from these standards are permissible). We also ask respondents to number all pages and include the respondent's name and RFI #31786-00105 on each individual page.

Provide three (3) hard copies of your RFI response and one (1) digital document in PDF format properly recorded on its own otherwise blank, standard CD-R recordable disc labeled with the respondent's name, and "RFI #31786-00105 Response, (date)".

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D.2. Reference **Request for Information # 31786 - 00105** in your response to this request.

D.3. Respond by 4:00 p.m. central standard time on **Thursday, January 7, 2010**.

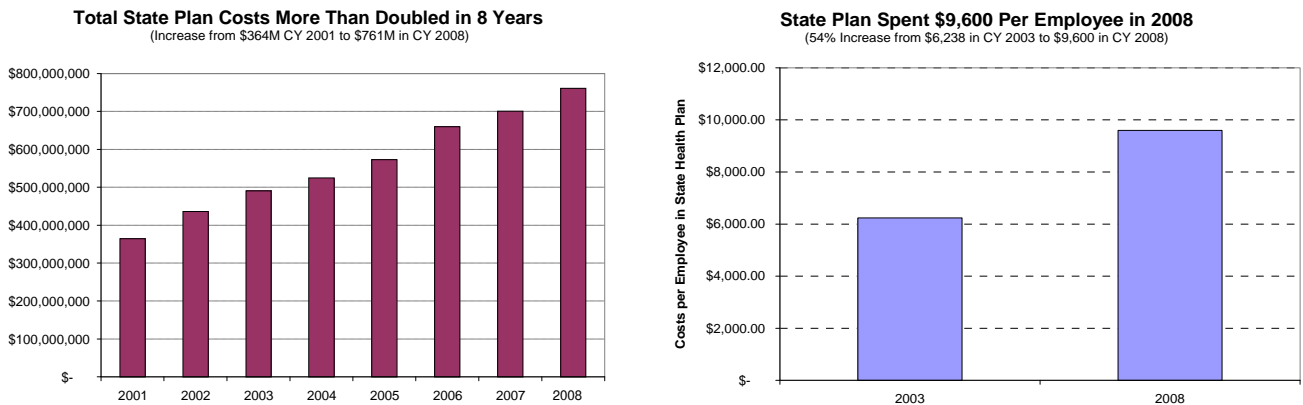
ATTACHMENT A ADDITIONAL BACKGROUND

Background

The State's public sector plans provide health benefits to 145,000 employees and retirees of the State, the University of Tennessee (UT) system, the Tennessee Board of Regents (TBR) system, Local Education Agencies (LEAs), and local government entities. In total, the plans cover 270,000 employees, retirees and dependents.

Costs for these health benefits have increased dramatically in the last few years. By way of illustration, expenditures on medical claims in the State's public sector plans increased on a per member per year basis by over 50% in the five year period between 2003 and 2008.¹

Additionally, the total expenditures in the state and local education plans more than doubled in just eight years.²



One of the principal drivers of the growth in costs appears to be the excess disease burden in the public sector plans. Members of the public sector plans appear to have both a higher prevalence of chronic conditions and higher utilization than other comparable populations. Unless we arrest the trend and control costs, neither the public employers nor the employees will be able to afford the current, comprehensive benefits package. In short, we have to "bend" the health care cost in order to continue to provide the same array of benefits. Otherwise, we will have to cut benefits and shift more costs to employees.

Planning Process

In May 2008, Benefits Administration launched a strategic planning process for the public sector plans. We worked extensively with stakeholders and our actuarial consultants at Aon, Inc. to analyze our options and the likely actuarial impact. These produced the framework for a new plan design. We then collaborated with AcademyHealth, a Robert Wood Johnson-funded think tank in Washington DC, to

¹ The actual increases between 2003 and 2008 are 53.9% for the State Plan, 52.0% for the Local Education Plan, and 38.8% for the Local Government Plan.

