



## HEALTH CARE BENEFITS CONSULTANT TO THE STATE OF WISCONSIN FOR HEALTH INSURANCE PROGRAMS

### State of Wisconsin Employee Trust Funds Board

Technical Proposal

RFP# 28154-BD

July 14, 2014 2:00p.m. CST

Segal Consulting

2018 Powers Ferry Road, Suite 850

Atlanta, Georgia 30339-7200

[t] 678.306.3100

**ORIGINAL**



 Segal Consulting

# TRANSMITTAL LETTER

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2018 Powers Ferry Road SE Suite 850 Atlanta, GA 30339-7200  
T 678.306.3100 www.segalco.com

July 11, 2014

Ms. Brenda Derge/ RFP #28154-BD  
Wisconsin Department of Administration  
Division of Enterprise Operations  
101 E. Wilson Street, 6th Floor  
Madison, WI 53703

**RE: RFP #281540BD Health Care Benefits Consultant for Health Insurance Programs**

Dear Ms. Derge:

The Segal Company (“Segal”) is pleased to submit our proposal to provide health care benefit consulting services to the Wisconsin Department of Employee Trust Funds (“ETF”), under the authority of the State of Wisconsin Group Insurance Board (“GIB”). This complicated project, providing actuarial consulting services for the State and Wisconsin Public Employer Group Health Insurance Programs, will ultimately affect the lives of more than 570,000 Wisconsinites.

Segal has been assisting public plans and employers for more than 70 years and currently consults to more than one-third of the state-level plans in the country. Serving the public sector is a key focus at Segal and is the primary focus for our senior consulting team proposed to ETF. We are a recognized industry leader, sponsoring and participating in many service and professional organizations, including the State and Local Government Benefits Association (SALGBA), National Association of State Retirement Administrators (NASRA), and participating in the Public Sector Health Benefits Roundtable.

Segal has made a continued and significant commitment to our public sector clients. We reflect that commitment in our organizational structure, where the Public Sector is one of our three primary client markets. By focusing on the particular needs of public sector clients, Segal is able to bring specialized expertise and experience to our clients that may not be emphasized in other consulting firms that cater primarily to private sector corporations.

Your Segal team has been carefully selected for this engagement to match our experience and skill sets with your specific needs. Our proposed team of consultants, actuaries, and analysts work with a wide array of public employers and public employee benefit programs across the country and within your region. With the exception of a few strategic additional consultants, this is essentially the same team that was recently hired as the health benefits consultant and actuary by the Wisconsin Employee Trust Funds.

We have extensive experience working on complex benefit structures with state governments and large municipal governments and are sensitive to both the fiscal and political environment in which benefits are delivered for your employees and retirees. In addition, our work with a number of large multiemployer funds and private sector employers provide a well-rounded experience set.

The following highlights our commitment to ETF:

1. **Commitment to Service:** Our well-recognized position as a benefits consulting firm ensures the ETF of highly qualified services and a full range of consulting perspectives upon which we are able to draw for our clients. In addition to having Ken Vieira, ETF will benefit from the addition of Rick Johnson and Chris Mathews to the ETF project team. They have led strategic redesign projects for a number of states. Our team is available and will begin work immediately upon contract award, making the transition seamless for you.
2. **Commitment to Quality:** We constantly measure our performance through internal quality standards to ensure we deliver services and products that meet our clients' expectations. The depth of our experience in health care pricing, design, administration, compensation, and communication enhances our dedication to quality.
3. **Commitment to Dependability:** Many of the services we perform must be completed within a very tight time frame. We will collaborate with you to establish mutually attainable work schedules and will dedicate the staff and resources necessary to meet those deadlines. The trust we will seek develop over time with the ETF is something we value and strive to reinforce.
4. **Commitment to Innovation:** Technical competence is important, but we also strongly believe that our role as consultant is to add value to the ETF and GIB, as well the employees and retirees it serves. We will identify emerging issues and propose innovative solutions to assist the ETF in meeting its operational challenges.
5. **Commitment to People:** Through collaborative consulting combined with our objectivity, Segal provides unique insights into your strategic objectives. We supply customized strategy-to-implementation solutions aligned with your goals, rather than answers simply tied to products or pre-packaged solutions. We believe this approach helps create lasting relationships built on mutual trust.
6. **Commitment to Resources:** We have also gone to great length to integrate our technical talent. Our consultants work side by side with actuaries, lawyers, clinicians, accountants, data analysts, benefit consultants, etc. Although ETF is primarily seeking consulting, our analysis will incorporate the particular expertise of each team member as it relates to the various tasks. Your proposed Account Manager, *Kenneth C. Vieira, FSA, FCA, MAAA* has extensive experience in leading teams that service state-level plans. Ken is a seasoned actuary and consultant, working with over a dozen state health plans. He also serves as the Account Manager on the recently awarded contract with the ETF.
7. **Commitment to Independence:** Segal does not consult with any HMOs or provider groups specializing in this area. This strategy enables us to remain independent and ensure that our consultants have no conflicts. Segal believes firms that work both for the State and for providers have direct conflicts and cannot be impartial.

This proposal outlines how Segal's experience will benefit the ETF and the GIB and meet each of the consulting aspects identified in the request for proposal. We present our proposed principals', actuaries' and consultants' experience working with other state governments, public entities and large private entities on similar issues.

Segal complies with or addresses the following:

- Our proposal is signed by an individual, **Kenneth C. Vieira, FSA, FCA, MAAA**, Senior Vice President & East Region Public Sector Market Leader, who is authorized to commit Segal to the services, compliance requirements and prices stated in our proposal. Ken's home office is in Atlanta, Georgia. Our Atlanta Office information, along with Ken's email address is as follows:

Segal Consulting  
2018 Powers Ferry Road, Suite 850 | Atlanta, Georgia 30339-7200  
T 678.306.3154 | F 678.669.1887  
[kvieira@segalco.com](mailto:kvieira@segalco.com)

- We have provided one (1) original and five (5) courtesy copies, in addition to one (1) electronic version on CD-ROM, un-locked and non-password protected. This includes an electronic copy of the cost sheet on the same CD-ROM.
- Information that demonstrates recognition of our professional responsibility and capability.
- The Atlanta and Chicago Offices will be the primary offices we will use to service your account.
- Information regarding pending litigation and/or litigation resolved within the past five years that relates to the provision of services by our organization and/or our employees.
- Information concerning any complaints filed about the Respondent's entity or its employees with or by professional and/or state or federal licensing/regulatory organizations within the past five years.
- Our cost proposal is submitted as a separate and sealed part of our proposal and clearly identified as the Cost Proposal. We have not included any cost information in our technical proposal. We have provided one (1) original and one (1) electronic copy on CD-ROM.
- We have included all required forms. See our completed "Completed Proposer Checklist".
- We have read the First Set of Vendor Questions and ETF Answers for Request for Proposals (RFP) 28154-BD that were posted on June 9, 2014. We have also read the Second Set of Vendor Questions, Correspondence Memorandum, dated June 25, 2014.
- Our proposal is firm and irrevocable for a period of six (6) months after the closing date.

Should you or your evaluation committee have questions about the materials contained in this proposal, please do not hesitate to contact me at (678) 306-3154. We would welcome the opportunity to meet with representatives of the ETF and the GIB to answer any questions or to discuss how our public sector experience and qualifications can benefit the State, the Board and the Plan.

We look forward to the opportunity to expand our work with the State of Wisconsin on this important engagement.

Sincerely,

A handwritten signature in blue ink, consisting of a stylized 'K' followed by a horizontal line and a 'V' with a horizontal line extending to the right.

Kenneth C. Vieira, FSA, FCA, MAAA  
Senior Vice President  
East Region Public Sector Health Market

# Tab 1 - Table of Contents

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## State of Wisconsin Employee Trust Funds Board – Health Care Benefits Consultant Services for Health Insurance Programs – Technical Proposal

RFP# 28154-BD

July 14, 2014 2:00 p.m.

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## Tab 2 - Required Forms

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Segal Consulting has completed and included these forms in our proposal. They are signed by Kenneth C. Vieira, Senior Vice President, who has the authority to bind the firm. The following are included in this tab, as required by the ETF:

- Cover Page
- Signed Request for Proposal Sheet (DOA-3261)
- Designation of Confidential and Proprietary Information (DOA-3027)
- Vendor Information (DOA-3477)
- Vendor References (COA-3478)

## COMPLETED PROPOSER CHECKLIST

REQUEST FOR PROPOSAL (RFP) # 28154-BD

FOR: Wisconsin Department of Employee Trust Funds (ETF) Health Care Benefits Consultant

### PROPOSER CHECKLIST

**Proposer: The Segal Company (Eastern States), Inc.**

Instructions: This form shall be completed by marking the check boxes shown below. By marking these boxes you are acknowledging compliance with these items. Please sign the appropriate forms when submitting your Proposal.

Request for Proposal (DOA-3261)	<input checked="" type="checkbox"/> Have read, completed, and signed.
Vendor Information (DOA-3477)	<input checked="" type="checkbox"/> Have read, completed, and signed.
Vendor References (DOA-3478)	<input checked="" type="checkbox"/> Have read, completed, and signed.
Designation of Confidential and Proprietary Information Form (DOA-3027)	<input checked="" type="checkbox"/> Have read, completed, and signed.
Preparing and Submitting a Proposal RFP Section 2.0	<input checked="" type="checkbox"/> Have read and complied with all requirements.
Proposal Section and Award Process RFP Section 3.0	<input checked="" type="checkbox"/> Have read and understand.
Attachment B: Mandatory Proposal Qualifications RFP Section 4.0	<input checked="" type="checkbox"/> Have read, completed, and complied with response instructions.
Attachment C: Mandatory Requirements Verification RFP Section 5.0	<input checked="" type="checkbox"/> Have read and understand.
General Requirements RFP Section 6.0	<input checked="" type="checkbox"/> Have read and provided a response in the same sequential number as in the RFP.
Technical Requirements RFP Section 7.0	<input checked="" type="checkbox"/> Have read and provided a response in the same sequential number as in the RFP.
Proposer References RFP Section 8.0	<input checked="" type="checkbox"/> Have read and complied with instructions.
Cost RFP Section 9.0	<input checked="" type="checkbox"/> Have read and complied with instructions.
Contractual Terms and Conditions RFP Section 10.0	<input checked="" type="checkbox"/> Have read, understand, and complied with instructions.
Standard Terms and Conditions (DOA-3054)	<input checked="" type="checkbox"/> Have read and understand.
Supplemental Standard Terms and Conditions for Procurement for Services (DOA-3681)	<input checked="" type="checkbox"/> Have read and understand.
Attachment A: Cost Sheet	<input checked="" type="checkbox"/> Have read, completed, and complied with all requirements.

Omission of any of the above may be cause for rejection of your Proposal.

The Segal Company (Eastern States), Inc.

Company

2018 Powers Ferry Road, Suite 850, Atlanta, Georgia 30339-7200

Address



Authorized Signature

7/11/2014

Date

**SIGNED REQUEST FOR PROPOSAL SHEET (DOA-3261)**

**PROPOSALS MUST BE SEALED AND ADDRESSED TO:**

**AGENCY ADDRESS:**

Department of Administration  
Division of Enterprise Operations  
State Bureau of Procurement  
101 East Wilson Street, 6th Floor  
Madison, WI 53703

If using PO Box, P.O. Box 7869, 53707-7869

**REQUEST FOR PROPOSAL  
#28154-BD**

**THIS IS NOT AN ORDER**

PROPOSER (Name and Address)

Proposal envelope must be sealed and plainly marked in lower corner with due date and Request for Proposal # **28154-BD**. Late proposals will be rejected. Proposals MUST be date and time stamped by the soliciting purchasing office on or before the date and time that the proposal is due. Proposals dated and time stamped in another office will be rejected. Receipt of a proposal by the mail system does not constitute receipt of a proposal by the purchasing office. Any proposal which is inadvertently opened as a result of not being properly and clearly marked is subject to rejection. Proposals must be submitted separately, i.e., not included with sample packages or other proposals. Proposal openings are public unless otherwise specified. Records will be available for public inspection after issuance of the notice of intent to award or the award of the contract. Proposer should contact person named below for an appointment to view the proposal record. Proposals shall be firm for acceptance for one hundred eighty (180) days from date of proposal opening, unless otherwise noted. The attached terms and conditions apply to any subsequent award.

Proposals MUST be in this office no later than		No Public Opening
<b>July 14, 2014 2:00 PM CT</b>		
Name (Contact for further information)		
Brenda Derge, <a href="mailto:Brenda.Derge@wisconsin.gov">Brenda.Derge@wisconsin.gov</a>		
Phone	Date	
608-266-8613	May 23, 2014	
Quote Price and Delivery FOB		
Services - Destination		

Description

**Wisconsin Department of Employee Trust Funds (ETF)  
Health Care Benefits Consultant**

Faxed and e-mailed Proposals are not accepted.  
This page must be signed and included with your Proposal.

**Please provide the information listed below.**

- We claim minority bidder preference [Wis. Stats. s. 16.75(3m)].** Under Wisconsin Statutes, a 5% preference may be granted to CERTIFIED Minority Business Enterprises. Bidder must be certified by the Wisconsin Department of Administration. If you have questions concerning the certification process, contact the Wisconsin Department of Administration, 101 E. Wilson St., 6<sup>th</sup> Floor, Madison, Wisconsin 53703, (608) 261-2510. **Does Not Apply to Printing Bids.**
- We claim certified disabled veteran-owned business preference.** Under Wisconsin Statutes, a 5% preference may be granted to CERTIFIED disabled veteran-owned business. Bidder must be certified by the Wisconsin Department of Administration. If you have questions concerning the certification process, contact the Wisconsin Department of Administration, 101 E. Wilson St., 6<sup>th</sup> Floor, Madison, Wisconsin 53703, (608) 261-2510. **Does Not Apply to Printing Bids.**
- We are a work center qualified under Wis. Stats. s. 16.752.** Questions concerning the qualification process should be addressed to the Work Center Program, State Bureau of Procurement, 6th Floor, 101 E. Wilson St., Madison, Wisconsin 53703, (608) 266-2605.

Wis. Stats. s. 16.754 directs the state to purchase materials which are manufactured to the greatest extent in the United States when all other factors are substantially equal. Materials covered in our bid were manufactured in whole or in substantial part within the United States, or the majority of the component parts thereof were manufactured in whole or in substantial part in the United States.

Yes  No  Unknown

In signing this proposal we also certify that we have not, either directly or indirectly, entered into any agreement or participated in any collusion or otherwise taken any action in restraint of free competition; that no attempt has been made to induce any other person or firm to submit or not to submit a proposal; that this proposal has been independently arrived at without collusion with any other proposer, competitor or potential competitor; that this proposal has not been knowingly disclosed prior to the opening of proposals to any other proposer or competitor; that the above statement is accurate under penalty of perjury.

We will comply with all terms, conditions and specifications required by the state in this Request for Proposal and all terms of our proposal.

Name of Authorized Company Representative (Type or Print)  neth C. Vieira	Title  Senior Vice President	Phone ( 678 ) 306-3154
		Fax ( 678 ) 669-1887
Signature of Above 	Date  7/11/2014	E-mail <a href="mailto:kvieira@segalco.com">kvieira@segalco.com</a>

**DESIGNATION OF CONFIDENTIAL AND PROPRIETARY  
INFORMATION (DOA-3027)**



## VENDOR INFORMATION (DOA-3477)

STATE OF WISCONSIN  
 DEPARTMENT OF ADMINISTRATION  
 DIVISION OF ENTERPRISE OPERATIONS  
 BUREAU OF PROCUREMENT  
 S. 16.765, WIS. STATS.  
 DOA-3477 (R01/08)

Wisconsin Department of  
 Employee Trust Funds (ETF)  
 Health Care Benefits

Commodity / Service Consultant

**Vendor Information**

1. BIDDING / PROPOSING COMPANY NAME The Segal Company (Eastern States), Inc.  
 Phone (678) 306-3100 Toll Free Phone (866) 872-6991  
 FAX (678) 669-1887 E-Mail Address kvieira@segalco.com  
 Address 2018 Powers Ferry Road, Suite 850  
 City Atlanta State GA Zip + 4 30339-7200

2. Name the person to contact for questions concerning this bid / proposal.  
 Name Kenneth C. Vieira Title Senior Vice President  
 Phone (678) 306-3154 Toll Free Phone (866) 872-6991  
 FAX (678) 669-1887 E-Mail Address kvieira@segalco.com  
 Address 2018 Powers Ferry Road, Suite 850  
 City Atlanta State GA Zip + 4 30339-7200

Any vendor awarded over \$25,000 on this contract must submit affirmative action information to the department. Please name the Personnel / Human Resource and Development or other person responsible for affirmative action in the company to contact about this plan.  
 3. Name Patrick Knuff Title VP Staffing and HR Planning  
 Phone (212) 251-5410 Toll Free Phone (866) 872-6991  
 FAX (646) 365-3243 E-Mail Address pknuff@segalco.com  
 Address 333 West 34<sup>th</sup> Street  
 City New York State NY Zip + 4 10001-2402

Mailing address to which state purchase orders are mailed and person the department may contact concerning orders and billings.  
 4. Name Betty Wanjiru Title Financial Services Liaison  
 Phone (678) 306-3110 Toll Free Phone (866) 872-6991  
 FAX (678) 669-1887 E-Mail Address ewanjiru@segalco.com  
 Address 2018 Powers Ferry Road, Suite 850  
 City Atlanta State GA Zip + 4 30339-7200

5. CEO / President Name Joseph A. LoCicero

**VENDOR REFERENCE (DOA-3478)**



Bid / Proposal # 28154-BD

**VENDOR REFERENCE**

A handwritten signature in blue ink, appearing to be 'K. J.', written over a horizontal line.

**FOR VENDOR:** The Segal Company (Eastern States), Inc.

Provide company name, address, contact person, telephone number, and appropriate information on the product(s) and/or service(s) used for four (4) or more installations with requirements similar to those included in this solicitation document. If vendor is proposing any arrangement involving a third party, the named references should also be involved in a similar arrangement.

**Company Name** The North Carolina State Health Plan

Address (include Zip + 4) 4509 Creedmoor Road, Suite 201, Raleigh, NC 27612

Contact Person Ms. Mona Moon Phone No. 919-785-5000

Email Address Mona.Moon@nctreasurer.com

List Product(s) and/or Service(s) Used:

Actuarial and General Consulting – comprehensive array of actuarial and consulting services including premium development, financial monitoring, legislative impact, health informatics, data warehousing, risk analysis, EGWP, Part D attestation. Medicare Advantage. data mining. Board Strategy. ROI. pharmacy audits. etc.

**Company Name** Illinois Central Management Services

Address (include Zip + 4) 801 S Seventh, Franklin Complex Fl 6, Springfield, IL 62706

Contact Person Ms. Nancy King Phone No. 217-558-1829

Email Address Nancy.King@Illinois.gov

List Product(s) and/or Service(s) Used:

Actuarial and General Consulting – recent projects include: Procurement of MA Plans with PDP, Actuarial Support, Pharmacy Plan Management, Communication campaign, open enrollment and wellness initiatives, review of financial information and IBNR/reserving methodologies, HMO strategies, Part D attestation, plan design modeling.

**Company Name** Alabama Public Education Employees' Health Insurance Plan

Address (include Zip + 4) P.O. Box 302150, Montgomery, Alabama 36130-2150

Contact Person Ms. Diane Scott Phone No. 334-517-7302

Email Address Diane.scott@rsa-al.gov

List Product(s) and/or Service(s) Used:

Actuarial and General Consulting - analysis of proper funding level for medical and pharmacy programs, plan design cost effectiveness and competitiveness, compliance including PPACA, plan provider negotiations, claim projections twice a year, IBNR calculations, RFPs, MA-PDP feasibility, EGWP support, etc.

**Company Name** Pennsylvania Public School Employees' Retirement System

Address (include Zip + 4) 5 N. Fifth Street, Harrisburg, PA 17108

Contact Person Mr. Mark Schafer Phone No. 717-720-4859

Email Address mschafer@pa.gov

List Product(s) and/or Service(s) Used:

Segal provides ongoing benefit consulting, actuarial communications, claims audit, strategic planning, prescription drug consulting, wellness consulting, competitive bid analysis, Part D, EGWP, compliance review and operational analysis services.

# Tab 3 – Response to Section 4.0 (Attachment B) Mandatory Proposal Qualifications

## *Response to Section 4.0 (Attachment B) Mandatory Proposal Qualifications*

Segal certifies that we meet all mandatory proposal qualifications. We have provided our supporting documentation at the end of this section.

REQUEST FOR PROPOSAL (RFP) # **28154-BD**  
FOR: **Wisconsin Department of Employee Trust Funds (ETF) Health Care Benefits Consultant**

**ATTACHMENT B** Proposer: The Segal Company (Eastern States), Inc.

### MANDATORY PROPOSAL QUALIFICATIONS

The following requirements are mandatory and the Proposer must satisfy them. If the Proposer cannot meet ALL the qualifications, the Proposer will be removed from further consideration or in the event there is an individual mandatory requirement that no Proposer is able to meet, the State reserves the right to eliminate that individual mandatory requirement; in such case, the State shall continue the evaluation of Proposals.

The Proposer **must** respond. Answer each item as to whether the Proposer either can (check “yes”) or cannot (check “no”) meet these mandatory requirements on Attachment B. It is the Proposer’s responsibility to submit any required supporting documentation for a mandatory requirement.

The State reserves the right to clarify a requirement with a blank response or a response that has checked both “YES” and “NO” within the same section.

**MANDATORY REQUIREMENT, RFP Section 4.1**

Pursuant to s. 16.705(1r), Wis. Stats., services must performed within the United States. The inability to perform all services in the United States shall be grounds for disqualifying your Proposal for this contract.

**YES**, we certify that all of the above statement is true. We meet this mandatory qualification.

**NO**, we cannot certify the above statement is true. We cannot meet this mandatory qualification.  
I understand that we will be disqualified and our Proposal will not be considered.

**MANDATORY REQUIREMENT, RFP Section 4.2**

Proposer shall agree that any work products developed as part of the project (e.g. all written reports, drafts, presentation and meeting materials, etc.) shall remain the property of the Department.

**YES**, we certify that all of the above statement is true. We meet this mandatory qualification.

**NO**, we cannot certify the above statement is true. We cannot meet this mandatory qualification.

I understand that we will be disqualified and our Proposal will not be considered.

**MANDATORY REQUIREMENT, RFP Section 4.3**

Proposer has signed and submitted an unedited Wisconsin Health Information Organization (WHIO) Data Use Agreement Contract and Non-Disclosure Agreement. See Appendix A1 and A2. Appendix A2 is signed.

**Required Documentation:**

Proposer submitted a signed and submitted an unedited Wisconsin Health Information Organization (WHIO) Data Use Agreement Contract and Non-Disclosure Agreement. Proposer must return both Appendix A1 and the signed Appendix A2.

**YES**, we certify that all of the above statement is true. We meet this mandatory qualification and have submitted the two signed documents as required for this requirement.

**NO**, we cannot certify the above statement is true. We cannot meet this mandatory qualification.

I understand that we will be disqualified and our Proposal will not be considered.

**MANDATORY REQUIREMENT, RFP Section 4.4**

Proposer will comply with the terms of the ETF Business Associate Agreement. See Appendix B.