² The actual increases in claims expenditures between 2001 and 2008 are 121.2% for the State Plan, 148.1% for the Local Education Plan, and 32.5% for the Local Government Plan. The relatively low increase in the Local Government Plan is explained largely by changes in membership; note that this plan also had the largest increase in per member per year basis between 2001 and 2008.

convene a summit in Nashville on September 3, 2009. At this event, we received a robust “peer review” of our proposed redesign by public sector plan managers from several states. The process in its entirety identified several key goals for a benefits options redesign. These include:

- Addressing key drivers of health care costs with proven cost containment and health management practices;
- Modernizing benefits options design and contribution strategy;
- Encouraging and rewarding member engagement for healthy lifestyle choices and effective health care delivery;
- Leveraging the State’s purchasing power and vendor core competencies; and
- Increasing the value of the benefits options to members by offering broader spread of price, greater accountability, and improved health management.

The new plan design is based on the following premise: The plans and members can partner together to prevent costs or the plans can simply shift ever-increasing medical costs to members. For members who wish to partner with us, we would offer a benefit plan with lower premiums and reduced cost sharing in exchange for member engagement in health management activities. This plan will promote wellness and achieve efficiencies, which will help us control costs and allow us to preserve benefits. For members who do not select this option, we would offer a different benefit structure at a higher price point. Both options cover the same services, but member costs would be lower for those in the plan featuring enhanced health and disease management.

Procurement Strategy

Based on these discussions and subsequent analyses, we developed the framework for the public sector plan redesign and a related health care procurement strategy. Consistent with the new health care procurement strategy, Benefits Administration is planning to implement several changes to the current benefit options for the 2010 plan year (beginning January 1, 2010) and then transition to the redesigned benefit options for the 2011 plan year (beginning January 1, 2011).

The State’s proposed health care procurement strategy leverages several opportunities to achieve greater efficiencies. Specifically, the State’s approach provides for:

- Carve-outs of Pharmacy Benefits Manager (PBM) in 2010, and the possibility of carving out disease management in 2011 (see table below);

Pharmacy (2010)	Carve out to specialty vendor
TPA (2011)	Two carriers administer all benefit options statewide
Health Management (2011)	Carve out to specialty vendor. Includes wellness, prevention, disease management, quality reviews, provider profiling and intervention.
BHO & EAP (2012)	Carve out to specialty vendor

- Capability to standardize, and therefore better manage wellness, prevention, and disease management through carve out to specialty vendor.
- Capability to more fully integrate medical and behavioral health care delivery at the primary care level, with continued specialty support through the existing Behavioral Health Organization (BHO) carve out; and
- Capability to “layer in” even lower cost-sharing for members receiving services for “high performing provider network”.

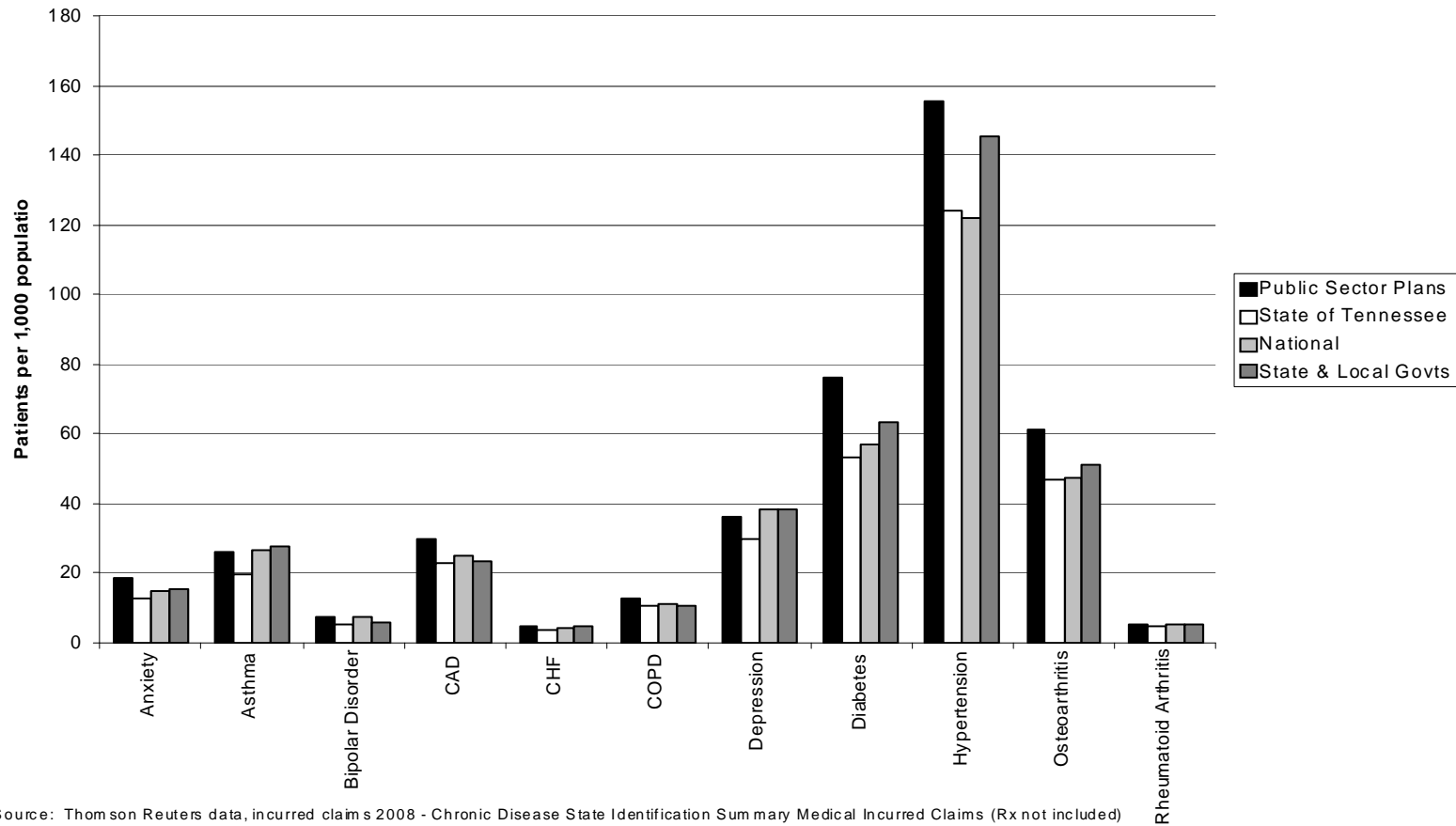
Tennessee's Disease Burden Exceeds All Benchmarks



11 Disease Categories Considered	State of Tennessee		National Norms	Excess Disease Burden		Tennessee Norms	Excess Disease Burden		State & Local Govts Norms	Excess Disease Burden	
	Patients per 1,000	Medical Costs per Patient	Patients per 1,000	Marginal Patients per 1,000	Marginal Cost	Patients per 1,000	Marginal Patients per 1,000	Marginal Cost	Patients per 1,000	Marginal Patients per 1,000	Marginal Cost
Anxiety Disorder	18.33	\$167	14.68	3.65	\$166,786	12.57	5.76	\$263,202	15.48	2.85	\$130,230
Asthma	26.09	\$400	26.63	-0.54	-\$58,943	19.50	6.59	\$719,322	27.55	-1.46	-\$159,364
Bipolar Disorder	7.20	\$865	7.20	0.00	\$0	5.48	1.72	\$406,094	5.75	1.45	\$342,347
Coronary Artery Disorder	29.56	\$4,764	24.79	4.77	\$6,203,885	22.88	6.68	\$8,688,040	23.42	6.14	\$7,985,713
CHF	4.89	\$3,462	4.18	0.71	\$671,016	3.81	1.08	\$1,020,701	4.41	0.48	\$453,645
COPD	12.86	\$860	11.15	1.71	\$396,964	10.54	2.32	\$538,571	10.26	2.60	\$603,571
Depression	35.69	\$440	38.17	-2.48	-\$297,593	29.58	6.11	\$733,183	38.08	-2.39	-\$286,799
Diabetes	76.03	\$503	57.15	18.88	\$2,593,974	53.29	22.74	\$3,124,310	63.19	12.84	\$1,764,122
Hypertension	155.76	\$182	122.18	33.58	\$1,657,814	124.01	31.75	\$1,576,924	145.34	10.42	\$517,529
Osteoarthritis	61.11	\$2,040	47.48	13.63	\$7,589,852	46.88	14.23	\$7,923,962	51.30	9.81	\$5,462,689
Rheumatoid Arthritis	5.41	\$1,932	5.02	0.39	\$205,732	4.53	0.88	\$464,216	5.15	0.26	\$137,155
	Marginal Cost Due to Excess Disease Burden			\$19,139,488 or 2.1% of total medical cost			\$25,458,524 or 2.7% of total medical cost			\$16,960,844 or 1.8% of total medical cost	