**YES**, we certify that all of the above statement is true. We meet this mandatory qualification.

**NO**, we cannot certify the above statement is true. We cannot meet this mandatory qualification.

I understand that we will be disqualified and our Proposal will not be considered.

**MANDATORY REQUIREMENT, RFP Section 4.5**

Proposer must have at least five (5) years of experience in providing health benefits consulting services to one (1) or more customers each with at least 10,000 employee lives.

**YES**, we certify that all of the above statement is true. We meet this mandatory qualification.

**NO**, we cannot certify the above statement is true. We cannot meet this mandatory qualification.

I understand that we will be disqualified and our Proposal will not be considered.

#### **MANDATORY REQUIREMENT, RFP Section 4.6**

Proposer must have client experience working with both public and private sector as a health benefits consultant within the past 10 years.

**Required documentation:**

- Proposer shall state their public and private sector experience as a health benefits consultant within the past 10 years.
- Indicate the name of the customer, note if the experience was public or private, and indicate the years the project was worked on.

**YES**, we certify that all of the above statement is true. We meet this mandatory qualification and have submitted the required documentation.

**NO**, we cannot certify the above statement is true. We cannot meet this mandatory qualification.

I understand that we will be disqualified and our Proposal will not be considered.

#### **Mandatory Requirement Supporting Documentation**

##### **RFP Section 4.3**

We have signed the (WHIO) Data Use Agreement Contract and Non-Disclosure Agreement and have returned both signed copies of Appendix A1 and Appendix A2. These signed documents are found in **Appendix 3**.

##### **RFP Section 4.5 and 4.6**

Segal is a nationwide actuarial and consulting firm that maintains a client base of over 1,000 clients.

We have provided our Top 50 clients that we have worked with over the last ten (10) years, by revenue, for each market – public sector, corporate and multi-employer. We cannot contractually provide all of their names unless cleared by the client. In addition, because our client list is so expansive, we cannot provide contract duration figures. However, if during the finalist evaluation phase ETF would like to see a sample set of years we have worked with a particular client, we will provide that to ETF. We have worked with many of the clients for over 20 years.

The following table shows our Top 50 clients for each market. Most on the public sector list and many of the Multi-Employer and Corporate Client list have over 10,000 lives.

<b>Public Sector</b>	<b>Multi-Employer</b>	<b>Corporate</b>
<ul style="list-style-type: none"> <li>➤ Public School Employee Retirement System</li> <li>North Carolina State Health Plan</li> <li>UCRS</li> <li>➤ City of Detroit Retiree Committee</li> <li>➤ Georgia Municipal Employee Benefit System</li> <li>➤ Large Eastern State*</li> <li>➤ City of Houston</li> <li>➤ State of Colorado</li> <li>➤ State of Delaware</li> <li>➤ PSC CUNY Welfare Fund</li> <li>➤ State Of New Hampshire</li> <li>➤ PERS of Nevada</li> <li>➤ Pennsylvania State University</li> <li>➤ OCERS</li> <li>➤ Illinois Dept Central Mgmt Services</li> <li>➤ North Dakota Public Ees Ret System</li> <li>➤ Montana Unified Schools Trust</li> <li>➤ City of Stockton</li> <li>➤ State of Hawaii</li> <li>➤ University of Missouri</li> <li>➤ Contra Costa CERA</li> <li>➤ City of Boston</li> <li>➤ Los Angeles Unified School District</li> <li>➤ LACERS</li> <li>➤ SDCERA</li> <li>➤ ACERA</li> <li>LAFPPS</li> <li>CAP</li> <li>➤ New Jersey Transit NJT All Plans</li> <li>➤ CTA Retiree Healthcare Trust</li> <li>➤ No Ariz Public Ees Bft Trust</li> <li>➤ State of Alaska</li> <li>➤ City of Chattanooga Pol Fire Ins PF</li> <li>➤ Birmingham Water Works Board</li> <li>➤ Chicago Teachers Pension Fund</li> <li>➤ County of Kern</li> <li>➤ Parochial Employees Retirement</li> <li>➤ City of Jacksonville Retirement System</li> <li>➤ Kansas City Public School Retirement System</li> <li>➤ Salt River Pima Maricopa Indian Comm</li> <li>➤ City of Memphis Retirement System</li> <li>➤ Ohio Teachers Retirement System</li> <li>➤ Sacramento CERS</li> <li>➤ Louisiana School Ees RS</li> <li>➤ County of Sonoma</li> <li>➤ University of Oklahoma</li> <li>➤ NY Virgin Islands Retirement</li> <li>➤ LCG Health Plan</li> <li>➤ Transt Mgmt Se LA Ret Income Pl</li> <li>➤ SBCERA</li> </ul>	<ul style="list-style-type: none"> <li>➤ National Elevator/IUEC</li> <li>➤ Central States SE SW Areas Funds</li> <li>➤ IAM National Pension Fund</li> <li>➤ 73 Sheet Metal Workers PF</li> <li>➤ Boilermaker Blacksmith Natl PT</li> <li>➤ Heartland Health and Wellness Fund</li> <li>➤ No CA H W</li> <li>➤ Bakery Conf Un Ind Intl PF</li> <li>➤ HEREIU Welfare Fund</li> <li>➤ UFCW National Pension Fund</li> <li>➤ Bakery Conf Un Ind Intl Hlth</li> <li>➤ So Cal Food Benefit</li> <li>➤ AFL CIO Staff Retirement Plan</li> <li>➤ NIGPP</li> <li>➤ So Cal Food Pension</li> <li>➤ Chicago Carpenters Pension Fd</li> <li>➤ MM P All Plans</li> <li>➤ SEIU Health Welfare Fund</li> <li>➤ ILWU PMA Pension</li> <li>➤ Allied Pilots Association</li> <li>➤ Southern California Local 831 Employer Pension Plan</li> <li>➤ Sheet Metal Workers National PF</li> <li>➤ Iron Wkrs DC So Ohio Vic PT</li> <li>➤ Rocky Mountain UFCW Health Pl</li> <li>➤ UFCW Midwest Clerks Pension Fund</li> <li>➤ GCC IBT National Pension Fund</li> <li>➤ SEIU Affiliates Offers Ees PF</li> <li>➤ No CA Joint Pension</li> <li>➤ Transit Employees Welfare Plan</li> <li>➤ UA LU Officers Ees Pension Fd</li> <li>➤ Natl Automatic Sprinkler Ind WF</li> <li>➤ Laborers PF Western Canada</li> <li>➤ UAW Strike Fund</li> <li>➤ RWDSU Pension Fund</li> <li>➤ Sheet Metal So Cal Ariz Nev HF</li> <li>➤ IAMAW PP</li> <li>➤ Equity League Pension Fund</li> <li>➤ AFL CIO Welfare Fd Consulting</li> <li>➤ UAW Master Trust</li> <li>➤ California Ironwkr's Field WF</li> <li>➤ National Shopmen Pension Fund</li> <li>➤ Directors Guild of America H WF</li> <li>➤ Boilermakers National H W Plan</li> <li>➤ Southwest Carpenters Pension Trust</li> <li>➤ Paper Ind PACE Union Mgt PF</li> <li>➤ Pipeline Industry PF</li> <li>➤ Chicago Carpenters Welfare Fund</li> <li>➤ Iron Workers Tri State WF</li> <li>➤ Greyhound ATU National Local 1700</li> <li>➤ MILA</li> </ul>	<ul style="list-style-type: none"> <li>➤ L-3 Combined</li> <li>➤ Delta Air Lines Inc</li> <li>➤ National Basketball Association NBA</li> <li>➤ BMW</li> <li>➤ L-3 Communications</li> <li>➤ Schlumberger</li> <li>➤ NFL National Football League</li> <li>➤ Weil Gotshal Manges LLP</li> <li>➤ Cisco Systems Inc</li> <li>➤ Loral Combined</li> <li>➤ Wells Fargo Bank</li> <li>➤ Olin Corporation</li> <li>➤ Lockheed Martin (LMC) Combined</li> <li>➤ National Hockey League</li> <li>➤ Meggitt MABS Salaried</li> <li>➤ Lyondell Chemical Co</li> <li>➤ Chevron Corporation</li> <li>➤ Curian Capital</li> <li>➤ University of Minnesota</li> <li>➤ Nomura Securities Co LTD</li> <li>➤ Scottsdale Healthcare</li> <li>➤ Daiichi Sankyo Inc</li> <li>➤ Community Hospital Pension Plan</li> <li>➤ Physical Optics Corporation</li> <li>➤ Muscular Dystrophy MDA Assoc</li> <li>➤ Central National Gottesman Inc</li> <li>➤ Lincoln Center for Performing Arts</li> <li>➤ Richardson GMP Limited</li> <li>➤ Skidmore College</li> <li>➤ H Charles Price</li> <li>➤ Bashas Inc</li> <li>➤ BNP Paribas</li> <li>➤ Honeywell Inc</li> <li>➤ Reilly Auto Parts</li> <li>➤ Flagstar Bancorp Inc</li> <li>➤ Genuity</li> <li>➤ SKL</li> <li>➤ Raymond James LTD</li> <li>➤ BWXT Pantex</li> <li>➤ American Basketball Association</li> <li>➤ Dana Farber Cancer Institute</li> <li>➤ Alkermes</li> <li>➤ Avnet Inc</li> <li>➤ Greenberg Traurig Loral Parent</li> <li>➤ Macquarie Private Wealth</li> <li>➤ Catholic Medical Center</li> <li>➤ Charlotte Hungerford Hospital</li> <li>➤ Texas Health Resources</li> <li>➤ Wyncote Foundation</li> </ul>
<p>*Cannot be named for contractual purposes</p>		



**WISCONSIN HEALTH INFORMATION ORGANIZATION, INC.**

**DATA ACCESS AGREEMENT  
FOR  
CONTRACTORS  
OF  
WHIO MEMBERS AND SUBSCRIBERS**

Agreement made this \_\_\_ day of \_\_\_\_\_, 20\_\_\_, by and between the Wisconsin Health Information Organization, Inc. (WHIO), the undersigned WHIO Member or Subscriber (Member/Subscriber), and the undersigned contractor of such Member/Subscriber (Contractor).

Whereas, WHIO and Member/Subscriber are parties to the Data Use Agreement dated December 1, 2008, as amended, which governs their use of Data Mart Data (Data); and

Whereas, the Data Use Agreement in Section 6.2 permits Member/Subscriber to provide access to the Data for its contractors to accomplish tasks on its behalf consistent with the terms of the Data Use Agreement, provided that Member/Subscriber obtain, each year, an agreement signed by its contractors acknowledging the limitations imposed on the use of Data and agreeing to abide by such limitations;

Now, therefore, the parties agree as follows:

1. Contractor hereby:

(a) acknowledges that it has read the Data Use Agreement in its current form as provided to it by Member/Subscriber;

(b) agrees that Contractor's use of the Data made available to it by Member/Subscriber is solely for the purpose of helping Member/Subscriber accomplish Member/Subscriber's own tasks and business objectives;

(c) agrees that Contractor may not use the Data for any other purpose; and

(d) agrees that Contractor's use of the Data will be solely as directed by Member/Subscriber and will remain within the limitations imposed upon Member/Subscriber as set forth in the Data Use Agreement.

2. Member/Subscriber hereby:

(a) agrees to provide sufficient oversight and control of Contractor to ensure that Contractor's use of the Data will be within the limitations imposed on Member/Subscriber by the Data Use Agreement;

(b) agrees to provide to Contractor all amendments to the Data Use Agreement within thirty (30) days of their adoption so that Contractor remains informed of its then current obligations;

(c) agrees to require that Contractor re-execute this Data Access Agreement on or prior to the annual anniversary of the date it is first executed as shown above, and provide a copy of the initial and each such re-executed agreement to WHIO for its retention.

3. Member/Subscriber and Contractor agree that this Data Access Agreement is for the benefit of WHIO and all of WHIO's Members and Subscribers, and WHIO may enforce the terms of this agreement as a party hereto.

Executed as of the dated first set forth above.

Member/Subscriber:

Contractor:

\_\_\_\_\_  
Printed Name of Member/Subscriber

\_\_\_\_\_  
Printed Name of Contractor

By \_\_\_\_\_  
Its: \_\_\_\_\_

By  \_\_\_\_\_  
Its: \_\_\_\_\_

Wisconsin Health Information Organization, Inc.

By \_\_\_\_\_  
Its: \_\_\_\_\_



A handwritten signature in blue ink, appearing to be "L. J. ...".

**WISCONSIN HEALTH INFORMATION ORGANIZATION, INC.**

**DATA USE AGREEMENT**

**As of January 20, 2014**

Agreement

In consideration of their mutual promises set forth herein, the Parties agree to the following terms.

1. Defined Terms. The capitalized words in this Agreement shall have the following meanings, unless otherwise expressly defined herein:
  - 1.1 Confidential Information means proprietary information and intellectual property, such as trade secrets, business plans, designs, drawings, specifications, computer programs, support materials, or other records concerning a business entity's finances, contracts, services or personnel; information concerning a business entity's clients; information a business entity desires to protect against unrestricted disclosure or competitive use; information designated as confidential by a party; or individually identifiable health information as defined at 45 CFR § 160.103. None of these listed items are Confidential Information if releasable upon request under public records law at Wis. Stats § 19.31, et. seq.
  - 1.2 Customer Data means health care data provided by, or obtained on behalf of, WHIO, a Participating Entity, and other data sources pursuant to the Master Agreement.
  - 1.3 Data Mart means the Impact Intelligence data mart created by OptumInsight, formerly known as Ingenix, for WHIO as part of the System, which includes a patient de-identified copy of Customer Data received from WHIO, the Participating Entities, and other data sources that has been aggregated by OptumInsight, and which meets the specifications and has the attributes and capabilities set forth in the Master Agreement.
  - 1.4 Data Mart Data means data held in the Data Mart.
  - 1.5 De-identified Data means Patient-identifiable Data that has been de-identified in accordance with 45 CFR § 164.514 of the Privacy Rule promulgated under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), as amended from time to time.
  - 1.6 DHS means the Wisconsin Department of Health Services.

- 1.7 Effective Date means the date of this Agreement set forth on the first line above.
- 1.8 ETF means the Wisconsin Department of Employee Trust Funds.
- 1.9 Extracted Data means Data extracted from the Impact Intelligence Data Mart or a physical copy of the Data Mart.
- 1.10 Impact Intelligence Software means the software of OptumInsight that is provided to WHIO pursuant to the Master Agreement.
- 1.11 Ingenix means Ingenix, Inc. now OptumInsight, Inc.
- 1.12 Joinder Agreements means those agreements executed by Ingenix or OptumInsight and Participating Entities pursuant to which each such Participating Entity becomes a party to the Master Agreement.
- 1.13 Master Agreement means the Master Services and License Agreement and the Data Aggregation, Data Analysis, and Reporting Services Product Schedule, both entered into by WHIO and Ingenix on March 31, 2008.
- 1.14 Patient Charter is the Consumer-Purchaser Disclosure Project's Patient Charter for Physician Performance Measurement, Reporting and Tiering Programs: Ensuring Transparency, Fairness and Independent Review, dated April 1, 2008.
- 1.15 Patient-identifiable Data means any data element that if displayed alone or in combination with other patient-identifiable data elements would reveal a patient's identity to the recipient or viewer of the data. For information submitted by insurers/administrators to WHIO and/or its subcontractors, patient-identifiable data includes but is not limited to the following data elements: name, address, telephone number, medical record/chart number; control number; date of birth; date of admission and discharge; date of principal procedure; encrypted case identifier; Medicaid resubmission code; Medicaid prior authorization number; whether condition is related to employment, and occurrence and place of auto accident or other accident; date of first symptom of current illness, injury, or pregnancy; first date of same/similar illness; dates unable to work in current occupation; dates of receipt of medical services; patient's city, village or town. It does not include calculated variables.
- 1.16 Participating Entities shall mean those entities that have signed a Joinder Agreement (except DHS and ETF). DHS and ETF have the obligations, rights, and benefits of Participating Entities even though they have not signed the Joinder Agreement.
- 1.17 Party means WHIO, each of the undersigned Participating Entities, ETF, or DHS as the context requires, and Parties means all of the undersigned entities collectively.

- 1.18 Reporting System means the Impact Intelligence software user interface and reporting tool.
- 1.19 Services mean all consulting, training, research, data management, support, maintenance, reporting and other services WHIO obtains from OptumInsight pursuant to the Master Agreement.
- 1.20 Software means all computer software programs WHIO obtains from OptumInsight pursuant to the Master Agreement, including the Impact Intelligence Software, all updates and revisions to such software, and all documentation provided with such computer software programs.
- 1.21 Standard Reports means Template Reports in the "Buck E. Badger" formats provided by the Impact Intelligence Reporting System.
- 1.22 State means ETF and DHS collectively.
- 1.23 State Agreement means the agreement between WHIO, ETF and DHS under which WHIO provides to ETF and DHS access to the Data Mart and the Software and Services it receives from OptumInsight.
- 1.24 Summary Level Analytical Results means reports, other than Template Reports generated using the Impact Intelligence Reporting System.
- 1.25 System means the Software and Services operating together that are provided to WHIO by OptumInsight pursuant to the Master Agreement.
- 1.26 Template Report means a standardized report created by macros written by OptumInsight.
- 1.27 WHIO means the Wisconsin Health Information Organization, Inc.
2. Limitations on Reporting.
  - 2.1 All public reporting at the individual physician level published by WHIO will comply with the Patient Charter.
3. Transparency. Each report created with Data Mart Data that contains performance measures will include the following disclosures, either within the report or with a link within the report to a web site containing them, or other reasonable means:
  - 3.1 The physicians, practices, specialties and/or geography included in each measure;
  - 3.2 The specifications used to calculate each measure;
  - 3.3 The method used to attribute patients to physicians or practice groups for each measure;

- 3.4 The minimum number of observations used for assessment of the performance of physicians and practice groups for each measure;
- 3.5 The confidence interval and/or reliability, as applicable, of each measure;
- 3.6 The definition of the peer group used for comparison for each measure;
- 3.7 The risk adjustment methodology used for each measure;
- 3.8 The method of identifying and handling outlier cases for each measure; and
- 3.9 The known limitations inherent in the data set for each measure.

4. Performance Measures. The Parties agree to use appropriate statistical testing methods with respect to performance measures and analytics using the Data Mart Data consistent with the goal of reporting information that is meaningful. This will be accomplished through the following provisions:

- 4.1 Each Party will use nationally recognized, industry standard and/or endorsed performance measures, except as otherwise permitted in Section 4.3 below.
- 4.2 Each Party will use only those quality measures that rely on a minimum of 30 observations and a minimum confidence interval of 90% or a measure reliability of at least 0.70, unless the creator of the measure recommends a different number of observations and minimum confidence interval or a different reliability threshold or other parameters, in which case WHIO shall use what is recommended by the creator of the measure. WHIO will use only those cost/efficiency measures that have a minimum confidence interval of 90% or a measure reliability of at least 0.70, unless the creator of the measure recommends a different number of observations and minimum confidence interval or a different reliability threshold or other parameters, in which case WHIO shall use what is recommended by the creator of the measure.
- 4.3 All Parties will endeavor to abide by the guidelines in Section 4.1 and 4.2, but may generate reports that include other methodologies that deviate from these guidelines, provided that the reports are accompanied by an understandable disclosure of the data and methodology used in the report.
- 4.4 Measures on cost or resource utilization for a physician or practice group will use all reasonably available patient data attributed to that physician or practice group. When comparing data contained in the Impact Intelligence Data Mart and/or Reporting System to data derived elsewhere, the Parties should make commercially reasonable efforts to align the populations being compared.
- 4.5 Reports containing measures on clinical conditions (without regard to physician or physician group) will use all reasonably available data for the clinical condition with the exception of outlier information.

- 4.6 Each Party agrees to report both cost and quality measures together wherever reasonably possible.
- 4.7 WHIO will give priority to measures that have both a cost and quality component. Where a cost/utilization measure exists without a corresponding quality measure, WHIO will work proactively with other organizations to develop and publish a corresponding quality measure.
- 4.8 Each Party may engage a qualified outside third party to audit from time to time such Party's use of performance measures to assure its compliance with provisions set forth in this Section 4.
- 4.9 On the Effective Date of this Agreement, the Parties have determined by action of the WHIO Board of Directors, and have so directed OptumInsight in the project plan of the Master Agreement, that the Data Mart Data will not include amounts actually paid to providers, whether called "allowed amounts" or "negotiated charges" or some other terminology. The Parties agree they will not hereafter change this decision to include in the Data Mart amounts actually paid to providers unless and until the WHIO Board of Directors has fully debated the issue, received advice of counsel on the antitrust and other legal issues associated with such decision, and then duly approved by resolution, following such debate and advice of counsel, to include amounts actually paid to providers in the Data Mart.
5. Extracted Data. With respect to data extracted from the Impact Intelligence Data Mart or a physical copy of the Data Mart:
- 5.1 No Participating Entity may sell or distribute Extracted Data except to those of its customers, members, or providers if (and only to the extent) necessary to justify report outputs, and then only if such Extracted Data is distributed in a form that cannot be manipulated and will be collected and/or destroyed immediately following such use; and
- 5.2 Any Participating Entity that receives a physical copy of the Data Mart may share access to the physical copy with and/or provide Extracted Data to other Participating Entities that are authorized by WHIO to receive a physical copy of the Data Mart but choose not to. The Participating Entity may recover a fair share of the costs from the other Participating Entities to which they provide this access and/or data extracts; and
- 5.3 Each Party may share Extracted Data with its independent contractors and agents to accomplish tasks on its behalf consistent with the terms of this Agreement; and
- 5.4 DHS and ETF may distribute Extracted Data only as expressly permitted in the State Agreement.

6. Reports. Reports may be shared by the Parties as follows: Should any Party other than WHIO charge a fee for an action taken under this Section 6, WHIO shall be compensated in accordance with a fee schedule approved by the Board. This fee schedule may be obtained from WHIO.
- 6.1 Each Participating Entity may share Standard Reports, Summary Level Analytical Results, or other information derived from the Data Mart Data and/or Extracted Data with its customers, agents, members, and other similar business stakeholders so long as that sharing does not violate any applicable laws;
- 6.2 ETF and DHS, either directly or through WHIO, may publish or otherwise distribute to the public Standard Reports, Summary Level Analytical Results, or other information derived from the Data Mart Data pursuant to the terms of the State Agreement and as ETF, DHS and WHIO may otherwise agree. This Section 6.2 is not intended to limit WHIO's ability to share Standard Reports or other information with the public to that which is required by the State Agreement, nor to require ETF and/or DHS agreement prior to WHIO sharing information with the public;
- 6.3 Each Party may share Standard Reports, Summary Level Analytical Results, or other information derived from the Data Mart Data and/or Extracted Data with any physician, practice group, or other health care provider or facility to help them improve clinical services and/or outcomes;
- 6.4 Each Participating Entity may share analytical outputs and summary reports beyond the Standard Reports generated by the Impact Intelligence Reporting System for their business purposes, but only if such outputs contain summary-level data. The intention of this Section 6.4 is that only WHIO (and to a limited extent ETF and DHS as set forth in Section 6.5 below) may be the source of such outputs and reports containing detail data that can be manipulated, to give WHIO the opportunity to derive revenue from the same; and
- 6.5 WHIO may share analytical outputs and summary reports beyond the Standard Reports generated by the Impact Intelligence Reporting System in a form by which the data they contain may be manipulated by the recipients, pursuant to the business plan of WHIO. In addition, ETF and DHS also may share analytical outputs and summary reports beyond the Standard Reports generated by the Impact Intelligence Reporting System in a form by which the data they contain may be manipulated by the recipients, but only with local health departments and as otherwise necessary to meet their statutory responsibilities and public missions.
- 6.6 Notwithstanding any other provision in this Agreement, if an organization has been approached by WHIO to join WHIO as a Participating Entity and has refused, the Parties may not share with that organization without charge<sup>1</sup>, any

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<sup>1</sup> According to the terms of the Fee Schedule approved by the WHIO Board

Standard Reports, Summary Level Analytical Results, or other information derived from the Data Mart Data that either:

- (a) has application for any purpose other than quality and/or efficiency improvement, or
- (b) is a report that the Party would typically charge a fee to produce.