Source: Thomson Reuters Data, Chronic Disease State Identification Summary – Medical Paid Claims (pharmacy not included)

Public Sector Plans Fare Worse with Disease Prevalence



Source: Thomson Reuters data, incurred claims 2008 - Chronic Disease State Identification Summary Medical Incurred Claims (Rx not included)

ATTACHMENT B RFI QUESTIONS

1. With respect to health management activities, we are most interested in verifiable activities and prefer to focus on these over self-reported activities. Please provide some examples of numeric scoring methods for engagement (i.e., “wellness points”) and examples of numeric value that might be attached to participation.
2. The majority of our plan members are employed by entities outside of state government (e.g., higher education campuses, local education agencies, local government, etc.). Consequently, we may not consistently receive contact information updates, etc. from members. We have considered requiring members of the Partnership Plans to provide email and phone contact information when they complete the health risk assessment. What options are available for collecting telephone numbers or email addresses?
3. With respect to biometric screening, we are considering the following in the panel of tests that we might require from Partnership Plan members in 2011: blood glucose, lipid levels, blood pressure, height and weight, body mass index, and (possibly) bone density. Which specific tests do you recommend including in biometric screenings?
4. We would like to provide members with the choice between scheduled screening events and having the screenings done by their own physicians. Please describe available options for collecting biometric data from clients. Please do **not** address any legal concerns in your response (e.g., implications of recently promulgated Genetic Information Non-Discrimination Act (GINA) regulations, etc.)
5. When using either (or both) biometric screening and/or health risk assessments, is a scoring methodology normally used to communicate results to participants? If so, please detail at least one approach/methodology and provide example(s) for calculating individual wellness scores. Also:
 - a. Please provide a comprehensive list of the factors that may be included in health risk assessments.
 - b. Of the risks screened for, how could one weigh each health factor relative to other health factors (e.g., smoking vs. obesity)? How should risk factors be weighted?
 - c. In what ways could scoring mechanisms account for or incorporate the age of the member (either in the metric itself or in the presentation of the results)?
6. Please describe in detail the approach to providing telephonic health coaching services. Is it typically based on broad-based enrollment, disease-specific members, individual outreach or some other method?
7. Given the debate and extended commentaries on the utility of the Prochaska score and other readiness-to-change metrics, we are interested in your views as to whether it makes sense to employ such measures. For example, see Hunnicutt, D. (2008). *Expediting Employee Behavior Change By Implementing The Right Incentives*. WELCOA's **Absolute Advantage**, 7(5), 17-23.

8. We are concerned about the lack of the evidence for success of long-term weight loss. Based on our review of the literature, successful interventions must address nutrition, emotional and mental health issues, physical activity, medical co-morbidities, and other factors. Interventions may also need to deal with a family as a whole rather than as an individual member. What types of interventions with which you are familiar offer this type of comprehensive support? Please provide as much detail as possible.
9. Please describe possible direct interventions (including provider profiling and peer-to-peer outreach) with individual health care providers to promote quality improvement? Do **not** discuss untailored, generic mailers addressed to providers.
 - a. Please describe how provider data may be used to shape the health management services offered to each individual participant.
 - b. What kind of provider specific metrics, such as Healthcare Effectiveness Data Information Set (HEDIS) or HEDIS-like measures, will influence the decision to intervene with specific healthcare providers?
 - c. What type or pattern of provider performance warrants an intervention?
 - d. To what extent can/should the health management contractor intervene with training, corrective action plans, etc. with poorly-performing providers?
 - e. What types of interventions have been the most and least effective? Describe what types of interventions are more appropriate for the State, and what types of interventions are more appropriate for the health management contractors, third party administrators, pharmacy benefits managers, etc.
 - f. What is the most appropriate entity or entities to aggregate claims, utilization and outcome data in order to develop robust provider profiles? How might this work in practice?
10. What specific operational methods can be used in order to realize improvements with:
 - a. Identifying and tracking referrals,
 - b. Providing specialty care locator assistance,
 - c. Facilitating appointment scheduling, and
 - d. Coordinating post-visit physician communication and follow-up?
11. What methods of coordination between an independent pharmacy benefits manager (PBM) and a disease management program would provide optimal drug compliance monitoring?
12. What disease management programs are considered best practice for anxiety and depression and how could these programs coordinate with a behavioral health organization (BHO).

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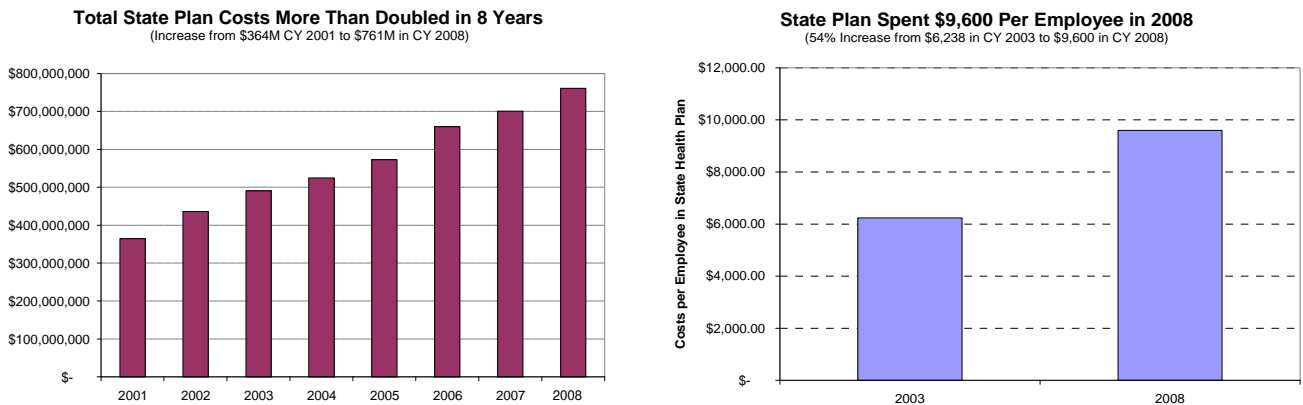
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ATTACHMENT A ADDITIONAL BACKGROUND

Background

The State's public sector plans provide health benefits to 145,000 employees and retirees of the State, the University of Tennessee (UT) system, the Tennessee Board of Regents (TBR) system, Local Education Agencies (LEAs), and local government entities. In total, the plans cover 270,000 employees, retirees and dependents.

Costs for these health benefits have increased dramatically in the last few years. By way of illustration, expenditures on medical claims in the State's public sector plans increased on a per member per year basis by over 50% in the five year period between 2003 and 2008.¹ Additionally, the total expenditures in the state and local education plans more than doubled in just eight years.²



One of the principal drivers of the growth in costs appears to be the excess disease burden in the public sector plans. Members of the public sector plans appear to have both a higher prevalence of chronic conditions and higher utilization than other comparable populations. Unless we arrest the trend and control costs, neither the public employers nor the employees will be able to afford the current, comprehensive benefits package. In short, we have to “bend” the health care cost in order to continue to provide the same array of benefits. Otherwise, we will have to cut benefits and shift more costs to employees.

Planning Process

In May 2008, Benefits Administration launched a strategic planning process for the public sector plans. We worked extensively with stakeholders and our actuarial consultants at Aon, Inc. to analyze our options and the likely actuarial impact. These produced the framework for a new plan design. We then collaborated with AcademyHealth, a Robert Wood Johnson-funded think tank in Washington DC, to

¹ The actual increases between 2003 and 2008 are 53.9% for the State Plan, 52.0% for the Local Education Plan, and 38.8% for the Local Government Plan.

² The actual increases in claims expenditures between 2001 and 2008 are 121.2% for the State Plan, 148.1% for the Local Education Plan, and 32.5% for the Local Government Plan. The relatively low increase in the Local Government Plan is explained largely by changes in membership; note that this plan also had the largest increase in per member per year basis between 2001 and 2008.

convene a summit in Nashville on September 3, 2009. At this event, we received a robust “peer review” of our proposed redesign by public sector plan managers from several states. The process in its entirety identified several key goals for a benefits options redesign. These include:

- Addressing key drivers of health care costs with proven cost containment and health management practices;
- Modernizing benefits options design and contribution strategy;
- Encouraging and rewarding member engagement for healthy lifestyle choices and effective health care delivery;
- Leveraging the State’s purchasing power and vendor core competencies; and
- Increasing the value of the benefits options to members by offering broader spread of price, greater accountability, and improved health management.