Examples of this type of information include, but are not limited to, market share analysis, referral pattern analysis, detailed clinical analysis, and competitive cost benchmarking. This Section 6.6 does not apply to reports WHIO makes available to the general public or to requests made to substantiate information contained in reports made available to the general public.

This Section 6.6 also applies to entities that (i) have an equity interest in, (ii) are owned in-part or in-total by, or (iii) are under common ownership with the above-described organizations.

7. Disputes. Disputes regarding any Party's violation of the terms of this Agreement will be settled under the Grievance Policy and Procedure of WHIO, which is set forth on Attachment A to this Agreement. Notwithstanding the foregoing, neither ETF nor DHS shall be bound by any dispute resolution that materially impedes their ability to meet their statutory responsibilities and public missions.
8. Prerequisite to Access to Data Mart. The Parties agree that no Party may have access to the Impact Intelligence Data Mart or Reporting System, unless such Party has executed this Agreement, and is in continuous compliance with the terms of this Agreement.
9. Required Reviews Annually. The Parties agree to review this Agreement every twelve (12) months, and revise it as necessary to assure alignment with changing market conditions and emerging national standards and for such other reasons as the Parties may determine.
10. Amendments and Revisions. This Agreement may be amended and revisions adopted upon the affirmative vote of two-thirds (2/3) of the WHIO Directors then in office. Each Party agrees to be bound by each amendment and revision so adopted even if its representative on the WHIO Board of Directors did not cast an affirmative vote for such amendment or revision, except as provided in the final sentence of this Section 10. Each such amendment and revision shall become effective upon the approval of the WHIO Board of Directors by the required vote noted above, without further action by any Party to this Agreement. Notwithstanding the foregoing, neither ETF nor DHS shall be bound by any amendment or revision that materially impedes their ability to meet their statutory responsibilities and public missions.
  - Amendment Record:
    1. Section 7. Reports (now Section 6) Amended April 23rd, 2009
    2. Amended December 15, 2011.
    3. Amended January 23, 2014.

## Attachment A

### Wisconsin Health Information Organization

#### Grievance Policy and Procedure

##### Section 1. Definitions

"Grievance" means a dispute between WHIO and a Participating Entity of WHIO and/or ETF and/or DHS, or between two or more such entities, regarding the application of the WHIO Data Use Agreement (DUA), the use of WHIO data, or the publication of results produced using the WHIO data set.

"Party" means: i) a person or entity who has filed a Grievance (referred to herein as the "Grievant"); or ii) a person or entity against whom a Grievance is filed (referred to herein as the "Respondent"). Together the Grievant and Respondent are the "Parties".

##### Section 2. Right to be Represented

Each WHIO Participating Entity, ETF and DHS who is a Party to a Grievance has the right to be represented by an attorney, but is not required to have one. If a Party chooses to be represented by an attorney, all communications should be with the attorney. An attorney's letter of retention is sufficient documentation for purposes of establishing the attorney's appearance on behalf of a Party.

##### Section 3. Grievance Procedure

All Grievances will be adjudicated by means of the following Grievance Procedure.

###### A. Initiating a Grievance

A WHIO Participating Entity, ETF, or DHS who believes that WHIO or another WHIO Member, ETF, or DHS has violated the DUA may file a written Grievance with WHIO within thirty (30) days of the Grievant first learning of the action or event giving rise to the Grievance. The Grievance may be submitted in any form, but must include the following information:

- i. The Grievant's name, address and telephone number and the name of the person authorized to represent the Grievant in the Grievance procedure.
- ii. The name and address of the Respondent.
- iii. A brief explanation of the issue in dispute, including the DUA provision allegedly violated, the manner in which it was allegedly violated, and the date and manner in which the Grievant first learned of the alleged violation.

iv. Details of steps previously taken by the Grievant to resolve the dispute between the Parties

v. Any other information thought to be relevant, such as dates and events, in chronological order.

vi. Copies of any documents that relate to the Grievance.

vii. What the Grievant believes would be a fair resolution of the Grievance.

**B. Acknowledging the Grievance and Notifying the Respondent**

1. The Grievance file. Within 10 business days of receipt of a Grievance, WHIO will log the Grievance, create a Grievance file that contains information relating to the Grievance, and:

i. Incomplete Grievance. If the Grievance does not contain the elements specified in Section 3.A., contact the Grievant by letter or email, explaining why the Grievance cannot be accepted and what must be done to correct the deficiency;

ii. Untimely Grievance. If the Grievance is untimely, return the Grievance to the Grievant with a letter explaining that the Grievance is untimely and will not be accepted; or

iii. Acknowledgement of Grievance. If the Grievance is timely and contains all of the required elements, acknowledge receipt of the Grievance in writing:

- a. by sending the Respondent a copy of the Grievance and other documents submitted by the Grievant (if WHIO is the Respondent, the letter and materials shall be sent to WHIO's Chief Executive Officer); and, by sending an acknowledgement letter to both Parties informing them of WHIO's requirement that the Parties attempt to resolve their dispute informally before the Grievance will be submitted to a WHIO Grievance Committee (the "Committee"); and,
- b. notifying the Parties that the Grievance will be presented to the Committee for resolution only if a Party notifies WHIO within thirty (30) days from the date of the acknowledgement letter that the Parties have met and have been unable to resolve their dispute informally. (If the Parties are working on an informal resolution as the thirty (30) day period is reaching an end, WHIO will postpone presenting the Grievance to the Committee upon the mutual request of the Parties, as they continue to work on an informal resolution.)

### C. Informal Dispute Resolution

1. The Grievant and Respondent shall meet, telephonically or in person, and discuss the Grievance, seeking a mutually acceptable solution to the dispute before the Grievance is presented to the Committee for resolution. Upon the request of the Parties, WHIO's Chief Executive Officer will participate in meetings with the Parties and attempt to help them reach an informal resolution of the Grievance.

2. If the Parties reach a settlement of their dispute, they shall sign an agreement (a "settlement agreement" or "stipulation") and notify WHIO in writing, setting forth the terms of the settlement. Upon receipt of the agreement, WHIO will dismiss the Grievance.

3. If the Parties are unable to reach an informal resolution of the Grievance within thirty (30) days from the date of the acknowledgement letter, or within such longer time period that the Parties mutually agree to work towards an informal resolution of the Grievance, and one of the Parties notifies WHIO that their efforts at informal resolution have failed, the Grievance shall be handled according to the formal Grievance Procedure described below.

### D. Review and Recommendation of the Grievance Committee

If the Parties notify WHIO within thirty (30) days of the date of the acknowledgement letter or within such longer time period that the Parties mutually agree to work towards an informal resolution, that they have met and failed to reach an informal resolution of the Grievance, WHIO will handle the Grievance as follows:

1. The WHIO Data Use Policy Committee will convene a multi-stakeholder ad hoc Committee of no less than three and no more than five members of the WHIO Board, consisting of one Provider, one Payer and one Purchaser, and, optionally, the State of Wisconsin and a Consumer representative. All WHIO Board Members, except those involved in the dispute, shall be presumptively eligible to serve on the Committee. The Committee will designate one of its members to chair the Committee, promptly investigate and evaluate the Grievance, and develop a recommended resolution for the WHIO Board.

2. WHIO will contact the Respondent by letter and request a written answer to the Grievance within ten (10) days from Respondent's receipt of the letter.

3. WHIO will send a letter to both of the Parties notifying them:

i. that the Grievance will be reviewed by the Committee and that the Committee will prepare a recommended resolution for the WHIO Board;

ii. that each Party has a right to know the other Party's evidence and that each Party must furnish the other Party with a copy of all written information submitted to WHIO concerning the Grievance;

iii. that the Grievant must provide WHIO and the Respondent any supplemental documents or written statements that the Grievant desires the Committee to review within ten (10) days from the date of the letter and that the Respondent must provide any supplemental

documents or written statements to WHIO and the Grievant within twenty (20) days from the date of the letter.

4. WHIO will send a copy of the Grievance, the Respondent's answer, and all supplemental documents and written statements submitted by the Parties to each member of the Committee no less than seven (7) days prior to the meeting at which the Committee will review the Grievance. The Committee will review the information submitted and will render and communicate its recommendation to the Chief Executive Officer in writing within 15 days of receiving the information.

#### E. Formal Resolution by the WHIO Board

1. The Chief Executive Officer will promptly share the Committee's written recommendation with the Parties after receipt of the recommendation from the Committee; notify the Parties in writing of the time and place at which the WHIO Board will consider the Committee's recommendation; and, inform the Parties of their right to appear before the Board to present oral information concerning the Grievance and to answer any questions that the Board may have.

2. The Chief Executive Officer will submit the Grievance and all other documents and written information concerning the Grievance submitted by the Parties together with the Committee's recommendation to the WHIO Board of Directors, and schedule the Grievance to be reviewed by the Board at its next meeting, provided that the material is received by the Board members at least five (5) business days prior to the meeting. If the information cannot be provided to the Board at least five (5) business days prior to the next Board meeting, the Grievance will be scheduled for the following Board meeting.

3. At the meeting during which the Board reviews the Grievance, the Parties will each be given up to fifteen (15) minutes to address the Board with representatives of their choice and members of the Board may ask the Parties any questions they may have. Following the Parties presentations, they will be excused from the meeting and the Board will make a final determination on the disposition of the Grievance and any further action to be taken.

#### Section 4. Judicial Review

WHIO and its Participating Entities and ETF and DHS shall make every effort to resolve Grievances in a manner satisfactory to WHIO and each of the Parties. However, nothing in this Grievance Procedure precludes an aggrieved Party from seeking injunctive relief for disputes in a court of competent jurisdiction or from bringing an action at law or in equity appealing a WHIO Board decision.

# Tab 4 – Mandatory Requirements Verification (Attachment C) of Section 5.0

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REQUEST FOR PROPOSAL (RFP) # 28154-BD  
FOR: Wisconsin Department of Employee Trust Funds (ETF) Health Care Benefits  
Consultant

## ATTACHMENT C

Proposer: The Segal Company (Eastern States), Inc.

### MANDATORY REQUIREMENTS VERIFICATION

Proposer must indicate response by checking either “YES” or “NO” box for each question. Failure to check “YES” box for each question may disqualify your proposal.

Proposer acknowledges by checking that Section 5.0, Mandatory Contract Performance Requirements, can be met as listed in the RFP document. Conditions that include the word “must” or “shall” describe a mandatory requirement.

**YES**, we certify that all of the above statement is true. We can meet the mandatory requirements in RFP, Section 5.0.

**NO**, we cannot certify the above statement is true. We cannot meet the mandatory requirements in RFP Section 5.0. I understand that we will be disqualified and our Proposal will not be considered.

# Tab 5 – Responses to Section 6.0 General Requirements

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*The purpose of this section is to provide the State with a basis for determining a Proposer's capability to undertake this Contract. Be specific when answering the following questions. Proposers shall concisely answer each question thoroughly.*

*Proposer shall restate the number, question, and then provide your response. Proposal responses shall be in the same sequential number as in the RFP.*

**6.1** *Describe your understanding of the scope of work described in this RFP and include an outline of proposed steps and timeline for executing the tasks and deliverables. Describe your strategy and practices for controlling the costs of this Contract and adhering to Contract schedules. Actual rates or discussing your cost must not be submitted within the response to this question.*

## **Understanding of the Scope of Work**

### **Program Structure**

Segal understands that the State of Wisconsin administers retirement, health, life, income continuation, disability, and other insurance programs for over 570,000 state and local government employees and annuitants. Of these, approximately 240,000 participate in the health insurance program. The Employee Trust Fund's (ETF) Division of Insurance Services administers the state employee health insurance program. The Group Insurance Board (GIB) sets policy and oversees administration of the group health, life insurance, and income continuation insurance plans for state employees and retirees and the group health and life insurance plans for local employers who choose to offer them. We also understand that the Board can provide other insurance plans, if employees pay the entire premium.

The State administers a three-tier system for plans and employee contributions. Most plans are offered in Tier 1 but there are Tier 2 and Tier 3 options. The State also administers a small self-insured offering through the "Standard Plan" and "State Maintenance Plan". The majority of the health insurance benefits are administered through 18 competing, fully insured health plans. Health insurance benefits follow a "uniform benefit" design, in that all participating health plans are offering the same benefits package. Pharmacy benefits are self-insured and are carved out from the medical benefit plans.

Even though ETF has been successful over the last few years with their health benefits program, the State still seeks a partner who can help them with health care challenges and solutions and will continue to improve the State's health benefits program. ETF also seeks a consultant, who will work with the ETF to support and re-design, if necessary, a competitive benefits package and procure the vendors and carriers who can best support the State's benefits program.

We understand this is a new initiative of the GIB Strategic Planning Workgroup. This RFP has been distributed because the workgroup members expresses interest in procuring the services of

a benefits consultant to assist with data analysis and plan design development for the state employee health insurance program.

The primary objective of ETF is to analyze data from a variety of sources to develop and recommend strategies to improve health outcomes and increase the efficient delivery of quality health care to participants in the state employee health insurance program.

## **Segal's Approach to Wisconsin's Employee Trust Fund Scope of Services**

We understand this is a new initiative of the GIB Strategic Planning Workgroup. This RFP has been distributed because the workgroup members expresses interest in procuring the services of a benefits consultant to assist with data analysis and plan design development for the state employee health insurance program.

After the contract is awarded, Segal will work with ETF to ensure a smooth implementation. We will help ETF focus on the current program's performance in order to maintain and develop a long-term plan to ensure the program remain sustainable for the foreseeable future. During the Kick-Off meeting held at the end of July we will immediately undertake a comprehensive review of the current benefits. We will do much of this work to support our Actuarial Contract as well. This review will include:

- Summary of current and prospective benefits, including disease management and wellness;
- Collection of all benefit plan financial data;
- A review of claims and utilization versus premiums paid; and
- Review of the three tiered plan system and the self-insured offering through the Standard Plan and the State Maintenance Plan. We will compare these plans in comparison to other "like" plans of comparable size.

This review will identify underutilized benefits and uncover opportunities to negotiate lower premiums on behalf of ETF and its members. It will enable the State to remain an employer of choice and provide the most competitive benefits package possible that maximizes quality and value, while remaining compliant with current and upcoming laws, regulations, and mandates. This also will support any long-term strategic plan focus for the insurance programs operating under the GIB. Segal will work with the ETF to ensure the Strategic Insurance Initiatives are met. These include the following goals:

- Maximize Quality and Value;
- Contain Costs;
- Improve Health and Wellness;
- Engage and Educate our Members and Employers;
- Deliver Benefits that Enable Public Employers to Attract and Retain a Quality Workforce, and;
- Model Administrative Innovation.

We estimate that this kick-off meeting will not be as comprehensive as our typical kick-off meetings. In July, Segal will begin its review of all the above documents for the ETF as part of our actuarial services contract. We anticipate by the time this contract is awarded and implemented we will be thoroughly knowledgeable in the ETF program. This kick-off meeting

will be used more as a strategy session and learning detailed specifics of the Strategic Insurance Initiative goals and what the ETF is looking for in the priority program areas that support the goals of the GIB and ETF insurance initiatives.

The result of this initial review will be a list of strategic recommendations and considerations for ETF regarding the types of benefits offered, the level of benefits offered and the number of options provided to employees. Particular attention will be paid to the plan design strategies and priority issue areas surrounding the following benefits:

- Data and Measurement / Data Warehousing
- Tiering, Steerage Models, Reference Pricing, Centers of Excellence
- Prevention / Wellness / Disease Management / Chronic Care
- Shared Decision Making
- Pharmacy and Specialty Pharmacy
- Member Education / Communication / Engagement
- Consumer Driven Health Care Design
- Affordable Care Act Impacts
- Benefits and Challenges of Insured vs. Self-insured Models

Already, the current products offered provide the same level of choice that we see offered by similar organizations but there may be additional or more optimal products that will maximize the ETF benefits program.

Through our experience with other state level clients, Segal does possess the following desirable capabilities:

- experience with large, public sector employers,
- ability to analyze the Wisconsin Health Information Organization (WHIO) data,
- ability to integrate and analyze data from multiple sources,
- knowledge of the Wisconsin healthcare/insurance landscape,
- knowledge of successful strategies used by other large employers, and
- auditing capabilities.

**Maximizing member value and choice, while enhancing your member' understanding of their benefits, is paramount.**

## **Project Deliverables**

Segal has reviewed, understands and will provide the following services to the Employee Trust Fund of the State of Wisconsin:

- Within 6 months of the beginning of the contract, Segal will provide a documented report ("Report 1") and a presentation to the Board (February 2015) outlining potential benefit design changes and strategies for the 2016 plan year.
- Within 12 months of the beginning of the contract, Segal will provide a documented report ("Report 2") and a presentation to the Board (November 2015) outlining potential benefit design changes and strategies for the 2017 plan year

These deliverables will include, as a minimum, the following ETF priority state employee health insurance program areas:

- Data Analytics / Measurement
- Steerage Models: Tiering, Reference Pricing, Centers of Excellence
- Prevention / Wellness
- Disease Management / Chronic Care
- Shared Decision Making
- Pharmacy and Specialty Pharmacy
- Consumer Driven Health Care Design
- Insured vs. Self-insured Plan Design
- Multi-year Contracting
- Depression / Behavioral Health

**Segal Consulting is the most qualified consulting firm to provide the above project deliverables and meet the technical requirements as mentioned in Section 7.0.**

## **Project Work Plan**

Segal proposes the following work plan as a starting point for discussion with ETF. We note that this is a complex engagement that requires careful attention to a number of different areas of inquiry being reviewed simultaneously. We also understand that while ETF desires to work broadly to analyze a number of changes to current policy that will result in program and benefit changes when implemented, the program is ongoing and the magnitude of impact of wholesale changes will be felt across many employment groups.

Based on the Request for Proposals, Segal has identified the following key areas for review and analysis:

- Data analytics and data warehousing needs
- Program structure and vendor array
- How Wisconsin ETF's programs compare to others in the marketplace
- ETF's standard benefit design and its competitiveness in the health insurance marketplace
- Health intervention and cost containment programs
- ETF's program financial and risk structure

Our proposed work plan focuses efforts around these key components of a successful statewide benefits program.

The study anticipates two major reports. The first report will include findings and recommendations intended to support implementation for the 2016 benefit year, while the second report will identify and develop additional changes and new initiatives targeted for the 2017 benefit year. It is our belief that the initial study will surface many potential improvements and changes that will need to be winnowed down to a reasonable number for implementation in 2016, with additional programs as well as further enhancement of existing programs targeted for 2017 implementation. Our work plan anticipates that reality by placing much of the initial feasibility into the early months of the engagement, with the ability to then discuss and prioritize the timing for each of the elements. This approach, we believe, will allow ETF to gain a broad

picture of the current and developing health benefits marketplace, while still offering the ability to make changes at a reasonable pace both for the plan members and for ETF.

The following table outlines more specific steps and analytical components anticipated for each major area of review delineated by the major topic areas identified above. We believe these topic areas will allow the project to proceed smoothly while interlacing the findings and recommendations across the entire program. We have assigned general timing to each of the identified task areas, subject certainly to discussions with ETF to stage the project along your timetable. Segal will be glad to discuss each of these recommended tasks to help assure that they meet ETF's needs while offering a significant opportunity to make major structural changes to the current system in an orderly manner.

<b>Proposed Project Plan</b>	
Deliverable	Date
<b>Initial Project Activities and Project Management</b>	
Contract Effective Date	September 2, 2014
Kick-off meeting with ETF	September 5, 2014
WHIO Data Dictionary Received	October 2, 2014
ETF Database Crosswalk Received	October 2, 2014
Initial meetings: WHIO MCOs Interested parties (e.g., unions, carriers)	September 2014
Bi-weekly face to face meetings	Biweekly as scheduled
Semi-monthly written status reports	15 <sup>th</sup> and last day of each month
Update presentation to Board	November 18, 2014
Update presentation to Board (present Report 1 draft)	February, 2015
Deliver Report 1 to ETF (6 months after contract date)	February 27, 2015
2016 Open Enrollment Materials Finalized	September 1, 2015
Deliver Report 2 to ETF (12 months after contract date)	September 2, 2015
Update presentation to Board (present Report 2)	November, 2015
Additional special reports (status presentation, page vendor, RFP related reports, etc)	As scheduled

## Proposed Project Plan

Deliverable	Date
<b>Review Data Analytics and Data Warehouse Needs</b>	
WHIO Data Dictionary Received	October 2, 2014
ETF Database Crosswalk Received	October 2, 2014
Initial meeting with WHIO regarding data	October 2014
Work with ETF to identify the current capabilities of the WHIO Data Mart and other available databases	September-October 2014
Review all current and planned functions in use by ETF regarding member eligibility, enrollment, claims and risk data	October 2014
Identify current best practice employer health plan data warehouse and data mining usage and reporting	October 2014
Survey data warehouse marketplace to identify potential vendors that could support the desired complexity and business functions	October-November 2014
Develop best practice business needs document including identification of general and specific ETF needs with timing of needed implementation.	November-December 2014
Develop working draft set of data warehouse reports and functions desired, including reports needed to satisfy state and other plan requirements	December 2014 – January 2015
Recommend structure and best practice criteria for data warehouse, including amounts and types of data to collect and retain, retention longevity, etc.	January 2015
Develop a report of observations, findings and recommendations regarding data warehouse functions for ETF, including both external and internal solutions as well as hybrid solutions involving combinations of internal and external sources	January 2015
Discuss draft findings and recommendations on data analytics with ETF and prioritize key objectives for a data warehouse solution	February 2015
Recommend structure and best practice criteria for data warehouse, including amounts and types of data to collect and retain, retention longevity, etc.	February 2015
Incorporate findings, observations and recommendations into Report 1	February 2015
Develop target list of required and desired services and features for a contracted database provider	March 2015
Prepare additional data analytic reports	April-June 2015
Review clinical profile of group	April-June 2015
Look for opportunities in program	July-August 2015
Incorporate findings, recommendations and bid results into Report 2	September 2015
<b>Review Program Structure and Vendor Array</b>	
Review program design for regional managed care offerings	October 2014
Identify program penetration within managed care marketplace	October-November 2014
Analyze network availability through current structure	October-November 2014
Gather information on other best practice structures for a statewide benefits system taking into account managed care vendors	October-November 2014

## Proposed Project Plan

Deliverable	Date
Evaluate effectiveness of current structure in achieving stated goals and in meeting employee and retiree needs	November 2014
Analyze how the current program structure assigns claims risk across available managed care organizations	November 2014
Develop first cut program design alternatives for 2016 and 2017 (staged where necessary)	December 2014
Identify additional networks capable of absorbing state population	December 2014 – January 2015
Review three-tier system for plan rating and employee contributions and recommend changes to reset the structure for more control over participating vendors	January 2015
Incorporate findings and recommendations into Report 1 for 2016 implementation and into draft for Report 2 for 2017 implementation.	February 2015
<b>Benchmark Wisconsin Health Benefits Marketplace</b>	
Identify and assess available providers / services, including at least: State insurance marketplaces Private exchanges Primary health benefit insurers Primary third party administrators	September – October 2014
Identify and benchmark primary health plan populations and current health benefit program structures for those groups, including: State employees Municipal employees Collectively bargained employees Early retirees not eligible for Medicare Medicare-eligible retirees	September-November 2014
Compare Wisconsin ETF to other similar states for: Overall plan structure Benefit designs offered Costs Value based benefit design features Retiree health strategy Quality promotion and measurement	October-November 2014
Meet with ETF to discuss findings and observations and to identify key areas for future development and change	November 2014
Develop work plans for agreed future development areas	November 2014 – January 2015
Incorporate findings and recommendations into Report 1 for 2016 implementation and draft Report 2 for 2017 implementation	February 2014

<b>Review ETF Benefit Design</b>	
Review ETF standard plan design	September 2014
Gather information on plan designs recommended by participating managed care vendors for their own greatest success if they had no required overall plan of benefits to provide	September-October 2014
Identify relative value of current standard plan design compared to alternative designs	October 2014
Identify changes or additional options to help contain program cost and encourage more appropriate utilization	October-November 2014
Assess current ACA plan compliance status and identify benefit design changes required or suggested for continued ACA compliance	October-November 2014
Review Consumer Driven Health Plan design and operation for feasibility of building and expanding.	October-November 2014
Develop recommendations for changes to benefit features for 2016 and 2017	December 2014
Incorporate findings and recommendations into Report 1 for 2016 and outline of Report 2 for 2017 implementation	January-February 2015
<b>Review ETF Health Intervention and Cost Containment Programs</b>	
Gather and review information on intervention program and cost containment components currently in place, including disease management and chronic care, depression/mental health.	September-October 2014
Review feasibility of implementing/expanding Centers of Excellence program	October-December 2014
Review feasibility of implementing wellness and prevention programs	October-December 2014
Review pharmacy and specialty pharmacy benefits and operation for ETF members	October-December 2014
Review feasibility of onsite clinics	October-December 2014
Review feasibility of expanding or modifying disease management initiatives to best fit program design	October-December 2014
Array findings for discussion with ETF	January 2015
Incorporate findings and recommendations into Report 1 for 2016 implementation and draft Report 2 for 2017 implementation, and map recommended changes	February 2015

<b>Review ETF Program Financial and Risk Structure</b>	
Review current ETF program financial structure, including overall design, high level flow of contributions and reconciliations, payment of contractors and claims, etc.	October 2014
Review advantages and disadvantages of self-insuring the health benefit plan compared to the current primarily fully insured arrangements	October 2014
Assess reserve policy for self-funded arrangements	October 2014
Review current three-tier managed care organization pricing structure to identify reasons most carriers are ranked at the top level and to look at potential alternatives for ETF consideration	October-November 2014
Review the financial feasibility of using reference pricing benefit designs	October-December 2014

Review current managed care contracting rules and procedures and identify advantages and disadvantages of multi-year contracting	October-November 2014
Compare discounts available in the market to current program discounts and cost levels using billed and paid claims amounts from current contracts	November-December 2014
Meet with ETF to discuss initial findings and recommendations and to identify and prioritize key items for implementation	January 2015
Incorporate findings and recommendations into Report 1 for 2016 and outline of Report 2 for 2017 implementation	February 2015
<b>Develop Recommendations and Prepare Report 1 for 2016 Benefits</b>	
Assemble observations and findings and develop recommendations. Report to present strategies for at least the following: <ul style="list-style-type: none"> <li>• plan design recommendations</li> <li>• data warehousing design</li> <li>• quality improvement initiatives</li> <li>• cost containment strategies</li> <li>• targeted population interventions</li> <li>• identification of trends and utilization patterns</li> <li>• employee/member engagement and communication</li> <li>• process improvements</li> <li>• aligning efforts with other large purchasers</li> </ul>	January-February 2015
Draft Report incorporating observations, findings and recommendations	January-February 2015
Deliver Draft Report 1 to ETF for Review	February 2015
Discussion with ETF on Open Questions	February 2015
ETF Feedback on Draft Report	February 2015
Deliver Final Report 1 to ETF	February 14, 2015
Board Presentation of Report 1 Results	February 20, 2015
<b>Review Changes Accepted for 2016 Implementation and Identify Additional Progressive Changes for 2017</b>	
Meet with ETF staff to prioritize open structural, program, plan design, quality and financial questions and issues from initial report that have been identified for implementation and development for 2017	March 2015
Review changes decided for 2016 implementation and identify specific additional changes to be discussed for 2017 implementation	March-May 2015
Develop work plans for identified priority items targeted for program implementation in 2017	May 2015

<b>Develop Recommendations and Prepare Report 2 for 2017 Benefits</b>	
Recap outcomes of recommendations in Report 1 and assess next steps for continued changes for 2017	April 2015
Assemble observations and findings and develop recommendations. Report 2 will present at least the following strategies: <ul style="list-style-type: none"> <li>➤ plan design recommendations</li> <li>➤ data warehousing design</li> <li>➤ quality improvement initiatives</li> <li>➤ cost containment strategies</li> <li>➤ targeted population interventions</li> <li>➤ identification of trends and utilization patterns</li> <li>➤ employee/member engagement and communication</li> <li>➤ process improvements</li> <li>➤ aligning efforts with other large purchasers</li> </ul>	May-July 2015
Draft report incorporating observations, findings and recommendations	August-September 2015
Deliver draft Report 2 to ETF for review	October 2015
Discussion with ETF on open questions	October 2015
ETF feedback on draft report	October 2015
Deliver final Report 2 to ETF	October 2015
Board presentation of Report 2 results	November 2015
<b>Continued Assistance to ETF in Implementing Approved Changes **</b>	
Meet with ETF to recap changes approved for 2017	November 2015
Develop work plans as required to implement agreed changes	November-December 2015
Assist ETF in bid processes and negotiations to contract identified services	January-May 2016
Review and monitor implementation success and set up ongoing vendor review and reporting meetings	May 2016 – January 2017

\*\* Note that these are not included in the scope of work requested in the RFP but we cannot stress enough that ETF should plan accordingly for this impending implementation.

Due to the size, length and complexity of this proposed engagement, there is a need for strong project management across the tasks and activities. Segal will work with ETF to assert enough ongoing project management to help bring the work through to completion on time and within budget. However, we are also aware that review and restructuring projects of this type can take unexpected directions, particularly when conducted in a public environment. We will be prepared to adjust quickly and smoothly to changes that emerge during the course of the project, to help ETF stay on the agreed track.

*Describe your strategy and practices for controlling the costs of this Contract and adhering to Contract schedules. Actual rates or discussing your cost must not be submitted within the response to this question.*

## **ETF Contract Quality and Cost Control**

Client satisfaction based on the delivery of high quality, client-focused consulting services is the backbone of our business. We place a premium value on our relationships with clients. Segal's commitment is evidenced by the loyalty of our clients, many of whom have maintained long-standing relationships with us spanning over 50 years.

Our approach to account management and client satisfaction is proactive—to understand client business issues and anticipate client needs, rather than react to them. We believe this focus on the client's issues helps us manage our time and efforts efficiently to keep projects within budget and on time. We also believe that our extensive quality review processes and practices help reduce the opportunity for mistakes to occur without detection and correction at their earliest emergence. This section describes how we approach helping our clients control consulting costs through careful project and team management and through concentration on the quality of our work.

### **Project Cost Control**

Segal is experienced in working with large public sector clients under fixed and/or capped project budgets. We have developed a number of techniques that help us manage our clients' resources through careful management of our professional resources combined with thorough assessment of progress and thoughtful handling of obstacles. We outline a number of these techniques as follows:

- **Establishing Clear Objectives.** The starting point for managing project cost is to have a clear definition of project objectives, tasks and deliverables, both at the outset of the project and revisited as scope changes become necessary or as unforeseen obstacles arise. We begin each project with open discussion with our client of the tasks, deadlines and formats for deliverables, as well as understanding of our clients' internal processes and approval requirements.
- **Proper Staffing.** Controlling the cost of professional services starts with assigning the most appropriate level of staff with the experience to complete the task at hand. This approach helps to ensure that the work is being performed at the lowest cost to the client while still meeting our quality control procedures. The client leader and key consultants and actuaries work closely with our practice leaders to identify the best staffing for each engagement to meet both the experience and the timing needs within the engagement.
- **Team Communications.** Segal makes a point of keeping our entire project team apprised of the current status and developing issues and questions. This policy helps the professionals working for a client to be familiar with developments that might affect their particular portion of the project. It also encourages active contributions by team members with fresh perspectives.

- **Frequent and Flexible Client Contact.** Segal’s consultants make a point of staying closely in touch with the client throughout a developing project. We have found that working with our clients as if we are part of their staff helps us avoid dead ends and unnecessary analytical work, and helps to control costs rather than increase costs. Also, by having an ongoing forum for discussion of project and program issues, we can help deal with emerging issues while they are fresh.
- **Effective Project Communication Tools.** We provide our consultants and actuaries with a suite of state of the art project communication tools to help encourage close and frequent contact with clients. Our “meet me there” teleconferencing is a valuable way to have specialists in multiple office locations collaborate with clients quickly. Segal conducts many client conference calls that are scheduled immediately when the issue arises. We also make frequent use of both WebEx and Lync online meeting and desktop sharing platforms, external secure websites for common storage and availability of pertinent files needed by all on the project, and secure file transfer for moving sensitive data smoothly between Segal and our clients. We work closely with each client to identify the tools that will be most effective to the specific needs.
- **Sophisticated Time Management System.** Segal manages time records online with a client time tracking system that provides full details of the work each person does on the project. Our time system is linked directly to our billing and invoicing systems to allow up to date monitoring of work in progress and billing on the agreed cycle. The client manager and lead consultants have real-time access to these systems to manage staff utilization. We also have significant flexibility in our billing formats and we monitor and report the project-to-date costs against the agreed budgets. Our time system allows us to set up separate matters within the client relationship so we can easily track time on more specifically identified tasks.
- **Client Manager Depth.** In addition to all the tools and processes in place to help manage client cost, Segal also believes strongly in assigning at least two experienced senior practitioners to each client engagement. This policy helps to develop cost and work efficiency by creating a broader pool of knowledge for each client’s toughest issues, where two senior consultants are much more likely to have had experience with a given question. This policy also helps assure that each client has built in continuity of senior professionals with distinct knowledge of their programs.

## Maintaining Quality

Segal pays close attention to the quality of our work on every project and engagement. The following programs help us maintain high quality output and therefore help keep our clients’ costs down:

- **Work Product Quality Assurance.** Reports, memoranda and letters on complex or technical matters are prepared by an experienced team member and reviewed by the senior consultant who is an expert in the area addressed by the material. This person ordinarily is one who has enough experience and judgment not only to grasp the substantive matter being discussed, but also to understand the nuances that might have unique application to a particular client’s circumstance or need. In doing so, he or she tries to be the "perfect client" who asks every difficult question.

- **Team Consulting.** Through the client service team, we make quality review checks an organic feature of the consulting process. Meetings, significant phone calls, and other contacts with the client are documented in file memoranda that are shared with the team. In the course of keeping one another informed about client developments, the team members go through an automatic quality-review procedure.
- **Early Warning System.** Each office and region has an early warning system to identify and address potential difficulties and anomalies as they emerge and before they become problematic.
- **Company-wide Standards and Training.** By setting and enforcing uniform national professional standards, and by company-wide training programs that equip our staff to achieve those standards, we stress consistency and quality in the delivery of services.
- **Client Satisfaction Surveys.** Detailed satisfaction interviews are conducted periodically by senior managers not involved with the clients' work. Results are shared with the team and needed changes incorporated into our work processes.
- **Relationship Management.** Segal realizes that each project's success depends on the team supporting the project. Therefore, we focus on involving the appropriate mix of technical and resource staff in each project to develop achievable solutions.
- **Software.** To maintain accuracy and quality, actuarial software is developed and tested nationally. The same software is used in all valuations.
- **Audits.** Our offices that provide actuarial and health analytical work for clients are audited each year to assure compliance with quality standards. Non-compliance may have a direct impact on the compensation of the employees in that office.
- **Mandatory Peer Review of Actuarial Reports and Client Correspondence.** Segal has separate, detailed quality control standards that require a 3-stage review process for all technical actuarial work.

We have learned through experience that our clients look to the principal consultants to help provide historical and business perspective on changes being contemplated. Segal's commitment is to involve our best technical specialists in each client project, while maintaining clear account management through seasoned professionals who are directly involved in the day-to-day benefit consulting and actuarial work.

## ***6.2 Identify obstacles your company has experienced with similar projects, and describe your approach to managing them.***

To be honest and fully transparent, we see no issues or insurmountable challenges in working with ETF. We have staffed your account accordingly and have consultants, clinicians and actuaries allocated to your account and ready to begin work once we are awarded the business. Our experience cited throughout should make you feel comfortable that we can work effectively with large sophisticated organizations such as ETF. Segal has already begun an onboarding process with ETF that will allow us to hit the ground running in September. Consistent with our other contract award, Segal will spend a significant amount of time and expense getting up to speed prior to the contract start date. This is our investment in your account.

With the above in mind, we believe there are a number of challenges or “obstacles” we will collectively face as we go through this project. We have outlined a few below:

- **Client Commitment** – In many instances, these types of strategic redesign projects evolve from another constituency than the one responsible. There may be a directive from the governor’s office, legislative branch, union leadership, etc. A likely outcome of such a significant project will change the healthcare landscape in the State. In order to make it successful, all parties involved need to be committed to its’ success. As you will see from our response to 6.1, a key step is to have meetings with appropriate leadership and give everyone a voice in the process. We understand the competing agendas and do an excellent job in gaining consensus and coming to logical, supportable, market and data driven recommendations. Being upfront and transparent in our approach will help all parties feel comfortable with the process and gain commitment.
- **Timing** – As demonstrated in our work plan, there is a lot of work to be completed in a short time period. Starting in September and presenting the first report in February effectively makes the first 6-month report be closer to a 5-month report, maybe even 4-months if award is delayed. Segal will commit the necessary resources to meet the accelerated final schedule. It is likely that substantial changes to the plan design will need to take place for 2017, with minor ones in 2016. For 2016, we will recommend actionable steps that can take the plan in the strategic direction.
- **Implementation** – We mention timing of the project above, but an even more important time constraint is the implementation schedule that will be required to execute the strategy. Depending on the recommendations and ETF approvals, there will be a number of cascading interdependent events. There would likely be new vendor procurements to support the plan designs, massive employee and marketplace communications efforts to ensure success, possible medical management vendor meetings with interested parties, etc. With the 12-month report delivered in August-2015 and Board Presentation the following November, a rapid chain of events will need to happen to get everything in place by 2017. With the 2017 open enrollment in October 2016, there is a practical deadline of early September 2016. Our team understands how to make it happen and implement the recommendations. We will support ETF throughout this process.

- **Lack of Evidence** – There have been a number of studies on wellness, disease management and quality, all with different conclusions. We have cataloged these various studies and their conclusion, compiling our recommendation and observations as well. We will need to demonstrate what we believe to be the opportunity cost and will apply the logic of the most relevant report (good or bad). In some instances, the emerging data is premature or non-existent. Our role will be to provide ETF and the Board supporting documentation for each recommendation. In some cases this may be theoretical vs. factual, but will still be the best available information.
- **Data Validity** – The WHIO data warehouse maintains data for the majority of your members. Segal will utilize this information and validate as best we can with plan financial information. As we do some statewide benchmarking with this information, we will have to rely on the data for the other 4 million members. If the data results are suspect, we will work with WHIO to smooth out anomalies and plug holes but many key assumptions will need to be made. Our data analytics team is familiar with this kind of situation.
- **Data Availability** – There is some uncertainty as to what data will be available to the consultant in addition to the WHIO data, self-reported HMO reports, enrollment data and pharmacy claims data from your PBM. In our initial meetings we will assess the various data sources and look for gaps or holes. We will likely need to pull from our client database for a number of project sub-components.
- **Political Environment** – This could likely be more of a challenge vs. an obstacle. It is important to understand all the stakeholders and their agendas. We will need to develop and understanding of the structuring of your organization and how each group fits together. We anticipate some initial holes or gaps in our knowledge and understanding. We will look to close these holes prior to the contract start date to avoid any unnecessary transition problems.

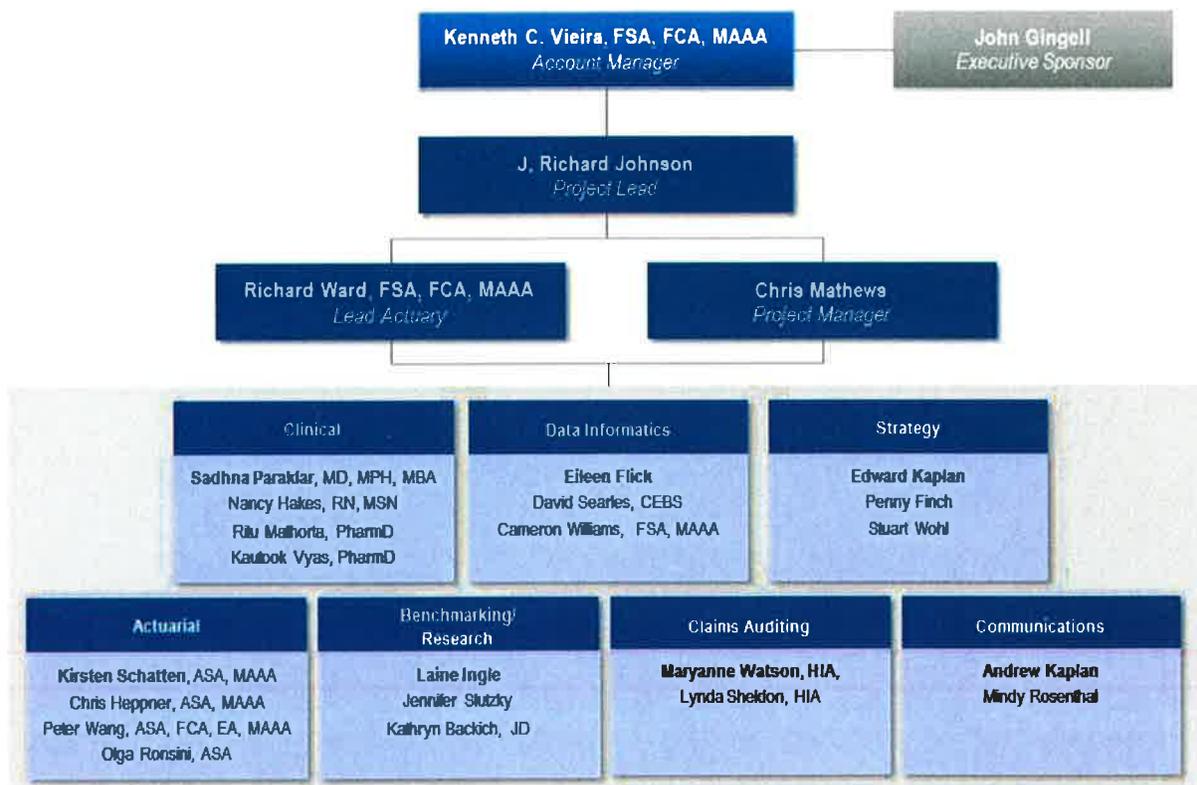
Each state has their own nuances and structure, which makes our job a challenge. Our experience with other state-level plans will enable us to quickly develop the organizational understanding required to effectively serve ETF. Implementing our project work plan will enable us to mitigate the challenges we listed above. Having weekly status calls will be necessary to keep the entire project on track. Segal will make this project successful.

**6.3 Provide an organizational chart that identifies key personnel from your company who will be assigned to this project, and appropriate staff for issue escalation to resolve problems between ETF and the Contractor. For each staff person, attach a resume and brief description of experience with a project similar to that described in this RFP.**

Segal has assigned an account team that will bring to this engagement extensive experience with state health plans and public sector entities. We understand the importance of having our top technical and consulting specialists knowledgeable with ETF’s benefit structure and programs and on call to allow rapid response to developing needs.

This is a challenging assignment, which we believe requires specialized knowledge and skill sets to complement our actuarial team. With that in mind, our highly qualified team consists of healthcare consultants, actuaries, subject matter experts, data specialists, lawyers and clinicians. All were assigned to the team with a public sector focus in mind. The team will be staffed primarily out of the Atlanta, Chicago office and will be supported, as needed, by our Regional and National Healthcare Practitioners.

Below is a summary of our proposed ETF account team and the lines of authority and escalation on your account:



Members of the team have worked with many large state and higher education institutions in the Midwest, most recently including the Illinois Central Management Services – Bureau of Benefits, State of Michigan, State of Colorado, State of Minnesota, State of Wisconsin, University of Oklahoma, State of Ohio, and South and North Dakota. Your senior team also serves a number of other large eastern and southern states, including the North Carolina State Health Plan, Alabama Public Education Employees Health Insurance Plan, Illinois Central Management Services, State of Wisconsin, Georgia Department of Community Health – State Health Benefit Plan, Pennsylvania Public School Employees’ Retirement System – Health Options Program, the State of Delaware, the State of New Hampshire, Large Eastern State (cannot be named), and the Texas Group Benefit Plan for State Employees.

Key members of your proposed ETF team are summarized on the following pages, highlighting their expertise and role on your account only.

## **ETF Management Team**

Your senior management team is composed of Ken Vieira, J. Richard Johnson, Richard Ward and Chris Mathews. They will be responsible for the bulk of your consulting work and have the following roles:

### **Account Manager**

**Kenneth (Ken) C. Vieira, FSA, FCA, MAAA** is a Senior Vice President in our Atlanta office and will serve as ETF Account Manager. Ken is Segal’s East Region Public Sector Market Leader and supports state level assignments in the Midwest. Ken has a broad range of experience in the design, administration and funding of public employee and retiree benefit plans. He has been working with public employers for over 20 years. His experience includes the development and ongoing management of benefits strategies to maximize their financial and operational performance.

Below is brief summary of Ken’s clients over the last few years and his primary role:

- North Carolina State Health Plan – Account Manager and/or Lead Actuary: 1995-present
- Illinois Department of Central Management Services – Account Manager: 2013-present
- Alabama Public Education Employees Health Insurance Plan - Account Manager: 2013-present
- Georgia Department of Community Health – Account Manager and Lead Actuary for the State Health Benefit Plan and the State Medicaid Agency: 2005-2012
- Bureau of TennCare – Account Manager and Lead Actuary: 2005-2012
- Kentucky Employees Health Plan – Account Manager: 2011-2012
- Tennessee Benefits Administration – Account Manager and Lead Actuary: 2007-2009
- Minnesota Department of Human Services – Account Manager and Lead Actuary: 2012-2013

Many of the services the ETF is requesting are performed for the above-mentioned State clients which Ken has/is managing. More specifically, Ken helped develop long-term strategic plans in North Carolina and Tennessee (both used as part of our sample reports).