The new plan design is based on the following premise: The plans and members can partner together to prevent costs or the plans can simply shift ever-increasing medical costs to members. For members who wish to partner with us, we would offer a benefit plan with lower premiums and reduced cost sharing in exchange for member engagement in health management activities. This plan will promote wellness and achieve efficiencies, which will help us control costs and allow us to preserve benefits. For members who do not select this option, we would offer a different benefit structure at a higher price point. Both options cover the same services, but member costs would be lower for those in the plan featuring enhanced health and disease management.

Procurement Strategy

Based on these discussions and subsequent analyses, we developed the framework for the public sector plan redesign and a related health care procurement strategy. Consistent with the new health care procurement strategy, Benefits Administration is planning to implement several changes to the current benefit options for the 2010 plan year (beginning January 1, 2010) and then transition to the redesigned benefit options for the 2011 plan year (beginning January 1, 2011).

The State’s proposed health care procurement strategy leverages several opportunities to achieve greater efficiencies. Specifically, the State’s approach provides for:

- Carve-outs of Pharmacy Benefits Manager (PBM) in 2010, and the possibility of carving out disease management in 2011 (see table below);

Pharmacy (2010)	Carve out to specialty vendor
TPA (2011)	Two carriers administer all benefit options statewide
Health Management (2011)	Carve out to specialty vendor. Includes wellness, prevention, disease management, quality reviews, provider profiling and intervention.
BHO & EAP (2012)	Carve out to specialty vendor

- Capability to standardize, and therefore better manage wellness, prevention, and disease management through carve out to specialty vendor.
- Capability to more fully integrate medical and behavioral health care delivery at the primary care level, with continued specialty support through the existing Behavioral Health Organization (BHO) carve out; and
- Capability to “layer in” even lower cost-sharing for members receiving services for “high performing provider network”.

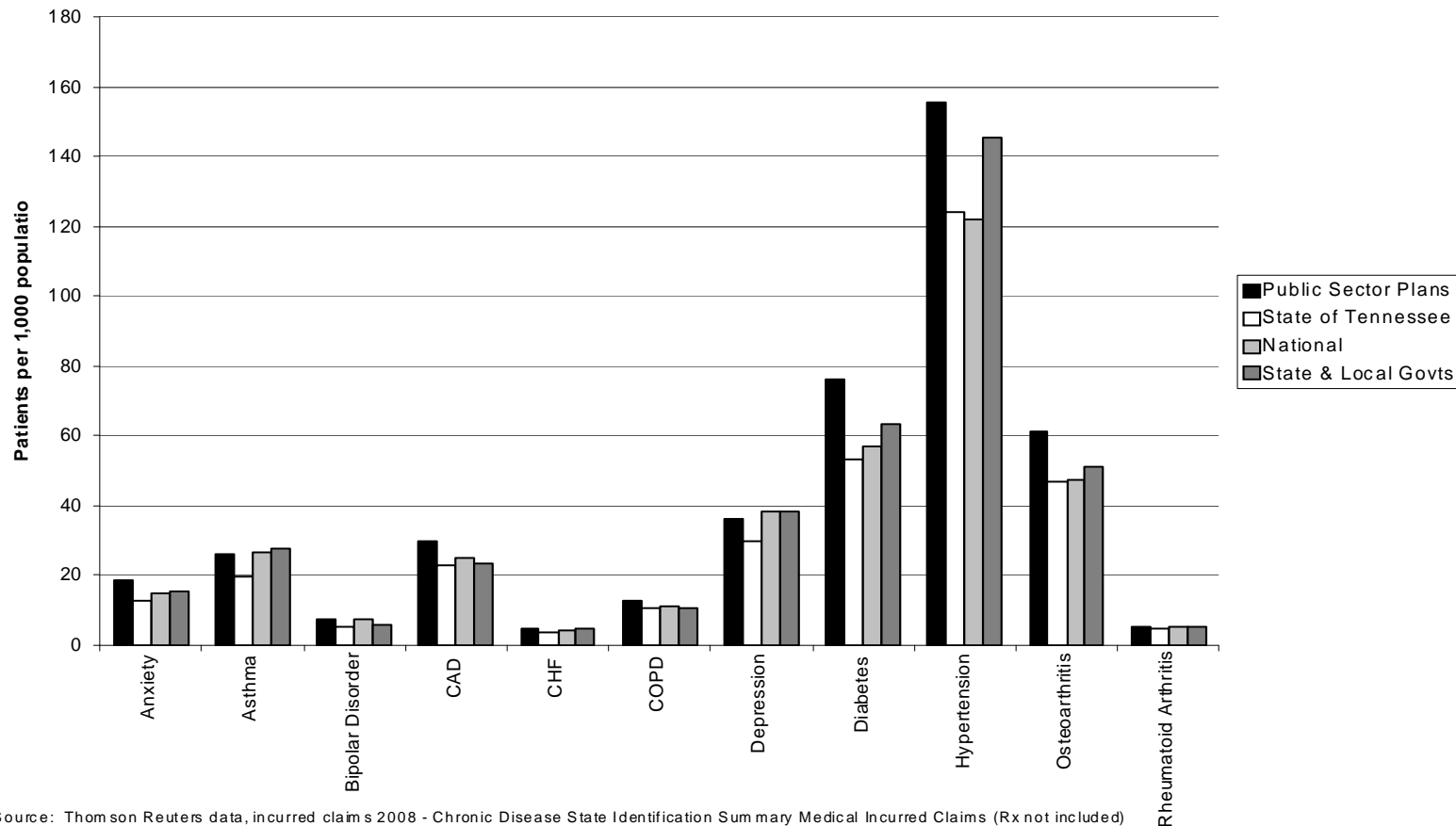
Tennessee's Disease Burden Exceeds All Benchmarks