Ken has long-term experience with managing large State engagements. Ken joined Segal two years ago with a focus of expanding and growing the public sector. With his prior employer, Ken led project teams for the States of Georgia, North Carolina, Tennessee and the Commonwealth of Kentucky, with membership levels ranging from 250,000 to 675,000. While at Segal, he has managed teams in North Carolina, Alabama, and Illinois and supported a number of other states. Ken is also the Account Manager and Supervisory Actuary for the ETF Consulting Actuarial Contract recently awarded to Segal. Ken brings a substantial amount of practical experience to the project, combining the knowledge of an experienced consultant with the technical expertise of a seasoned chief actuary. He has been working with public employers for more than 20 years. Ken is committed to the State of Wisconsin's health plans and the success of this engagement.

Ken will be responsible for the completion of each service component and deliverable of all work under the scope of this RFP. Ken will also have final sign off on any deliverable and report.

## **Project Lead**

**J. Richard (Rick) Johnson**, Segal's Public Sector Health Practice Leader will serve as the overall Project Lead. Rick brings extensive consulting and analytical experience in working with large public sector organizations with over 100,000 eligible lives, including several states and the federal government. He will provide senior-level guidance and review on all key project deliverables and be available to the Plan for strategic consulting.

Rick consults with a number of states on their health benefits and voluntary benefits programs. Over the past 35 years he has worked with dozens of programs and is a recognized industry leader, frequently asked to speak and co-present at numerous public sector conferences, covering a range of topics. Rick has particular expertise in developing total benefits strategy, managing complex vendor engagements and developing innovative solutions. He has implemented the original flexible benefit programs for a number of large clients, including the Commonwealth of Virginia and the U.S. Office of Personnel Management. His current and recent other clients include the Pennsylvania Public School Employees' Retirement System Health Options Program, the North Carolina State Health Plan, the University of Virginia, and Virginia Tech. He has served as the Account Manager for Segal's engagement with the State Health Plan since 2010.

Producing strategic plans is one of Rick's specialties, having recently completed the State of North Carolina and PSERS. Many of the services the ETF is requesting are performed for the above-mentioned State clients that Rick manages.

With Ken and Rick managing your project, ETF can be assured that all your needs and expectations will be met. They currently work together on the State Health Plan in North Carolina, one of Segal's largest accounts. Both have extensive experience managing large engagements, specifically in the public sector environment.

## Lead Actuary

**Richard Ward, FSA, FCA, MAAA** is a Senior Vice President & Atlanta Health Practice Leader in our Atlanta office and will serve as the Lead Actuary. Richard is also a Fellow of the Society of Actuaries, a Fellow in the Conference of Consulting Actuaries and a Member of the American Academy of Actuaries.

Richard is a Senior Vice President in our Atlanta office. He is a fully credentialed health actuary and serves as our Atlanta Health Practice Leader. Richard has a broad range of experience in the design, administration and funding of public employee and retiree benefit plans. He has been working with public employers since 1995. His experience includes development of employee and retiree contribution strategies, price tags and credits for flexible benefit plans, implementation and ongoing management of “consumer” health plans, retiree health strategies and the implementation and ongoing management of innovative health management strategies.

He is dedicated to serving the public sector and leads, or has led, client teams in serving, The Texas State Employees’ Group Benefits Program, State of Tennessee Public Plans, The City of Atlanta, the Georgia State Health Benefit Plan, Alabama Public Education Employees’ Health Insurance Plan, and Illinois Central Management Services.

Mr. Ward is devoted to serving the public sector and serves on Segal’s National Public Sector Leadership Group. He is a recognized thought leader in the public sector benefits arena and is a regular invited speaker by organizations such as the State and Local Government Benefits Association and the National Public Sector Health Care Round Table.

Richard will support all the actuarial work that will be necessary under each task. More specifically, Ken, Richard and Rick have worked with the same state level clients on reference pricing, tiering, insured vs/ self-insured plan design, and multi-year contracting, Centers for Excellence, in addition to many other areas of health care program management and operation.

## Project Manager

**Chris Mathews** is a Vice President in our Washington DC office and is our Total Health Management Practice Leader. Chris will serve as the Project Manager for ETF. He works with a variety of clients and leads our consulting team’s work on the North Carolina State Health Plan, having recently developed a strategic Ten-Year Plan with a focus on integrating medical management programs into the Plan’s overall benefit design. One of his key skills is performing analysis on ROI for various vendor medical management programs. He has been consulting with public employers for more than 10 years and he has 30-plus years in total employee benefits consulting experience. His current clients include the Pennsylvania Public School Employees’ Retirement System Health Options Program, the North Carolina State Health Plan, and the State of Delaware.

Many of the services the ETF is requesting are performed for the above-mentioned State clients, in which Chris provides total health management services. Chris has also provided strategic support and project management support with consumer driven health care design, prevention/wellness, disease management and chronic care.

## Executive Sponsor

**John Gingell** will serve as Executive Sponsor. John is a Senior Vice President and the Midwest Regional Manager. John is responsible for all accounts in his region. John will not bill time or work on your account, but he will make sure your needs are met and the projects have appropriate staffing. Over the course of our engagement John will privately meet with your senior team to discuss Segal's performance. These formalized meetings present a good platform for clients to provide feedback about our team and address any service issues, if any. In addition to our scheduled meeting, John will be available to discuss your account as needed.

As Segal's Midwest Regional leader, John is responsible for overseeing Segal's clients in the Chicago, Cleveland, Minneapolis and Detroit offices. Mr. Gingell is a member of Segal's Multiemployer Leadership Group, and has previously served as Head of the Cleveland office. John has over 25 years of experience within the healthcare industry. Many of the services the ETF is requesting are performed for Midwest state leave clients, in which John helps to oversee and provide executive sponsor support.

## Issue Escalation to Resolve Problems

We have provided great details of each member of your senior management team. All five are officers of the company and collectively strive to deliver the best consulting service to our clients. We have assigned a company Senior Vice President - in the ETFs case **Kenneth C. Vieira**, who is also your Account Manager. His responsibilities include making sure ETF is being properly serviced and that all issues are escalated by the proper channels and they are resolved quickly and efficiently.

Ken regularly meets with the Segal ETF Management Team (Project Lead, Lead Actuary and Project Manager) and will pull in the Executive Sponsor, John Gingell, when necessary. John has the power to resolve any problems that may exist and alter your management team if desired. Ken and/or John are available to meet with the ETF at your request. Our clients find that these open lines of communications manage expectations well. Our goal is make sure are 100% satisfied with Segal and we forge a long-term partnership.

## Senior Consulting Team

### Strategy

**Ed Kaplan** is the National Health Practice Leader based in our New York office. He will serve as a lead Health Strategies, providing national thought leadership. He will also be instrumental in managing the data analytics component of the report. Ed has worked with managed care programs since 1986, with special emphasis on pricing and plan design strategies for managed medical, dental, and prescription drug programs. He works with national and local corporations, governments, and collectively bargained plans. In 1996, Mr. Kaplan created the Segal *Health Plan Trend Cost Survey*, now a standard in the industry, and client appreciation and use of the survey has contributed to Segal's national reputation as a leader in prescription drug plan benefit consulting and pharmacy benefits management consulting.

**Penny Finch** is a Benefits Consultant in our Chicago, Illinois office. Penny will support Chris & Rick and be heavily involved in the day-to-day project management. She will serve our core strategy team in a role similar to what she does for the State of Illinois. Her past experience as the Chief Operating Officer of a large local government, Illinois-based pension & health fund, as an account executive with a prescription benefit manager and as a consultant gives, her unique qualifications to coordinate the State's needs and Segal capabilities.

Penny has 16 years of experience in the healthcare industry. Three of Penny's clients are the Illinois Central Management Services, a large multiemployer plan (cannot be named for contractual reasons), and the Chicago Transit Authority.

**Stuart Wohl**, is a Senior Vice President and East Region Health Practice Leader. He has been working with large public sector clients since he joined Segal in 1988. He will be an additional public sector practice resource for Ken, Rick and the team. Currently, he works with the State of New Hampshire, the New Mexico Retiree Health Care Authority, the North Carolina State Health Benefit Program, State of Delaware, and the Pennsylvania Public School Employees' Retirement System Health Options Program. He is responsible for Segal's Health work in the region and will provide senior level peer review on key project deliverables. He has over 20 years benefit consulting experience and serves as the National Retiree Health Practice Leader.

Many of the services the ETF is requesting are performed for the above mentioned State clients, in which Ed, Penny and Stuart provide expert health strategy support, shared decision making, multi-year contracting, reference pricing, Centers of Excellence, tiering, and insured vs. self-insured plan design.

### *Clinical*

A key component of our team that cannot be undervalued is our multi-talented wellness & clinical team. This team can meet a variety of needs for ETF:

**Sadhna Paralkar, MD, MPH, MBA** is our Medical Director and is in San Francisco. Dr. Paralkar's areas of expertise include health care informatics, medical management program design, clinical operations, benefit plan design and network management strategies to optimize health improvement while containing costs, and evaluation and implementation of disease management and wellness programs based on evidence based medicine (EBM) protocols.

Sadhna provides clinical support in various capacities for the North Carolina State Health Plan, Large Eastern State (cannot be named) and the City of Chicago. Additionally, for North Carolina, she has worked on the health management and vendor performance guarantees, as well as supported the wellness redesign.

Many of the services the ETF is requesting are performed for the above-mentioned State clients, in which Sadhna provides expertise on health care informatics, medical management program design, clinical operations, benefit plan design and network management strategies.

**Nancy R. Hakes, RN, MSN** is a Vice President and Health Care Benefits Consultant in Segal's Phoenix office. She is the Company's technical expert on operational issues regarding managed care. Ms. Hakes provides detailed research on specific health care issues pertinent to medical coverage, plan design, and quality of care, including disability; workers' compensation; wellness

and associated incentive programs; EAP and behavioral health; prescription drugs; disease management; telephonic nurse triage programs; and utilization management. She is skilled in analyzing the effectiveness of health care delivery systems that guide managed care organizations. Ms. Hakes leads the development and maintenance of a proprietary Segal program, Q-ValSM, which allows plan sponsors to assess the extent to which managed care organizations (such as PPOs, POS and HMO plans) oversee and assure the delivery of quality health care to their plan participants. Nancy's role with clients, similar to ETF, is to support Sadhna with operational issues regarding managed care.

Both Sadhna and Nancy have shared experience with state level clients where they worked on prevention/wellness, disease management and chronic care service issues.

**Ritu Malhotra, PharmD** is a Vice President, is Segal's Pharmacy Director and is in our Chicago office. Dr. Malhotra provides clinical consulting, analysis, support and strategic direction for clients nationally. She has extensive experience with the integration of clinical expertise in multiple managed care settings. Ritu will be responsible for any pharmacy project for ETF.

Ritu is the lead Pharmacy consultant on the following cases and manages the pharmacy program for these clients – Public School Employees Retirement System (PA), Alabama Public Education Employees Health Insurance, and Illinois Central Management Services.

Many of the services the ETF is requesting are performed for the above-mentioned State clients, in which Ritu provides clinical consulting, analysis and pharmacy and specialty pharmacy support.

**Kautook Vyas, PharmD** is a Clinical Pharmacy Consultant in Segal's Chicago office. He is a member of Segal's National Pharmacy Consulting practice and assists clients in optimizing benefit design and drug mix. He provides consulting services that incorporate the latest best-practice guidelines for clinical pharmacy. Dr. Vyas is a national resource for the firm and has experience working with a wide variety of plan sponsors and Pharmacy Benefit Managers.

Kautook works closely with Ritu on Alabama Public Education Employees Health Insurance Plan and Illinois Central Management Services. He also works on WisconsinRx/National Cooperative Rx. For this client his responsibilities include PBM bid procurements and general consulting. He provides additional support on pharmacy audits and market assessments.

### *Data Informatics*

**Eileen Flick.** Eileen is a Vice President in our New York office and serves as our National Data Analytics Leader. She will direct the data mining and predictive modeling efforts for the Segal Team. Eileen has extensive knowledge of data analytics systems and network analysis. She will lead a multi-talented data analytics team that can meet a variety of needs for the State. The team will provide detail reporting and analysis in support of financial projections and calculation of the ROI on wellness and care management programs. They will work effectively with ETF data warehouse to provide the most comprehensive and meaningful reporting available.

Eileen manages all the data reporting and ad hoc requests for the North Carolina State Health Plan, Large Eastern State (cannot be named) and the Public School Employees Retirement System (PA) . For North Carolina, she also provides annual clinical risk grouper analysis.

Many of the services the ETF is requesting are performed for the above-mentioned State clients, in which Eileen directs the data mining and predictive modeling effort and provides network analysis.

**David Searles, CEBS.** Mr. Searles is a Vice President and Health Analytics Consultant in Segal's New York office with over 20 years of experience working with health technology systems. He serves as the project leader for several key health practice initiative, including Segal's medical data mining and pricing tools and analytics. Mr. Searles works with clients to provide technical assistance for network discount analysis, pricing, wellness and disease management program effectiveness, and plan design analysis. Mr. Searles will support Eileen on various data analytic projects.

Many of the services the ETF is requesting are performed for the above-mentioned State clients, in which David provides assistance with network discount analysis, pricing, wellness and disease management program effectiveness.

**Cameron Williams, FSA, MAAA** is a Health Actuary in Segal's Chicago office. Mr. Williams' responsibilities have included pricing medical and prescription drug benefits, preparing health plan financial projections and conducting retrospective analysis of prescription drug claims. Mr. Williams currently supports Segal's National Pharmacy Benefits Practice through multiple projects, including prescription drug claim audits.

Cameron provided financial actuarial support to North Carolina State Health Plan, Large Eastern State (cannot be named), State of Delaware, State of Michigan, University of Oklahoma, Purdue University, and the Chicago Teachers Pension Fund. Cameron provides budget projections, rating strategies, reserves, healthcare reform modeling and HMO renewal. In addition, for Purdue, he did reporting and data warehousing, included risk analysis and for Chicago Teachers he worked with retiree medical plans and financing.

### *Actuarial*

**The Segal Actuarial Team is 100% staffed by credentialed actuaries. The high quality of our work, in conjunction with the sophistication of our large state clients, demands this level of expertise.**

**Kirsten Schatten, ASA, MAAA** is a Vice President and Actuary in our Atlanta office. She will serve as Lead Actuary and will assist Ken and Richard by providing actuarial projections, funding, reserves, Medicare program-specific analysis (EGWP, Medicare Advantage, RDS, etc) and a number of other actuarial assignments.

Kirsten has been serving public plans and employers for 20 years and has most recently worked with the North Carolina State Health Plan, Georgia State Health Benefit Plan, Alabama PEEHIP, Illinois Central Management Services, Bureau of TennCare, and the Commonwealth of Virginia.

Kirsten has been serving public plans and employers for 20 years and has most recently worked with the North Carolina State Health Plan, Georgia State Health Benefit Plan, Alabama PEEHIP, Illinois Central Management Services, Bureau of TennCare, and the Commonwealth of Virginia. Kirsten has worked with Ken and Richard for over 7 years as a team and will bring continuity to this engagement.

Kirsten has conferred with many clients to develop innovative benefit designs and pricing strategies to meet unique requests. Most recently, she has assisted plans with consumerism strategies, population health education needs, quality of care initiatives, and drivers of health costs (including drivers of disease prevalence).

She has developed pricing for unprecedented models of care management programs, developed studies to quantify savings from consumer and wellness initiatives, negotiated reimbursement and risk sharing scenarios for managed payers and providers, performed market valuations of health plans for mergers and acquisitions, approved rate filings for DOIs and helped to develop strategies with legal counsel for public rate hearings.

Her experience also includes the analysis and implementation of Retiree medical and prescription drug strategies including coordination of Medicare Advantage plans and Medicare Part D and working extensively with Medicare Advantage plans providing development of business strategies, claims analysis, network strategies, and pricing.

Many of the services the ETF is requesting are performed for the above-mentioned State clients, in which Kirsten provides develop innovative benefit designs and pricing strategies.

**Chris Heppner, ASA, MAAA**, is a Senior Vice President, Health Actuary and the Midwest Health Practice Leader in Segal's Chicago office with over 20 years of experience working with health plans. Mr. Heppner will be support the annual HMO renewal negotiations and support the core actuarial group.

Mr. Heppner assists clients in understanding their current cost components so that effective decisions could be made to manage those costs. He has developed interactive budget projection models to address client-specific interests, as well as engaged in successful negotiations with insurers to keep renewal increases consistently below trend.

Chris leads and manages all the actuarial work and renewals a Large Eastern State (cannot be named), Alabama Public Education Employees Health Insurance Plan, and the Illinois Central Management Services. Through his work with a number of clients, Chris has developed a unique and straightforward HMO pricing approach and renewal strategy that if effective.

Many of the services the ETF is requesting are performed for the above-mentioned State clients, in which Chris provides develop innovative benefit designs, renewal negotiations and pricing strategies.

**Peter Wang, ASA, FCA, EA, MAAA** will assist Kirsten by providing actuarial, financial and data analysis. Peter is an Assistant Actuary in our Atlanta office, and provides actuarial services to many clients, such as The Georgia State Health Benefit Plan, the North Carolina State Health Plan, Alabama PEEHIP, Illinois Central Management Services, and the City of Atlanta (GA).

Peter acted as an actuarial consultant on these account. For North Carolina he primarily does financial projections, fiscal impact research and a variety of actuarial support. He plays a similar role as North Carolina for Alabama. For Illinois, he has spent the majority of this time working on the retiree Medicare programs, most recently on the Medicare Advantage procurement, working with their encounter data.

Many of the services the ETF is requesting are performed for the above-mentioned State clients, in which Peter provides develop innovative benefit designs and pricing strategies.

**Olga Ronsini, ASA** is an Actuarial Analyst in our Atlanta office. She will provide a variety of actuarial functions, analytics and data management support to the team, and has experience in analyzing plan alternatives, budget projections, rate setting and discount analysis. Her primary client assignments include the Georgia State Health Benefit Plan, Alabama PEEHIP, Illinois CMS, Fulton County and the City of Atlanta. Olga works with Peter and Kirsten as an actuarial assistant. She recently completed IBNRs and financials for Alabama, RFP scoring for the State of Georgia and MA-PDP pricing for Illinois.

Many of the services the ETF is requesting are performed for the above-mentioned State clients, in which Olga analyzes plan alternatives, budget projections, rate setting and discount analysis.

### *Benchmarking/Research*

**Laine Ingle** is a Senior Health Benefits Consultant in Segal's Atlanta office with 16 years of industry experience in Project Management and Human Resource Management. Her responsibilities include the strategic design and supervision of many different areas for health benefit plans, including health plan strategy, vendor evaluation and selection, implementation of new programs, and plan performance management.

Laine has provided operational and administrative strategic support for many large public employers, including the Georgia State Health Benefit Plan, Illinois Central Management Services, Texas Group Benefit Plan, the City of Houston, and Alabama PEEHIP.

Laine led procurements in all three clients. For Georgia they bid medical, pharmacy, wellness and medical management programs. Laine managed the procurement and evaluation of the MA-PDP RFP in Illinois. She also managed RFPs for Medical, and Pharmacy for Houston. She has led RFPs and procurements for dental, vision, life insurance, disability, and ancillary benefits for a number of clients.

**Jennifer Slutzky** is an Associate Health Benefits Consultant based in our Atlanta office. She will serve as a Consultant to ETF. She will provide general support to the team and has expertise in compliance filings, annual renewal data collection/analysis, consumer driven health plans, local and national trend analysis, and request for proposals. Her clients include the Georgia State Health Benefit Plan, Illinois Central Management Services, the City of Houston, and Alabama PEEHIP.

Jennifer worked closely with Laine on the procurements for Houston, Georgia and Illinois. She has marketed a number of voluntary products for other clients and provides day-to-day program administration.

## **Research**

At Segal, we bring a Public Sector focus to our compliance and Health Care Reform strategies. The plan that EBD administers are public plans, which provides a unique set of opportunities and requirements separate from traditional single private employers plans, which are usually technically not even “plans” at all. As new laws and regulations emerge, or are revised, we provide our public sector clients with the targeted advice and information they need. We monitor regulatory and legislative activity at both the federal and state levels, and can monitor state legislative activity specifically in Alabama. We monitor the North Carolina legislature for the North Carolina State Health Plan, and this has proven to be a valuable service to the Plan’s staff and leadership.

Compliance and Health Care Reform consulting will be led by **Kathryn Bakich, JD**, a Senior Vice President in our Washington DC office and our National Compliance Practice Leader. Ms. Bakich is one of the country’s leading experts on employer sponsored health coverage. She specializes in providing research and analysis on federal laws and regulations affecting health coverage, including: ERISA, Medicare, HIPAA, COBRA, the Newborns’ and Mothers’ Health Protection Act, the Mental Health Parity Act, and the Women’s Health and Cancer Rights Act.

Ms. Bakich is a recognized expert on the Patient Protection and Affordable Care Act passed in 2010. She speaks regularly about the law, helps plan sponsors understand its short and long-term effects on their plans, and assists clients with preparing comments on the legislation for submission to regulatory Departments (Treasury, Labor, and Health & Human Services).

Many of the services the ETF is requesting are performed for the above-mentioned State clients, in which Kathy shared decision making on compliance and plan regulation issues.

## ***Claims Auditing***

Segal’s combination of technology capabilities, auditor knowledge, and benefit analysis experience will provide the State with a quality-focused partner. You can be assured you will have the benefit of working with persons experienced in similar plan designs, administrative concerns, and industry practices. **MaryAnne L. Watson**, Vice President and Senior Consultant, will lead our audit group in this engagement. MaryAnne is based out of our Phoenix office and has over 39 years of claims administration and audit experience. She is responsible for overseeing all aspects of Segal’s claims auditing services, and provides assistance with operational/organizational reviews, technology application assessments, and TPA searches. Ms. Watson’s experience as a group benefit analyst and auditor for The Segal Company, combined with her prior experience as a claims examiner, enables her to provide clients with a clear understanding of employee benefits and an administrative office’s responsibilities and workflow.

**Lynda Sheldon** is a Consultant in Segal’s Phoenix office and has over 30 years of experience in claims administration and auditing. In addition to claims auditing services, her responsibilities include reviewing detailed financial and claims data for various health, dental, vision, disability, life, and alternate provider benefit programs.

Prior to joining The Segal Company, Ms. Sheldon was employed for 17 years by a national third-party administrator working with insured and self-funded groups on both manual and computerized claims adjudication systems. She is experienced in customer service, claims

processing, staff training, the coordination of third-party subrogation recoveries, producing and reviewing carrier and network reports, the performance of internal audits, and the maintenance of provider profiles and federal tax reports

Our clinical staff (nurses and/or physicians) is an integral part of our audit team. During a claims or operational audit, they may be called on to determine if the administrator was prudent in their evaluation of a particular claim or if additional review is warranted.

Segal has recently conducted audits for state-level plans in New Hampshire, Florida, Mississippi, Hawaii and Montana. Many of the services the ETF is requesting are performed for the above-mentioned clients, in which MaryAnne and Lynda have worked with vast amounts of claims data used when auditing health care claims information for payment accuracy.

### *Communications*

**Andrew Kaplan**, Vice President, Senior Communications Consultant in our New York office, will serve as Project Manager and Lead Communications Consultant. When necessary, Andrew will lead a group of Communications consultants, to develop project deliverables. Andrew has 20+ years of project management and communications consulting expertise. He will also lead the communications strategy, implementation and survey efforts. Andrew's current and recent clients include the BMW, BNP Paribas, Illinois Department of Central Management Services, Yale-New Haven Health System, Greenberg Traurig LLC, Ohio State University, Skidmore College, and Xylem, Inc.

**Mindy Rosenthal** is a Vice President and Senior Communications Consultant in our Boston office. Mindy leads a team of communications consultants that enable our clients to utilize traditional and emerging communications strategies that range from print to social media. Mindy's current and recent clients include The Pennsylvania Public School Employees' Retirement System Health Options Program, the North Carolina State Health Plan, The State of New Hampshire and the Tennessee Department of Finance and Administration.

Many of the services the ETF is requesting are performed for the above-mentioned clients, in which Andrew provides communication services for plan implantation and survey support.

### *In Summary*

We believe our team is highly qualified and prepared to meet your needs. Given the complexity of this assignment, various team members will be needed. Our team might seem excessive but with our larger clients we have engaged similarly designed teams at different levels. The important point is that we have all your perceived needs covered. Note that this is the same team, with the addition of Rick Johnson and Chris Mathews, that was recently hired as the health benefits consultant and actuary by ETF. We would expect some efficiencies if we are awarded this contract as well.

Please refer to the **Appendix 1 – Segal Team Resumes** section of this proposal for additional details of each team member's qualifications.

**6.4 Provide a sample report (information does not need to be true data) that your company has produced for a project similar in size and scope. Based on the scope of this RFP describe what report elements would be included for the 6-month and 12-month deliverables required in this RFP.**

Under **Appendix 4, Sample Reports**, we have provided two sample reports that we have produced for two different state clients that are similar in size and scope. No two studies will be identical and the ones we presented were prepared by members of your client team.

**1. North Carolina State Health Plan: Report on State Health Plan's Next Generation HealthSmart Ten-Year Plan and Strategy**

Segal prepared this strategic plan in a 12-month project from June 2010 through May 2011. There were some components that would be consistent with the sections requested in this RFP. The three main components of the report concentrated on:

- Medical Management Strategies
  - Prevention & Wellness
  - Proactive Care Management
  - Community Care Centers as Patient Centric Medical Homes
  - Using incentives to drive patient enrollment, engagement and outcomes
  - Pharmacy programs – value based design, specialty drugs
- Provider/Network Opportunities
  - Cost and Quality of providers and facilities
  - Triage to most cost effective providers
  - Provider reimbursement incentives
  - Transparency
- Benefit Policy
  - Benefit plan redesign
  - Other consumer/member incentives
  - Value based benefit design

All of the components listed above were taken into account as our strategy was being developed. We believe all of these components are elements of the report requested in this RFP. We would anticipate each would be a component or section in both the 6-month and 12-month reports. The second report is more comprehensive and detailed.

**2. State of Tennessee: A Health Benefit Plan Strategy for the Public Sector Plans**

Members of your Segal team, specifically Ken Vieira, Richard Ward, Kirsten Schatten and Laine Ingle, worked with the State of Tennessee in 2008 to develop their long-term strategy. Upon completion and implementation, Segal's communications team was engaged to brand the message and deliver to its' membership. Some components of the strategy were implemented, while others, like plan design, required further modifications.

This report was much more data intensive than the North Carolina project. There was a significant amount of research evaluating the current health of the population and

quantifying the opportunity cost. This will be an important component in our report for ETF.

Like the North Carolina Report, we outlined some key components that needed to be included in their strategy. Those included:

- Choice-Based Plan Design and Value Based Contribution, or simply Value Based Plan Designs
- Provider Network Alignment
- Pharmacy Benefit Design
- Health Management
- Vendor Management
- Vendor Administrative Efficiencies – potential for consolidation

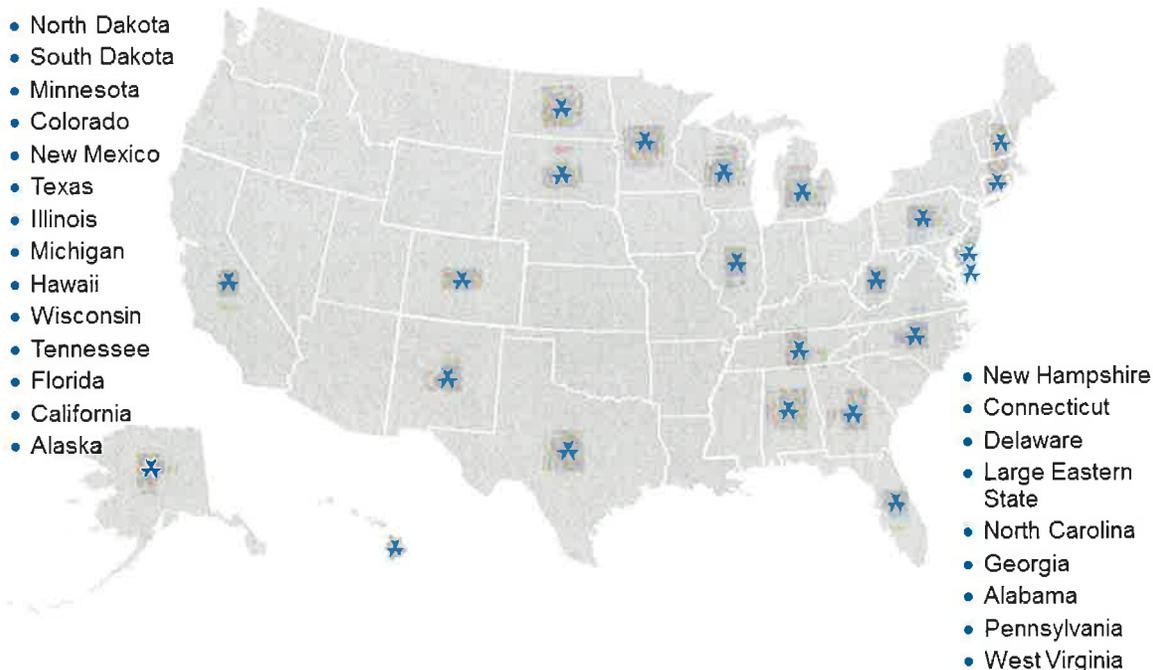
We would anticipate all of these elements in both the reports in varied detail.

**We believe these two reports can give ETF an idea of how our report will be customized to meet your needs. No two state reports will be identical in content or structure, but all result in a practical unique strategy for the client to implement.**

**6.5 Describe your experience with up to 5 clients (public and/or private sector) with over 10,000 employee lives where the scope of work performed was similar to that requested in this RFP.**

As one of the nation's leading independent consultants to the public sector, Segal has the knowledge, expertise and experience to understand the environment in which decisions are made by public plans. Not every emerging trend or market practice is suitable for every organization. We understand what solutions will work for a public plan, and what options are more suited for the private sector. Below is a visual representation of our state level plan experience and current clients:

**State Public Employee Group Client List**



We work with more than 20 state-level health plans and your Segal team looks forward to the opportunity to bring this perspective to this engagement. Over the following pages are brief summary of five (5) current clients, where similar services are performed, many of which are serviced by some members of your senior management team of Ken Vieira, Richard Ward and Rick Johnson.

**North Carolina State Health Plan (NCSHP)**

The NCSHP for Teachers, State Employees and Retirees is one of Segal’s largest accounts, covering approximately 670,000 members, with over 130,000 Medicare eligibles. Your Account Manager, Ken Vieira, is the Lead Actuary and managed this account for over 17 years (spanning his prior firm). Segal is currently the Plan’s Consultant and Actuary. We provide a broad range of services for NCSHP, including the following projects over the last 12-months:

- Providing ongoing actuarial analyses and financial projections over 5-years
- Calculation of participant and employer rates

- Data mining, warehousing and in depth utilization claims analysis, including EBD dashboards
- Clinical risk group analysis
- GASB OPEB actuarial valuations
- Quarterly and annual pharmacy benefit manager audits of claims, MAC pricing and discounts, and rebates
- Medicare Part D actuarial attestations
- IBNR analysis and reserve recommendations
- Analysis of return on investment of contracted disease management vendor
- Strategic consulting and planning with the Board of Trustees
- Alternative plan design, including incentives, penalties, and value based features
- Wellness program review and consulting
- HIPAA compliance review and consulting
- ACA program consulting, including the evaluation of the financial and compliance implications of upcoming legislation
- Medicare Advantage, PDP and EGWP consulting
- Employee and retiree communications consulting, including development and production of open enrollment materials and videos
- Review of medical management performance guarantees

Segal is a trusted advisor to the Plan, the Treasurer and the Board of Trustees. We believe this is one of best examples of how we work collaboratively with a large State Health Plan.

### **NC Ten Year Plan Study**

Segal recently completed a study of the state's Ten Year Plan for managing health care costs. The study focused on a variety of strategies to modify plan design and to refine medical management programs to improve member health, improve productivity, and decrease medical trend over the next ten years.

In addition, for the North Carolina State Health Plan (SHP) we conduct an annual analysis of health risk based on Clinical Risk Groupers (CRG). In this analysis we collect claims data from SHP medical and pharmacy administrators and, along with the enrollment/eligibility data provided by SHP directly, compile the data into a single data base with all medical and pharmacy claims stored within a standardized format. This first step of "scrubbing" the data, which is provided from multiple sources and in multiple formats, into a uniform layout is key to our ability to analyze the data across the entire population.

CRGs is a claims-based classification system for risk adjustment that assigns each individual to a single mutually exclusive risk group based on historical clinical and demographic characteristics to predict future use of healthcare resources. In other words, this enables us to group together members by health risk status, analyze their claims and demographics and draw some conclusions regarding the effectiveness of disease management programs, wellness initiatives, complex care management programs, etc.

All individuals are assigned to a single, mutually exclusive group, which is in one of nine health statuses, ranging from catastrophic (e.g., history of a heart transplant) to healthy (e.g., no chronic health problems or other indication of risk).

In 2014, SHP implemented a comprehensive wellness focused strategy, which requires member engagement (selection of PCP, complete health risk questionnaire, provide biometric data, etc.). The CRG analysis and 10 year baseline will enable us to track, measure and quantify the impact of health improvement and link results to vendor (BCBSNC, ActiveHealth, etc.) and program (specific condition management programs, complex care management programs, etc.).

## **Alabama Public Education Employees' Health Insurance Plan**

The Public Education Employees' Health Insurance Plan provides hospital medical health insurance benefits for all full-time employees, and certain part-time employees, of the Alabama public educational institutions, which provide instruction at any combination of grades K-14, exclusively under the auspices of the State Board of Education. These insurance benefits are also available to retired employees with a portion of the retiree's cost paid through the employer premium for active employees. The PEEHIP Division maintains insurance records for the approximately 300,000 active and retired members and eligible dependents on-line with on-line insurance status changes. All changes are reported to the third party administrators via electronic file transfer.

Segal began working with PEEHIP in 2013, current projects include:

- Analysis of proper funding levels for the Hospital Medical Insurance Program, Rx and Optional Plans.
- Consulting on plan design issues, focusing on cost effectiveness and competitiveness.
- Advice regarding legal/legislative developments regarding the Patient Protection and Affordable Care Act (ACA) and how it specifically impacts PEEHIP. This will involve keeping the PEEHIP staff and board timely informed of current.
- Negotiations with current plan providers as needed.
- Providing claim projections twice a year
- Retiree benefits design and strategy, including EGWP and prospective Medicare Advantage plans
- Pharmacy consulting and strategy, including contract negotiation
- Providing IBNR calculations by Active and Retired summarized by Medical, Drug, and by optional benefits - Dental, Cancer, Hospital Indemnity, and Vision.
- Medicare Advantage Opportunity Assessment
- Provide marketing for all Benefit Products every 3 years.
- Wellness Program Strategic plan design, marketing and program implementation

## **Pennsylvania Public School Employees' Retirement System – Health Options Program (PSERS HOP)**

PSERS HOP is a voluntary retiree-only health benefit program covering over 75,000 of 150,000 Medicare eligible retirees from over 700 school districts across the Commonwealth. More than 400,000 active school employees participate in the statewide PSERS retirement program. The HOP program offers retirees and their dependents an array of seniors' health options, including a Medicare supplement plan, a Medicare Prescription Drug Plan (PDP) and six Medicare Advantage plan options. Retirees pay all premium costs. Some retirees are eligible for a pension supplement for limited reimbursement of medical coverage costs based on long service.

Segal provides all health analytical, actuarial, strategic, communications and procurement consulting for the program, including regular claims audits. We provide ongoing health actuarial services that include development of premium equivalent rates, projections of plan cost, IBNR calculation, and budget reconciliations. We also assist the program with plan design review for both medical and prescription drug plans, Medicare Advantage plan evaluation, support of the program's direct contract Medicare Prescription Drug program, open enrollment communications, newsletters and Web site development and content.

In 2002, PSERS retained Segal to help determine the feasibility of self-insuring their Medicare supplement plan. Our recommendation to self-insure saved the program many millions of dollars and allowed the plan to avoid premium rate increases for most retirees for three years, while still building healthy reserves. One year later, PSERS hired Segal to conduct a similar study on the program's fully insured prescription drug plan, with a similar result.

With the implementation of Medicare Prescription Drug coverage (Part D), PSERS was faced with a dilemma on how to maximize federal subsidies for members' Rx coverage. With no employer contributions to the plan, there was no opportunity to receive the Retiree Drug Subsidy (RDS). Segal recommended that PSERS apply to Medicare for a direct contract PDP, where the plan would provide Part D benefits to its retirees similar to commercial insurers. The application was accepted and PSERS has since saved its members almost half of the cost of the prescription drug program. Segal consults on all aspects of the PDP program.

Segal was retained as PSERS' ongoing consultant in 2004 and since has assisted the client in conducting a number of competitive bid processes, including multiple pharmacy benefit manager bids, a bid for a national Medicare Advantage vendor, and a bids for third party administrator. Segal provides ongoing claims auditing for the medical benefit programs. We provide all communications and marketing consulting for the program, including development of personalized annual option selection statements for all participants; public and secure website development and content; and other special projects as requested. In addition, we have assisted PSERS in implementing a seniors' wellness and fitness program and are tracking the return on investment for that program.

## **Illinois Central Management Services**

The Illinois Department of Central Management Services (CMS), Bureau of Benefits (BOB), oversees the administration of group health benefits for over 440,000 enrollees including the State Employees Group Insurance Plan, the Local Government Health Plan, the Teachers' Retirement Insurance Program, and the College Insurance Program. There are nearly 180,000

retirees, of which, 123,000 are Medicare eligible. Segal provides a wide range of healthcare consulting and actuarial services to assist the department.

Segal began working with CMS in 2013, current projects include:

- Marketing the Medicare Advantage with Prescription Drug Program, including EGWPs
- Retiree Plan Design Modeling
- Actuarial Attestation for the Retiree Drug Subsidy under Medicare Part D
- Pharmacy Plan Management, including a Market Check of the current pricing as well as performing an annual audit
- Preparing a comprehensive communication campaign for the upcoming Medicare Advantage open enrollment and wellness initiatives
- Working with the wellness committee and various constituencies to develop a long-term wellness strategy and health initiative
- Review of financial information and IBNR/reserving methodologies

As their strategic partner, we consult on a wide range of actuarial and consulting topics, bringing the best of Segal to them.

### **State of Colorado**

Segal provides a full service of actuarial and benefits consulting services to the State of Colorado to include the following:

- Drafting and analysis of vendor proposals for medical and pharmacy and other lines of coverage
- Negotiation of stop-loss, HMO and other insured contracts
- Review and improvement of inherited contracts resulting in better contract provisions and guaranteed savings in new contracts
- Withdrawal liability analysis for eligible State institutions
- Educational seminars and informational presentations
- Data warehousing, predictive modeling and data analytics and reporting
- Monthly claims and utilization analysis
- Executive financial review and planning
- Monthly IBNR
- Annual rate setting and employee contribution modeling
- Development of performance standards and contract analysis
- Analysis of pharmacy discounts, contracts, rebates, formulary and drug management strategies
- Cost forecasting used in legislative session
- Evaluation of stop-loss contracts and risk position
- Special analysis related to legislative considerations
- Consulting on wellness program integration and total health management

Review and assistance with communication materials and strategy, health promotion and member engagement. We also have performed medical and pharmacy claims audits, performed a feasibility analysis of an on-site medical client, ACA analysis and HIPPA privacy training.

Colorado has two HDHP plans. We inherited these with no companion HSA / HRA or cost and quality comparison tools. We are in the process of helping them select cost and care comparison tools. They also have a fully insured HMO co-pay plan and a self-funded PPO Plan. Soon we will assist them in selecting an HSA bank. We have also modeled employer contributions to be provided as a capped match to employee funds (to encourage savings from higher premiums to be invested in the HSA) and/or linked to achievement of desired wellness tasks.

We also assisted them in adding prevention first benefits to their dental to help encourage below benchmark preventive services, and used the benefit enhancement as a launch pad for health improvement communications related to dental health.

**6.6 Describe your typical contractual arrangements with clients (e.g., fixed fee, retainer, commission, etc.), including a breakdown of the total arrangement (x% fixed fee, x% retainer, x% commission). Actual rates must not be submitted within the response to this question.**

Segal received a very small percentage of our revenue from clients with a commission structure. Our typical consulting contract arrangement is negotiated hourly rates, with some of these having fixed fees or capped project fees.

Below is a break-out of revenue between fixed fee, time charges and commissions for 2013:

Contractual Arrangement	2013 Revenue (in Millions)	% of Revenue
Fixed Fee Projects, including Retainers	\$110.1	50%
Negotiated Hourly Rates	\$68.9	31%
Negotiated Hourly Rates with caps	\$33.3	15%
Commissions	\$8.6	4%
Total	\$220.9	100%

Although commissions are only 4% of our revenue, we fully disclose any commissions on a dollar for dollar basis. Insurer incentive compensation/supplemental commission payments are used to finance national investments in research, technology, database development and client education to improve overall client services. Generally, any insurer incentive payments derived are based on Segal book of business activity and are limited to less than 1% of total Segal revenue.

### **Indirect Compensation**

It is important to note that what we report to clients is the sum total of compensation that Segal receives from a carrier based on individual client premiums. Although, as noted above, we will accept supplemental payments, we:

- **DO NOT** accept compensation or reimbursement from any carrier for any marketing expenses.
- **DO NOT** accept free entertainment, such as golf or sports tickets, or expenses associated with a carrier-sponsored conference. Segal Health Practice’s staff may periodically participate in a carrier sponsored educational seminars, industry events and/or underwriting meetings, but will generally reimburse the carrier for expenses that exceed a specific de minimis dollar threshold.

For more information, please read our “Compensation for Life and Health Benefit Services” disclosure at <http://www.segalco.com/uploads/life-and-health-benefit-services.pdf>.”

**6.7 How has your company effectively communicated recommendations to client leadership, members/end-users and stakeholders? In your response, include two examples. For each example, describe how your company incorporated feedback to alter your approaches. Also, for each example, define the resources and staffing you would dedicate in your communication strategy to each audience noted above.**

Throughout our history, Segal has helped client organizations explain and promote benefits and human resources policies. We have had a formal communications function since the passage of ERISA. Our National Communications Practice covers all markets (public sector, corporate, multiemployer), working with 300+ clients ranging in size from 100 to 425,000 employees.

- **We focus completely on internal communications.** We educate and connect people to their organization's programs, vision and goals.
- **We have both depth and bench strength.** You will find branding, communications strategy, organizational effectiveness, HR/benefits, transition communications and personalized statement gurus.
- **We deliver.** The team that sells the work does the work.
- **We are passionate about what we do.** That passion translates into fresh and innovative ideas that consistently stand out and get results.

Our professional staff includes consultants specializing in benefits, wellness, compensation and HR communications; personalized communications; graphic design; online media; video and print production.

### **We Start with Strategic Planning**

Segal's approach to effectively communicating recommendations to client leadership, members/end-users and stakeholders incorporates a structured communications planning process, consistency and persistency of messaging and information, development and transmission of the context for change (i.e., "Why is this happening?"), transparency of change rationale, and the use of multiple communications channels.

To kick off our communications work with the State's project team, we would facilitate an initial strategic communications planning meeting with your team. During this half-day planning session, we would explore the following areas:

- The State's health and wellness benefits strategy and desired changes in design and behavior;
- Your communications objectives and their fit with your HR and benefits program objectives and initiatives;
- The issues facing the State's programs that may require communications support (e.g., Annual Enrollment);
- The State's employment "brand"—and its representation of your value proposition to employees;
- Your key audiences/constituencies and their shared and unique information needs;

- The media you use to reach your audiences/constituencies—what is working now and what could be improved or developed for the first time; and
- The measures you might use to gauge the effectiveness of your communications investment.

The outcome of the session would be a comprehensive communications strategy and implementation plan that sets the course for 2016 communications, including Annual Enrollment communications. The plan will articulate the State’s communications priorities and initiatives to be completed; detail specific activities, events and media; document key milestones; and identify the resources (people and financial) required to support this effort.

For a sense of what a tactical plan could look like, below is a sample plan. The approach we ultimately fashion together with the State will likely be significantly different, based on what we learn in our planning session with you.

Time Frame	Deliverable	Audience
June/July	<p><b>Communications kick-off meeting:</b> In-person meeting to discuss the who, what, where, when and why of the State’s current benefit programs, wellness initiatives, and communications strategy. Identify key communications needs and goals and develop a preliminary timetable for 2014/2015 communications.</p> <p><i>Medium:</i> Deliver communications strategy for remainder of 2014 and for 2015, including Annual Enrollment.</p>	State project team members
August/September	<p><b>Advance notice to key stakeholders</b> about 2015 benefit changes and upcoming Annual Enrollment campaign. Remind stakeholders of importance of top-down support for change initiatives.</p> <p><i>Medium:</i> Email and webinar</p>	Senior Leadership/HR Leaders
September/October	<p><b>Annual Enrollment:</b></p> <ul style="list-style-type: none"> <li>• <b>Postcard mailed home, email, website content (“Annual Enrollment Coming Soon”):</b> Introduce new benefits branding (if applicable) and alert employees to be on the lookout for upcoming Annual Enrollment communications.</li> <li>• <b>Email announcement, common-area poster, website content, content for existing, regularly-scheduled email/print newsletters:</b> Introduce benefit changes and/or new programs, announce wellness focus areas to be targeted by the State (if applicable), and outline timing and elements of communications to come.</li> <li>• <b>Enrollment guide mailed to homes:</b> Emphasize wellness and preventive care, disease management programs, provide medical and other benefit summaries, plan overviews, FAQs, employee contribution rates, enrollment instructions, wellness initiative information, vendor contact information, etc.</li> <li>• <b>White board video, for website posting:</b> Provide an overview of Annual Enrollment, key 2015 plan changes, available benefit plan decision-making tools, etc.</li> </ul>	All Employees

Time Frame	Deliverable	Audience
	<ul style="list-style-type: none"> <li>• <b>Annual Enrollment webinar; employee meeting content:</b> Prepare and deliver a presentation (with speaker notes) to describe and explain new programs/benefit plan changes; wellness behaviors in which employees can/must engage, as applicable; provide answers to likely questions, discuss required enrollment actions. Segal could present a webinar for local HR staff as a train-the-trainer session; local HR staff would then conduct employee meetings.</li> <li>• <b>Enrollment reminder: common-area posters, website content, regularly-scheduled email/print newsletter content:</b> Remind employees of required Annual Enrollment action steps, the enrollment deadline and where to go for answers to questions.</li> </ul>	

## Effectively Communicating Recommendations

To gather feedback about our communications approach and make changes as needed, we typically recommend to clients that they use an existing—or constitute a new—committee or task force to review communications strategy and the communications elements as they’re being developed.