11 Disease Categories Considered	State of Tennessee		National Norms	Excess Disease Burden		Tennessee Norms	Excess Disease Burden		State & Local Govts Norms	Excess Disease Burden	
	Patients per 1,000	Medical Costs per Patient	Patients per 1,000	Marginal Patients per 1,000	Marginal Cost	Patients per 1,000	Marginal Patients per 1,000	Marginal Cost	Patients per 1,000	Marginal Patients per 1,000	Marginal Cost
Anxiety Disorder	18.33	\$167	14.68	3.65	\$166,786	12.57	5.76	\$263,202	15.48	2.85	\$130,230
Asthma	26.09	\$400	26.63	-0.54	-\$58,943	19.50	6.59	\$719,322	27.55	-1.46	-\$159,364
Bipolar Disorder	7.20	\$865	7.20	0.00	\$0	5.48	1.72	\$406,094	5.75	1.45	\$342,347
Coronary Artery Disorder	29.56	\$4,764	24.79	4.77	\$6,203,885	22.88	6.68	\$8,688,040	23.42	6.14	\$7,985,713
CHF	4.89	\$3,462	4.18	0.71	\$671,016	3.81	1.08	\$1,020,701	4.41	0.48	\$453,645
COPD	12.86	\$860	11.15	1.71	\$396,964	10.54	2.32	\$538,571	10.26	2.60	\$603,571
Depression	35.69	\$440	38.17	-2.48	-\$297,593	29.58	6.11	\$733,183	38.08	-2.39	-\$286,799
Diabetes	76.03	\$503	57.15	18.88	\$2,593,974	53.29	22.74	\$3,124,310	63.19	12.84	\$1,764,122
Hypertension	155.76	\$182	122.18	33.58	\$1,657,814	124.01	31.75	\$1,576,924	145.34	10.42	\$517,529
Osteoarthritis	61.11	\$2,040	47.48	13.63	\$7,589,852	46.88	14.23	\$7,923,962	51.30	9.81	\$5,462,689
Rheumatoid Arthritis	5.41	\$1,932	5.02	0.39	\$205,732	4.53	0.88	\$464,216	5.15	0.26	\$137,155
	Marginal Cost Due to Excess Disease Burden			\$19,139,488 or 2.1% of total medical cost			\$25,458,524 or 2.7% of total medical cost			\$16,960,844 or 1.8% of total medical cost	

Source: Thomson Reuters Data, Chronic Disease State Identification Summary – Medical Paid Claims (pharmacy not included)