## Examples of Specific Projects

### Example 1: A State University System

Formed in June 2013, a State University System’s Total Rewards Ad Hoc Task Force was charged with assisting the Vice President for Human Resources in developing and communicating recommendations to improve the University’s Total Rewards Program offerings. Task Force members were selected from a pool of recommended and self-nominated candidates. They were chosen to appropriately represent the diversity within the System’s population.

The Task Force was asked to focus on faculty and staff concerns that the System’s non-competitive pay levels negatively affect employee perceptions of Total Rewards and that a significant number of employees rate themselves as “unhealthy,” with low participation in wellness programs. The Task Force was also asked to focus on financial concerns. The System is facing unfunded pension and retiree medical liabilities of more than \$1 billion and the projected growth in benefits costs is unsustainable.

The Task Force provided the Vice President with recommendations that were also communicated to the System’s communities. We worked with the System to develop content for a microsite on their website devoted to the Total Rewards initiative. This site includes a video presentation summarizing the initiative, the Task Force’s purpose and the Task Force’s recommendations, feedback on those recommendations, and next steps (Segal wrote the script); the full report of the Task Force as presented to the Vice President of Human Resources (Segal edited the report); and a presentation made to the State University System’s Board (Segal developed the presentation). Campus faculty and staff discussions were held in April and May of 2014; the presentation made to the Board was presented at faculty and staff discussions to solicit feedback.

While this project is ongoing, preliminary outcomes of the feedback from Board members and faculty and staff, based on communications that were developed or edited by Segal, include the following:

- The implementation date for a health care coverage cost surcharge for tobacco users was changed from January 1, 2015 to January 1, 2016, to give faculty and staff a year to end tobacco use before the surcharge is implemented.
- The decision to discontinue the Health Care Flexible Spending Account (FSA) in light of its impact on triggering the Cadillac tax on the State University System's health plans was postponed—a Health Care FSA will be offered in 2015.
- The wellness incentive program will be expanded.
- A new, narrow network of providers affiliated with the State University System will be introduced.

Resources dedicated to developing communications for State University System include senior-level Segal Communications consultants who are responsible for communications strategy development and execution, including drafting content, Total Rewards theme development, providing ongoing communications counsel, and day-to-day project management. Other resources include an outside designer to help develop the System's graphic identity.

### ***Example 2: Large Northeast Healthcare Delivery System***

Segal currently works with one of the largest and most prominent health care delivery systems in the country and the largest in the Northeast U.S. It is comprised of multiple delivery networks (hospitals, physician groups and specialty care centers). As part of the System's desire to standardize benefits across all its networks, the System is moving to a common Paid Time Off (PTO) Program design starting January 1, 2015 (for most networks) and January 1, 2016 (for one network). Each delivery network will be affected differently by the change.

Representatives of each network were involved in the process of reviewing the proposed standardized design to ensure full buy-in of the final design from each entity. Once the standardized design was finalized and approved by senior management, we worked with System to establish a PTO Communications Subcommittee. The Subcommittee consists of representatives from all the System's networks, plus representatives from Corporate Communications. The Committee's charge is to provide input on the communications strategy and to review and provide feedback on each communications element.

While this project is ongoing, outcomes of feedback from the Subcommittee that changed the communications approach include the following:

- Rely primarily on print mailed to homes to ensure messages and information about the changes are received.
- Solicit top-of-mind questions from Subcommittee members about key concerns that the changes will engender at their respective network, and present these to the President's Cabinet to alert members to each network's key concerns about transitioning to the new program.

- Develop network-specific announcements focused on impacts related only to the applicable network.
- Use existing network newsletter channels (in print and online) to reinforce information and messages about changes.

Resources dedicated to the System include senior- and junior-level Segal Communications consultants who are responsible for communications strategy development and execution, including drafting content, theme development, providing ongoing communications counsel, and day-to-day project management. Other resources included Segal's production manager, who has over 30 years of print management experience and will be instrumental in coordinating print outreach to the System's 10,000+ employees, and a member of Segal's In-house Design team (our internal design and marketing group) to develop the Program's graphic identity.

## Tab 6 – Response to Section 7.0 Technical Requirements

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*The purpose of this section is to provide the State with a basis for determining a Proposer's capability to undertake this Contract. Be specific when answering the following questions. Proposers shall concisely answer each question thoroughly.*

*Proposer shall restate the number, question, and then provide a response. Proposal responses shall be in the same sequential number as in the RFP.*

Segal has consulted to state and local governments and the federal government on their health benefit and retirement programs for over sixty years. Our experience extends not merely to the routine plan design, premium rate renewals, actuarial valuations and rate setting, but also very strongly to the special projects where jurisdictions are exploring new options to meet new challenges. This provides us with the perspective and experience to understand what will work, and what will not work, in the public sector. Some industry trends are better suited for private sector employers.

Segal has served and currently serves as health consultant to hundreds of governmental clients.

***At Segal, serving the public sector is a primary focus – approximately 20% of our revenue is generated by our public sector client engagements.***

Segal serves many public sector clients at all levels from local jurisdictions to states to the federal government.

As one of the nation's leading independent consultants to the public sector, Segal has the knowledge, expertise and experience to understand the environment in which decisions are made by public plans. Not every emerging trend or market practice is suitable for every organization. We understand what solutions will work for a public plan, and what options are more suited for the private sector.

We work with a wide range of public plans and employers. The following is a representative list of our current clients.

### **State Governments and Statewide Retirement Systems**

- Alabama Public Education Employees' Health Insurance Plan
- Alaska Retirement Management Board
- State of Delaware
- The District of Columbia
- Georgia Department of Community Health
- North Carolina State Health Plan
- State of Colorado
- State of Connecticut
- State of Hawaii
- Georgia Municipal Employees' Retirement System
- Illinois Municipal Retirement Fund
- Illinois State Universities Retirement Systems
- Illinois Teachers' Retirement System
- Missouri Local Government Employees Retirement System
- Ohio School Employees Retirement System
- Pennsylvania Public School Employees' Retirement System
- New Mexico Public Schools Insurance Authority
- New Mexico Educational Retirement Board
- New Mexico Retirees Association
- Florida Division of State Group Insurance
- Large Eastern State (cannot be named)
- State of New Hampshire
- State of Tennessee
- State of West Virginia
- State of Wyoming
- State of Wisconsin
- State of Minnesota
- State of South Dakota
- Texas Group Benefit Plan for State Employees
- Illinois Central Management Services
- Arizona State Retirement Systems
- California State Teachers' Retirement System
- District of Columbia Retirement Board
- Minnesota State Retirement Systems
- Nevada Public Employees' Retirement System
- North Dakota Public Employees Retirement System
- North Dakota Teachers Fund for Retirement
- Michigan Office of Retirement Systems
- Rhode Island Employees' Retirement System
- Texas Municipal Retirement System
- University of California Retirement System
- Wisconsin Retirement System

### **Public Sector Higher Education**

- University of Oklahoma
- University of Tulsa
- University of Virginia
- Virginia Tech
- George Mason University (VA)
- Pennsylvania State System of Higher Education
- James Madison University
- Michigan State University
- Longwood University
- Duke University
- Florida State College at Jacksonville
- Central Michigan University
- Indiana State University
- Northern Michigan University
- Purdue University
- University of Michigan
- University of Missouri
- Northern Michigan University

## **Federal Government Clients**

- U.S. Office of Personnel Management
- Federal Reserve Bank
- Administrative Office of the U.S. Courts
- Postal Regulatory Commission
- Blue Cross Federal Employee Plan\
- Railroad Retirement Board

## **Local Governments and Public School Systems**

- Charleston County, SC
- City of Atlanta & Board of Education, GA
- City of Atlanta General Employees, GA
- Cobb County, GA
- City of Alexandria, VA
- Fulton County, GA
- Savannah-Chatham County Public Schools, GA
- Arlington, VA Public Schools
- Metro Atlanta Rapid Transit Authority GA
- City of Baltimore, MD
- Gwinnett County, GA
- Los Angeles County Employees Retirement Association, CA
- Los Angeles Unified School District
- San Antonio Fire and Police, TX
- City of Chicago, IL
- City of Chicago Retirees
- Chicago Public Schools
- City of Savannah, GA
- City of Springfield, MO
- City of Hubbard, OH
- City of Boston, MA
- City of Houston, TX
- City of San Jose, TX
- City of Tucson, AZ
- Chicago Transit Authority, Retiree Healthcare Trust
- Cook County, IL
- Cook County & Forest Preserve Pension Funds
- McHenry County, Illinois
- DeKalb County, GA
- Denver Public Schools, CO
- Fairfax County Public Schools, VA
- Fort Worth Retirement System, TX
- Los Angeles County Employees Retirement Association, CA
- Los Angeles Unified School District
- Jacksonville, FL
- Hollywood, FL
- Ocala, FL
- New York, New York
- New York Transit Authority
- City of Philadelphia, PA
- Village of Skokie, IL

## Public Sector Clients with Bargained Employees

We also regularly assist public plans and employers that have bargained employee populations. The following is a list of some of these public sector clients.

- Cook County (IL)
- Chicago Transit Authority
- Chicago Public Schools
- City of Springfield (MO)
- Village of Skokie (IL)
- City of Joplin (MO)
- City of Boston
- State of New Hampshire
- Metro Atlanta Rapid Transit Authority (MARTA)
- Montana Unified Schools
- Large Eastern State

Our team is also familiar with the Wisconsin Marketplace and works with many local jurisdictions and plans, including:

- City of Milwaukee
- Wisconsin Laborers Health & Pension Funds
- Milwaukee Drivers Health & Pension Trust Funds
- Fox Valley and Vicinity Construction Workers
- State of Wisconsin Investment Board
- Operating Engineers Local 139 Health Benefit Fund
- Milwaukee Painters Local Union No. 781 Health Fund
- Greater Wisconsin Employer Union Pension Trust Fund
- Wisconsin Sheet Metal Workers Health & Benefit Fund

We have reviewed the questions in this section and have selected an array of client examples that best demonstrate our unique approaches and successes. Many clients could be used in multiple questions and have significant overlap, but we have tried to minimize this. We have duplicated very few clients in our responses in our attempt to demonstrate our depth and breadth of experience.

For each question, Segal has provided a brief description of our services and expertise, including more extensive examples as requested. Per your approval in the Q&As, Segal has not provided the specific client names for our examples. If ETF would like additional information, we could request approval from our clients and disclose appropriately.

***7.1 Describe how your company has used data analytics to develop and recommend strategies relating to health care benefits, per RFP Section 1.2. In your response, include two examples. For each example, describe how you analyzed the data, developed and made recommendations, and evaluated the results of those recommendations.***

Segal has put together a team of professionals that are highly proficient in manipulating and analyzing large sets of health care data. Segal provides full data warehouse services and/or analytics to a number of state-level clients, including North Carolina State Health Plan, Illinois Central Management Services, Colorado, Alabama PEEHIP, Delaware and a large Eastern State we are contractually prohibited from naming in proposals. These plans cover state employees and local government employees, as well as public education employees, each of which bring their own unique challenges.

Our Health Informatics Group has experience using a variety of software and methodologies to analyze population health risk and predictive models. A risk-adjusted process will enable the ETF to appropriately profile health care costs and corresponding outcomes while taking into account the risk profile of the group.

A good health care strategy balances health promotion and cost effectiveness. Segal can help facilitate your data warehouse strategy and analyze your data to develop strategic considerations in managing costs and to impact member health over time. Segal has first-hand experience building their own warehouse to support fact-based data analytics. Our health Informatics team has expertise in the design of warehouses, creation of data standards, incorporation of extensive quality control checks to test data for accuracy, and interpreting information that can be turned into action to produce higher quality and more affordable care.

Segal's data warehouses provide a reporting tool and analytical engine that:

- Combines data across medical vendors, PBMs as well as other sources such as biometric screenings and medical management programs;
- Cleans and assembles data from different sources in a common format for health plan reporting; and
- Provides the technology to do sophisticated cost and utilization analysis, risk stratification to quantify disease burden and predictive modeling on an ad-hoc basis.

These tools will provide the fact-based data analytics necessary to measure ETF's progress toward achieving its strategy.

ETF's current employee and retiree population likely has certain predictable behavioral characteristics and costs under various design alternatives. Through the data analytic staff, ETF will be able to:

- Understand population/workforce health status;
- Use the information to target investments and make plan design decisions;
- Establish health metrics;
- Avoid benefit plan initiatives that might unnecessarily create human resource issues;

- Facilitate analysis of costs, utilization, discounts, provider quality and population health status across vendors and plans on a consistent basis accounting for case mix and severity adjustments;
- Provide the fact-basis that can be used to justify plan changes and investments in workforce health and wellness;
- Provide an independent review of the effectiveness of your current programs with respect to care and disease management;
- Identity high-performance networks; and compare the program and experience to benchmarks and standards of care.

In addition to the above, Segal analytics staff uses population-based risk adjustment and predictive models to quantify clinical risk and cost. These models can be used to:

- Prepare accurate budget forecasts
- Set premium rates based on predicted costs
- Understand changes in risk pools in larger accounts
- Determine the escalation of health status over time
- Reduce cost of reinsurance and stop loss arrangements
- Identify and stratify (prioritize) members for medical management, case management and disease management programs
- Evaluate the saving of case management and disease management programs that are “true savings” and not simply a regression to the mean
- Compare providers fairly, adjusting for differences in health risk between patient populations
- Accurately profile providers for utilization review and quality of care
- Negotiate payments/incentive arrangements based on members’ health status
- Compare providers to their peers
- Improve the detection of fraud and abuse

We are a firm believer that larger health plans should maintain their data, linking all the various programs. It will allow you to best manage your program and will highlight opportunities for improvement. With your continued focus on wellness through *Well Wisconsin*, this becomes a necessity to be successful.

We have provided two unique examples of how we utilize data analytics in our strategy and consulting work. The first example is one of Segal’s largest accounts and a key client for Ken Vieira and Rick Johnson. The second example demonstrates the experience of our clinicians and the Segal Chicago team members.

## Examples of Specific Projects

### **Example 1: Southern State Health Plan (“Plan”)**

Segal and your Account Manager have worked collectively on the Plan for more than 15 years. The Plan is one of Segal’s largest accounts, covering approximately 670,000 members, with over 130,000 Medicare eligible retirees. Segal is currently the Plan’s Consultant and Actuary, providing a broad range of services.

Over the past few years Segal has helped the plan through a complete program redesign. The first step involved developing a long-term strategy, somewhat similar to what ETF is requesting.

Segal conducted a study of the Plan’s “Ten Year Strategy” for managing health care costs. The study focused on a variety of strategies to modify plan design and to refine medical management programs to improve member health, improve productivity, and decrease medical trend over the next ten years. Components of the study included:

- a detailed analysis of alternative plan design elements being considered by the Plan, including incentives, penalties, and value based features;
- a ten-year financial forecast of medical costs;
- an evaluation of the impact of the Accountable Care Act on the Plan;
- a review of the impact of the current medical management and health promotion strategy; and
- recommendations to the State concerning their contribution strategy.

A key component of the study utilized claims and participation data to support the recommendations and quantify the opportunity cost. Every plan design component had its own supporting health informatics. Below are a few examples of our data analytics:

- Clinical profiles – we stratified the population using the 3M Clinical Risk Grouper software. This enabled us to track the risk profile of the population over the last 5 years and demonstrate that the overall health of the program has decreased 3% per year. Using our internal projection model, we projected how the membership’s risk profile will evolve over the next 10 years, noting increases in diabetics, COPD, asthma, etc. Strategies were recommended, and implemented, to mitigate this component.
- Participation rates – we collected data from their care management vendor and demonstrated the low level of participation. Our designs were developed to maximize participation and also target the appropriate population.
- Benchmarking – we pulled data and developed a dashboard, including key financial and clinical baselines. This data also included benchmarks of other higher performing plans, demonstrating a significant gap in compliance.
- Network analysis –Segal reviewed the provider network, looking at cost and quality of both hospitals and physicians. Approaches were recommended to drive members to the highest quality, most cost effective providers. Through plan design triggers, movement was attainable and both the member and Plan would benefit.

- Plan designs – With the data on hand we were able to model out a wide array of plan designs. Our final recommendations included a winners/losers analysis that demonstrated that the majority of members would fare much better under the new program design.

As a result of this study, the Board has adopted a comprehensive redesign of the program. Consumerism features were integrated into all the plan dressings, including the introduction of a high deductible consumer directed plan option. These options, in conjunction with a wellness and clinical management strategy, completed the overhaul for active and early retirees.

For Medicare retirees, the study also recommended implementing a Medicare Advantage based strategy. This resulted in significant cost reductions while enhancing choice and increasing overall benefit levels. We have developed a risk profile for the memberships in each MA plan option in order to monitor the performance of each option and to more effectively negotiate annual renewals.

After numerous presentations to the Board, Segal recommendations were implemented on January 2014. The first 6-month have been extremely positive. Below are a few preliminary outcomes:

- Incentive participation was higher than anticipated, currently 95% in the members have filled out their health risk assessment and selected a primary care provider. There is one plan that does not require participation for 2014 and have nearly half the population. That feature will be turned off in 2016.
- 85% of retirees moved into the Medicare Advantage program.
- 5% enrollment in the CDHP plan was anticipated. As plan consolidation occurs in the following years, enrollment is expected to rise rapidly.
- Some increased use of PCPs and Tier 1 providers reported, providing savings for both the plan and member.
- Due to the financial success to date, the Plan has decided to forego a premium increase for 2015 after only a 1% increase in 2014.

The results are premature at this point, but the Plan currently enjoys trends that are projected to be flat in the near term. As a key component of our recommendations, we provide quarterly updates of the dashboard to monitor results. We have included a sample of the dashboard in **Appendix 5 – Additional Presentations.**

### **Example 2: Labor-Management Cooperation Committee**

In 2010, Segal was engaged by the Labor-Management Cooperation Committees (LMCCs), formed by a large Public School System (PS), teachers union and their coalition unions, to analyze their aggregated health claim data. This group collectively represents 167,000 participants with more than \$350 million in annual benefit spend.

Segal completed a customized Health Analytics Study on PS' health benefits, to identify the cost drivers for future strategies on controlling health care costs. We collected two years of member-level data from PS's vendors, including BlueCross BlueShield of Illinois, UnitedHealthcare,

Encompass, and CVS/Caremark, as well as eligibility data from PS. We then scrubbed and aggregated the data to identify gaps in care and outliers compared to national norms.

The final report, which was presented to the LMCC, set the stage for future strategies, including a campaign focusing on a high prevalence, high-cost disease state. The initiative addresses individuals who are at risk for disease and those who are in various stages of health with the disease. Segal is working with the LMCC to communicate the new programs, and troubleshoot with the vendors that are implementing the program.

What follows is additional detail on the project, including some of our analysis and recommendations.

### **Framework**

The analysis considered five benefit options administered BCBS and UHC offering HMO, PPO and PPO/HRA (Health Reimbursement Arrangement) plans with CVS/Caremark as the pharmacy benefit manager and administrator for all PPO's.

- Approximately 56% of the total population is enrolled in an HMO plan, while the remaining 44% is in a PPO or PPO/HRA arrangement
- Wellness, disease management and pharmacy advisory programs are managed through Alere (subsidiary of CVS/Caremark)
- Pre-certification, utilization management, case management and maternity management programs for all PPO options is managed through Telligen

The analysis focused on a number of key components:

- Cost Drivers
- Primary Care Physicians (PCP), Specialist Utilization
- Emergency Room (ER) utilization
- Chronic conditions
- Maternity benefits
- Prescription drug utilization
- Wellness

### **Summary of analysis**

PCP vs. Specialists - PCP visits were found to be 43% below average, while the number of visits to specialist physicians was 19% above average. The average amount paid per visit for PCPs was \$132 versus \$175 for specialists and visits per 1,000 for radiology and lab procedures were significantly above averages. Finally, non-trauma and mental health visits to emergency rooms (ERs) were above averages.

Emergency Room (ER) - Trauma visits and cost per 1,000 were comparable to averages, while non-trauma visits and mental health services were found to be much higher than average.

Chronic Diseases - Individuals with significant chronic diseases represent 33% of the population and produce 55% of Plan cost. The Plan has a disease management (DM) program administered by Alere. Treatment protocols and compliance rates for diabetics were generally favorable, but some gaps in care do exist. This may in part be due to a lack of incentives and/or program awareness. Alere has had difficulty reaching members because almost one quarter of all identified participants has provided incorrect phone numbers.

The Plan's major trend drivers indicate the importance of identifying potential diabetics in the early stage of their condition, as the emergence and progression of the disease will add to future Plan cost. Effective treatment of chronic disease, particularly diabetes, should be a major focus. Alere, as well as BCBS, UHC and Telligen have facets of or full programs devoted to management of chronic disease.

Wellness - Although all benefit options include coverage for preventive screenings, colorectal screenings were lower than averages and utilization of physical exams for adults was very low. Improvement in these results could occur with more focused use of PCPs.

## **Recommendations for LMCCs based on analysis**

### **1. PCP vs. Specialists**

The disproportionate utilization of specialists rather than PCPs may be a function of participants self-referring to specialists, which can result in more costly radiological and lab tests. As the ER copayment is comparable to benchmarks of other plans that intend to curb ER utilization, the likely causes of high ER utilization for services that may be more appropriately directed to other levels of care are a lack of availability and awareness of alternatives, which include PCPs. Below are Segal's recommendations to encourage increased usage of PCPs:

- Require PPO enrollees to designate a PCP
- Reduce the copay for PCP visits and/or increase copays for specialist visits
- Waive the copay for PCP visits for preventive care services
- Encourage the use of "distinct" providers, through plan design and communications. Both BlueCross BlueShield of Illinois (BCBS) and UnitedHealthcare (UHC) have identified "designated" providers within their networks who have achieved better outcomes in terms of both quality and cost
- Consider outsourcing to a managed radiology network. This could reduce the cost of imaging services by providing fixed rates for these services. The LMCCs previously received a presentation from DiaTri, regarding their capabilities. The CPS procurement department could conduct an RFP and consider various vendors. Pursuit of this option would also involve determining any capabilities and barriers in coordinating with BCBS and/or UHC
- Encourage enrollees to participate in Accountable Care Organization (ACO) arrangements, which focus on coordination of care from a primary care physician. BCBS recently announced that it has entered into a contract with Advocate Health System's ACO. Under the Affordable Care Act, hospital and physician groups are encouraged to form ACOs for all patients, not just those on Medicare. We expect further developments from the provider community, as well as from BCBS and UHC on this issue -

### **2. Emergency Room (ER)**

The Plan could promote alternatives, such as MinuteClinics at CVS Pharmacies, urgent care centers, an EAP, and visits to primary care physicians. Below are Segal's recommendations to manage ER utilization:

- Conduct a focused communication process to include the following:
  - Information about the cost and use of ERs for non-traumas and mental health;
  - Promotion of urgent care centers and PCPs; and
  - Information regarding CVS/Caremark MinuteClinics. CVS/Caremark should be able to provide such materials to the Plan and should be encouraged to offer incentives to motivate utilization.