Public Sector Plans Fare Worse with Disease Prevalence



Source: Thomson Reuters data, incurred claims 2008 - Chronic Disease State Identification Summary Medical Incurred Claims (Rx not included)

ATTACHMENT B RFI QUESTIONS

1. With respect to health management activities, we are most interested in verifiable activities and prefer to focus on these over self-reported activities. Please provide some examples of numeric scoring methods for engagement (i.e., “wellness points”) and examples of numeric value that might be attached to participation.
2. The majority of our plan members are employed by entities outside of state government (e.g., higher education campuses, local education agencies, local government, etc.). Consequently, we may not consistently receive contact information updates, etc. from members. We have considered requiring members of the Partnership Plans to provide email and phone contact information when they complete the health risk assessment. What options are available for collecting telephone numbers or email addresses?
3. With respect to biometric screening, we are considering the following in the panel of tests that we might require from Partnership Plan members in 2011: blood glucose, lipid levels, blood pressure, height and weight, body mass index, and (possibly) bone density. Which specific tests do you recommend including in biometric screenings?
4. We would like to provide members with the choice between scheduled screening events and having the screenings done by their own physicians. Please describe available options for collecting biometric data from clients. Please do **not** address any legal concerns in your response (e.g., implications of recently promulgated Genetic Information Non-Discrimination Act (GINA) regulations, etc.)
5. When using either (or both) biometric screening and/or health risk assessments, is a scoring methodology normally used to communicate results to participants? If so, please detail at least one approach/methodology and provide example(s) for calculating individual wellness scores. Also:
 - a. Please provide a comprehensive list of the factors that may be included in health risk assessments.
 - b. Of the risks screened for, how could one weigh each health factor relative to other health factors (e.g., smoking vs. obesity)? How should risk factors be weighted?
 - c. In what ways could scoring mechanisms account for or incorporate the age of the member (either in the metric itself or in the presentation of the results)?
6. Please describe in detail the approach to providing telephonic health coaching services. Is it typically based on broad-based enrollment, disease-specific members, individual outreach or some other method?
7. Given the debate and extended commentaries on the utility of the Prochaska score and other readiness-to-change metrics, we are interested in your views as to whether it makes sense to employ such measures. For example, see Hunnicutt, D. (2008). *Expediting Employee Behavior Change By Implementing The Right Incentives*. WELCOA’s **Absolute Advantage**, 7(5), 17-23.

8. We are concerned about the lack of the evidence for success of long-term weight loss. Based on our review of the literature, successful interventions must address nutrition, emotional and mental health issues, physical activity, medical co-morbidities, and other factors. Interventions may also need to deal with a family as a whole rather than as an individual member. What types of interventions with which you are familiar offer this type of comprehensive support? Please provide as much detail as possible.
9. Please describe possible direct interventions (including provider profiling and peer-to-peer outreach) with individual health care providers to promote quality improvement? Do **not** discuss untailored, generic mailers addressed to providers.
 - a. Please describe how provider data may be used to shape the health management services offered to each individual participant.
 - b. What kind of provider specific metrics, such as Healthcare Effectiveness Data Information Set (HEDIS) or HEDIS-like measures, will influence the decision to intervene with specific healthcare providers?
 - c. What type or pattern of provider performance warrants an intervention?
 - d. To what extent can/should the health management contractor intervene with training, corrective action plans, etc. with poorly-performing providers?
 - e. What types of interventions have been the most and least effective? Describe what types of interventions are more appropriate for the State, and what types of interventions are more appropriate for the health management contractors, third party administrators, pharmacy benefits managers, etc.
 - f. What is the most appropriate entity or entities to aggregate claims, utilization and outcome data in order to develop robust provider profiles? How might this work in practice?
10. What specific operational methods can be used in order to realize improvements with:
 - a. Identifying and tracking referrals,
 - b. Providing specialty care locator assistance,
 - c. Facilitating appointment scheduling, and
 - d. Coordinating post-visit physician communication and follow-up?
11. What methods of coordination between an independent pharmacy benefits manager (PBM) and a disease management program would provide optimal drug compliance monitoring?
12. What disease management programs are considered best practice for anxiety and depression and how could these programs coordinate with a behavioral health organization (BHO).