- Lower the copay for use of an urgent care facility to a level below the ER copay
- Implement and promote an EAP, which would provide an alternative avenue for assessment, referral and some mental health counseling needs that currently may be happening at the ER. Programs typically include one to six visits and can provide a conduit to the managed behavioral health network for more complex treatment. A strong communications strategy can encourage patients to go through the EAP first, and if further counseling is needed, the EAP can steer patients toward an appropriate managed mental health network provider

### 3. Maternity

The results provided by Telligen regarding the enhanced maternity management program are encouraging. Segal's recommendation is to promote the program by distributing focused communication pieces that describe the program periodically and continue to monitor results.

### 4. Chronic Diseases

At this point, the Plan can pursue a variety of cost effective approaches. Below are Segal's recommendations with respect to DM:

- Consider redesigning the DM program to include incentives for participation
- Engage in an ongoing communication campaign to address participation in the program coupled with wellness (see below)
- Undertake a joint (City, Schools and Union) campaign to decrease the number of incorrect phone numbers to less than ten percent
- Negotiate specific performance guarantees with Alere, coupled with the City and School's commitment regarding incentives and communication of the program, that are measurable over two to 3 years
- Conduct a thorough review of the program after 2 to 3 years, and consider market alternatives if results fall short
- Consider a value-based benefit design to encourage those with chronic conditions to comply with their medications and treatment protocols.
- Consider a managed dialysis network, which could reduce the cost of these services and coordinate more effectively with Medicare. The LMCCs previously received a presentation from Golden Triangle, regarding their capabilities. The CPS procurement department could conduct an RFP and consider various vendors. Pursuit of this arrangement would involve determining any capabilities and barriers in coordinating with BCBS and/or UHC
- Review the number of benefit *options* available, and consider eliminating those determined to be less efficient
- Review the current benefit *designs* available, and remove features that could be barriers to receiving the appropriate care

### 5. Wellness

- Review the current plan design for screenings to assess whether there are gaps in coverage that discourage participants from following generally accepted recommendations for regular health screening based on age, gender and health status. Consider paying 100% for preventive screenings at a PCP office

- Consider a full range wellness program with a specialty provider. Such a program will need to include performance guarantees and an effective communication process, coupled with DM (see section above)
- Incorporate incentives or disincentives, to encourage participation
- Identify “wellness champions” at CPS and within the Unions to help promote the program and encourage enrollees to participate

Many of these recommendations have been implemented by PS. We have worked with PS to establish a monitoring tool to track the success of the program.

***7.2 Identify strategies for administrative process improvements suggested for previous clients of a similar size and scope to this RFP. In your response, include two examples and describe your approaches, why you proposed them, and how you evaluated the effectiveness.***

Before we can identify strategies for administrative process improvements, it is important that we fully understand the current benefits, funding practices, and how the benefits are communicated and administered when the project commences. We will begin by conducting an administrative, financial and plan design assessment of the Health Insurance Program. These reviews will typically take 8-10 weeks to complete. At the end of this initial assessment, we will be in a position to comment on how ETF current practices compare with the market, and begin to discuss strategic options to improve the ETF's performance.

### **Our Approach and Methodology**

Following is a description of the approach and methodology that Segal typically uses in our initial assessment of a program. This process is designed to address the unique needs and requirements of each entity and provide a common project structure that ensures that no important strategic areas are ignored or overlooked.

While the degree or depth of effort in each of these project activities can and will vary for each client, we believe that it is a "best practice" to follow this basic process and apply attention to each activity and analytical area.

### **Information Gathering**

The first step is to gain a comprehensive understanding of the Health Insurance Program, including your general business objectives and organizational structure. In addition, to consult effectively, we must have a thorough understanding of the financing and design of your current benefit programs, the various funds involved, and the demographics of your membership. At the outset of this project, we will request copies of the following information:

- A plan provision matrix summarizing the main provisions of each plan and indicated which groups of employees (e.g. State Employees, Local Education, Local Government, etc.) those provisions apply to
- Summary Plan Descriptions (plan documents if SPDs are not available) and list of all plan changes within the last two years
- Any recent initiatives (e.g., *Well Wisconsin*, consumer driven health, HSAs, disease management, pharmacy management, etc.)
- Vendor contracts
- Enrollment materials for last three years (e.g. forms, instructions, etc. for actives and retirees)
- Administration or benefit procedure guides
- Benefit handbooks
- Benefits communication materials, including any standard newsletters
- Results of any employee surveys regarding benefits

- Results of any competitor surveys
- Last two year's renewals and financial projections
- Current budget documentation and expectations
- Documentation from prior consultant that the State deems appropriate
- Current census showing age, sex, status, group, coverage type and level, salary and location/zip code
- Detailed claims files from your administrator or data management vendor access. We can also work to get customized reports to meet this need.
- Other relevant documentation and materials as may be noted in discussion with the State

### **Process Review**

The review stage will primarily focus on the medical, pharmacy, wellness/care management and behavioral health programs, with some minor review of the other optional employee paid benefits such as life, long-term care, disability, vision and dental. During this step, we will review various elements of the current plan(s). We will assess what the strengths and weaknesses are of the existing program. Criteria used to evaluate the current program will include:

- **Claim payment and processing** – we will review and benchmark the current administrators' and carriers' accuracy, efficiency and timeliness in processing claims.
- **Eligibility data management** – we will review current practices for collecting, updating and managing member eligibility. Our benefits administration review will include the timeliness and accuracy of eligibility data feeds to your vendors and their ability to accurately and efficiently process those feeds.
- **Vendor invoicing, billing and banking** – we will review and benchmark current invoicing practices and expense payment, including self-invoice, self-pay, direct invoice, and banking arrangements that may require a minimum balance in an escrow account.
- **Internal revenue and expense management** – this includes a review of member payroll/pension deductions, as well as revenue and expense exchanges with participating employers, and other state agencies, including timing, how payments/transfers are determined (premium, percent of pay, etc), and effectiveness of current approach(es) utilized.
- **Data management** – we will review how effective claims, cost, encounter and eligibility data is collected, stored and shared, with a focus on the availability for reporting and analysis, including timing and accuracy of required data exchanges between ETF and/or your vendors

### **Compliance Review**

Segal routinely conducts technical reviews of our clients' plan documents, plan enrollment procedures, employee communications materials, insurance policies, and participant correspondence for compliance with the Internal Revenue Code and Department of Labor provisions and regulations, internal and external consistency and the provision of clear rules and guidelines for plan operation. Our analysis will be specific to your plans' status as public plans,

and also comment on any relevant items particular to multi-employer plans that may impact ETF.

The *Crosscheck* will:

- Review of the documentary material governing the plans, including all relevant statutes, regulations, plan documents and administrative policies and procedures, etc. that are relevant to public plans.
- Review of administrative documents, such as service agreements, written administrative procedures, and employee communications and forms, include those for COBRA, HIPAA Portability and Privacy, plan enrollment, changes in status, the Women’s Health and Cancer Rights Act, IRS reporting forms, and related areas.
- A written report summarizing our findings and analysis to the client’s legal counsel, identifying areas of administration that warrant further attention, and presenting options for resolving potential problems or inefficiencies. Our analysis will be based on conclusions drawn from information gathered throughout the Review, relying on our team’s experience, judgment, and acceptable industry practices.

This *Crosscheck* review would provide a detailed analysis of the ETF daily operations and administrative practices. This global view of plan operations:

- Confirms that plan procedures correspond to what the plan provides and the law requires
- Reduces risk of significant IRS or DOL penalties
- May reduce expenses by identifying ways to streamline plan administration
- Can serve as a training vehicle or “refresher course” for staff
- Can be used as a template for self-audit guidelines for ongoing compliance efforts.

## **Examples of Specific Projects**

We have provided two unique clients examples to demonstrate a range of administrative process improvement situations. The first shows how we can successful streamline to help current administration. The second shows how limiting vendors can significantly reduce the program’s administrative burden.

### ***Example 1: Eastern State Employees Retirement System (ERS)***

ERS Health Option Program (HOP) is a voluntary retiree-only health benefit program covering over 75,000 of 150,000 Medicare eligible retirees from over 700 school districts across the State. More than 400,000 active school employees participate in the statewide ERS program. The HOP program offers retirees and their dependents an array of seniors’ health options, including a Medicare supplement plan, a Medicare Prescription Drug Plan (PDP) and six Medicare Advantage plan options. Retirees pay all premium costs. Some retirees are eligible for a pension supplement for limited reimbursement of medical coverage costs based on long service. Like Wisconsin, this program is made available to retirees at full cost and retirees have some potential for funding from the State.

For ERS, Segal has conducted a number of studies relating to their premium assistance program, which provides an eligible retiree reimbursement for up to \$100 per month for their out-of-

pocket medical premiums through an approved plan. With about 30,000 early retirees still participating in their local school employer plans, the agency must each year verify the out-of-pocket amounts to confirm the premium assistance, which is added to the retiree's monthly pension payment. While the burden of proof is technically on the individual retiree to obtain a statement from his or her employer plan verifying the amounts paid by the retiree by month, for administrative efficiency, the agency verifies the coverage directly with each school employer. This requires detailed lists of retiree participants along with school employer involvement to verify each person on the list, but saves a school employer from writing sometimes hundreds of verification letters for its retirees.

Segal studied the entire premium assistance structure, mapped the flow of data, verification and money, and met with agency staff and their third party administrator involved in the process as well as with many school districts to learn the processes they must complete to comply. We provided recommendations for change and improvement that the agency adopted as policies, including a change in how approved plans are defined and determined, elimination of extra steps not required in the paper process, and development of a secure online school employer web portal that would allow any-time updates of retiree coverage and premium data and would vastly simplify the current paper-based system. We are now working with the client to implement these new administrative approaches and programs. The initial changes to the paper-based system have resulted in significantly improved administrative efficiency as evidenced by reduced activity charges, and by earlier detection of premium assistance overpayments to retirees for months they did not have out-of-pocket premium cost, overpayments that must later be paid back to the system.

### ***Example 2: Southern State Health Benefit Plan***

Ken Vieira and Richard Ward have managed several different engagements over the last 6-years for this large southern State. The plan covers over 640,000 members, including teachers, state employees and retirees (80,000 Medicare eligible).

In 2008, Mr. Vieira managed a comprehensive vendor procurement for the State. The State had approximately 8 different vendors and 17 plan options, some with minimal membership. A large component was a vendor marketing was to select two statewide vendors, both offering the same two plan designs. In addition, both plans had identical wellness and medical management incentives in place. This strategy resulted from a comprehensive study of strategic options, similar to what ETF is requesting in this RFP. This analysis included an extensive review of the current plan options and the choice ("true choice") those option provided. It was determined that fewer, well designed options could provide expanded benefit option choices and provider access to the membership, which reducing the number of contracts to be managed and benefit options to be communicated and priced.

Shortly after Richard Ward joined Segal in 2012, Segal was engaged to assist the State with a reprocurement of their carrier and administrator contracts, to be effective 2014. These contracts have been in place since 2008, which coincided with the implementation of a consumer driven

Under the prior contracts, two vendors provided comprehensive services on an integrated basis: Medical TPA, MA-PD, PBM, wellness and medical management. The procurement was structured so that State will contract in 2014 on a best-in-class approach, which has resulted in

the top vendor in each service category being contracted for 2014. The new contracts are expected to reduce costs by more than 10% annually.

Having the appropriate “best in class” vendors and plan options can significantly affect the administrative burden of plan sponsors, while saving costs for both the State and its membership. Establishing a streamlined administrative process and structure is important, as managing several “carved-out” vendors can present challenges in ensuring that all parties are on the same page.

As part of the procurement and program strategy, we helped them conduct a cost/benefit analysis of the additional effort necessary to manage the additional contracts and determine that the impact on costs and member health was worth the effort to manage separate contracts for medical TPA, PBM, medical management and wellness services. The RFP focused on determining each vendor’s ability to operate cooperatively in such an environment and weight was provided in the scoring for each bidder’s ability to “play nice”. Segal also assisted SHBP in determining the internal resources (and expertise) necessary to effectively manage these contracts.

The two procurements had somewhat different approaches but resulted in significant cost savings and administrative efficiencies for the State.

***7.3 Identify cost containment strategies suggested for previous clients of a similar size and scope to this RFP. In your response, include two examples. For each example, describe your approaches, why you proposed them, and how you evaluated the effectiveness.***

Segal has extensive experience conducting analyses of health benefit programs, it is the core of our business. Each member of your senior team has lead assignments on strategic assessment of large State programs. This includes your senior team: Ken Vieira (State of North Carolina), Rick Johnson (Commonwealth of PA), Chris Mathews (Large Eastern State) and Richard Ward (State of Illinois). All serve as project leaders and subject matter experts, though in our experience these analyses often benefit from the presence of other individuals with skills in areas such as underwriting, actuarial, prescription drug plan analysts, or vendor management.

The foundation of effective plan management is to have complete and accurate financial and demographic information concerning all benefit programs. Your current employee population has certain predictable behavioral characteristics and costs under various design alternatives. With this information, Segal can:

- Identify the competitiveness and relative value of your current benefit package and alternatives;
- Determine whether benefits utilization differs for different demographic segments;
- Accurately project future costs; and
- Avoid benefit plan initiatives that might unnecessarily create human resource issues.

Preparing detailed financial analysis and benefit modeling is a core actuarial skill where our actuarial team is highly proficient. The proposed team includes **Richard Ward, FSA, FCA, MAAA, Kirsten Schatten, ASA, MAAA, Chris Heppner, ASA, MAAA, Peter Wang, ASA, FCA, EA, MAAA** and **Olga Ronsini, ASA**, all of whom have managed financial engagement for over a dozen states. These include state level plans in New Hampshire, Large Eastern State (cannot be named), North Carolina, Georgia, Illinois, Pennsylvania, Virginia, Tennessee, Colorado, Ohio, Alabama, Louisiana, Illinois and Kentucky.

At Segal, we bring a rigorous and analytical approach to developing cost containment strategies. By digging into the claims data, we are able to identify the true drivers of cost trend increases and utilization spikes. Our cost containment approaches are targeted and we develop strategic solutions to better serve your employees' benefit needs. This claims-driven analytic approach, coupled with our vast market experience will ensure that ETF is delivering benefits in the most efficient manner possible. This is one area where we are distinguished from our competitors.

### **Wellness and Disease Management Consulting**

Segal Consulting has extensive experience in helping clients implement a wellness program. The success of any medical management and/or cost containment initiative will depend on how well it is designed to address the medical cost drivers that are prevalent in the County's population. Part of our review will result in developing a wellness program that best meets ETFs' needs. **Chris Mathews** has extensive experience working on these types of projects with public sector entities. Chris is also the head of our Total Health Management Practice.

Segal employs a number of proprietary tools to identify utilization issues and possible solutions. We will first submit the current the County plans to review using our **Wellness Inventory** tool

and our **Disease Management Inventory** tool. These internally developed tools help to quantify program features that may be out of line with current best practice for wellness and disease management programs.

Upon the completion of the review, we expect to be in a position to discuss what investments are needed to:

- redirect care to high quality/low cost providers,
- improve participant compliance with clinical guidelines in managing their health conditions and
- generally improve population health in a more deliberate way than ETF may have done in the past.

Our client experience has demonstrated that changes of these types, when communicated carefully to participants, will not be perceived as negative changes in benefits or delivery style, and will even be embraced heartily by some participants.

A critical initial component to implementing these and other meaningful plan management programs is to better understand underlying population health, what issues are particular to it, how they compare to similar groups in terms of medical diagnoses and utilizations patterns, and which tools will be the most effective in managing the population's medical care. Data mining and predictive modeling, an approach many health plans are using, involves identifying trends in data in order to facilitate decision making.

Segal will tailor our analysis and recommendations specifically to the ETF's programs and needs. The following describes our Total Health Management Approach that integrates all elements of wellness and disease management program design and monitoring. We believe cost containment much include some of these elements to be successful.

### **About Segal's Total Health Management Approach**

An effective Total Health Management (THM) program is tailored to the needs of the population that will be using the program and the medical plan design must be refined to support health promotion and disease management efforts, as each worksite develops a culture of health day in and day out. Segal is ready and able to assist you in all aspects of your Total Health Management initiatives.

Total Health Management is an approach to develop cost control measures and measure ROI. The THM methodology follows a disciplined process that includes:

- **Analytics:** utilize medical and Rx drug claims data to identify the medical cost drivers of the plan, develop a population health risk profile, and detail the potential opportunities to reduce medical trend and lower population health risk factors.
- **Planning:** establish a vision among decision makers about the future state of the health plan by defining the plan's guiding principles, key objectives, and how success will be measured in the short-term and long-term.
- **Design:** review and modernize plan design features to eliminate barriers that inhibit effective medical management and support the objectives of the total health management strategy,

while providing a gap analysis of service needs with recommendations to remedy the gaps identified.

- **Communication:** create a multi-faceted communication strategy for educating plan participants about the health management/wellness design elements and program features; and determine the media requirements to implement the key communication messages. Initiate outreach to plan participants identified with high health risks and begin more effective support and medical delivery to these patients.
- **Management:** develop the reporting requirements to monitor success metrics to measure progress toward achieving key program objectives and develop a schedule for regular vendor reporting of those success metrics.

Hard dollar savings produced from medical management program will depend on whether the plan sponsor has documented baseline measures from which savings can be derived. A measure of hard dollar savings of the health management/wellness program is the degree to which the program was successful in helping employees be healthier, necessitating the use of fewer medical services. Generally, hard dollar savings from a health management/wellness program are difficult to measure because the variables influencing such a measurement are nearly impossible to control for. To say that medical claims are lower in 2013 because an employer implemented a wellness program in January of 2013 is likely not able to be substantiated with facts. More likely the savings in the short-term are related to random claim variations, than from the participation of a percent of employees in a medical management program.

Segal has found that by using a focused approach to monitor key factors linked to the success of a health management/wellness program, an organization can develop a solid financial model to measure savings. The primary methods for measuring the success of any health management/wellness program are through monitoring:

- **Participation:** the extent to which each of the program services are used by the eligible participants (e.g. 35% completed the health risk appraisal, 14% of smokers attended the Quit Smoking classes, etc.) will be an effective data point to monitor.
- **Behavior Change:** the extent to which the health management/wellness program motivates individuals to change their risky behavior, such as 8% of the people who signed up for the weight management program lost at-least 10 pounds in the 12-week program, or 22% of the people who had an elevated cholesterol level reduced their cholesterol level at least 5%. Other key changes in behavior that reduce medical costs include medication adherence, treatment compliance to medical guidelines for specific chronic conditions.
- **Satisfaction:** the extent to which participants were pleased with the wellness program (e.g. 76% of the employees who attended the health fair rated it as good or excellent, 59% of the employees who participated in the Quit Smoking classes found them helpful or very helpful).
- **Impact on Non-Claim Costs:** Comparing the baseline metrics the plan sponsor keeps on sick time, productivity, FMLA use, STD use and work comp use/costs to those same metrics after each year of the wellness program can yield some interesting and positive findings, which when multiplied by salary impact can show significant savings from the wellness program.

The impact of an effective health management/wellness programs will initially be seen in terms of increased employee productivity, lower use of sick time and FMLA, fewer STD claims and

lower workers comp costs as employees begin to focus on staying healthy. Studies suggest that the impact on medical claims may be realized 1 – 3 years later as employees who have participated in the health management/wellness program reduce their personal health risk factors. However, for members with certain illnesses, the impact is felt immediately as the employee feels better by taking their medication and receiving preventive care. Lower health risk factors are associated with managing weight, quitting smoking, reducing blood pressure, lowering cholesterol, increasing regular exercise, taking medications regularly, and following the treatment guidelines for chronic conditions.

Using the Segal Total Health Management methodology, we have developed effective approaches to measuring the ROI of health management/wellness programs. Our research shows that by focusing on the above four primary areas of monitoring success, medical trend will be reduced as follows:

- Annual improvements of 10% in medication adherence produce a 0.25% reduction in annual claims, up to a maximum of 2%.
- Annual improvements of 10% in treatment compliance produce a 0.25% reduction in annual claims costs, up to a maximum of 2%.
- Ultimately, the actual return on investment for a health management/wellness program is measured by an actual reduction in the client's medical trend. Segal will work with the County to develop strategies that reduce medical trend over the short-term and long-term.

## **Examples of Specific Projects**

We have provided two unique clients examples to demonstrate a range of cost containment strategies. The first example provides details on how our Total Health Management approach has been successful with a large union client. The second shows how our strategic approach helped a large state uncover millions of dollars of savings.

### ***Example 1: Large Union Plan***

A large, jointly trustee labor/management benefit plan with 70,000 members was looking to reduce the health care cost trend and improve its population's health and quality of care, because in the last six years, total claims cost were up 88%.

#### **Segal's Approach:**

Segal worked with the plan sponsor to offer a dual option plan. Members were given the choice of a less costly health improvement plan or more costly standard plan. Incentives for plan participation included:

- Strong management commitment to support the health improvement plan and engage members
- Implementation of a fully integrated claims, prescription drug, screening, HRA and other data to support predictive modeling and risk stratification

- Technological advances that enabled a virtual medical home, personal coaching and a personal health record
- One-on-one interaction with personal health care counselors and health coaches Access to online and in-person resources that help participants quit smoking, stay active and maintain a healthy weight

## Results:

The health improvement plan proved to be a success in both participation and outcome:

- Claims costs trends were reduced to under 5%
- There were 24% fewer absences due to health problems
- 100% of participants received the core screening and HRAs
- 10% increase with primary care physician visits
- 63% fewer tobacco users
- 36% fewer participants with high systolic blood pressure
- 27% fewer participants with high diastolic blood pressure
- 59% fewer participants with low HDL cholesterol
- 20% fewer participants with high LDL cholesterol

This plan obviously had a lot of opportunity from the start. Making dramatic changes can be a challenge but with the right communications and management support, it can be a win for all involved.

Segal's experience working with a number of large bargained plans gives us a unique advantage. We understand the challenges ETF will face and have a proven track record of producing results. Being fair and unbiased gives our recommendations added weight.

### **Example 2: Central State Health Plan**

A State agency in the Midwest oversees the administration of group health benefits for over 440,000 enrollees including the State Employees, Local Governments, Teachers' Retirement System and Colleges. There are nearly 180,000 retirees, of which, 123,000 are Medicare eligible.

This was a new contract for Segal in early 2013. Most of the ETF team are also key members of this State team. As we mentioned earlier in this proposal, we typically start our assignment with a high level strategic look at the program and look for immediate opportunities. In the first few weeks Segal completed our strategic review and found three main areas of opportunity:

1. **Pharmacy Plan** - on review of their contract we found that a "Market Check" was part of their PBM contract clauses. We believed the current financial terms were not aggressive for a plan of their size and we believed a significant savings opportunity existed in pricing alone.
2. **Medicare Retirees** – the State still had in place an archaic Medicare secondary plan with their HMOs and PPOs. The program did not make use of available federal programs to

minimize their costs on medical nor pharmacy. From our recent experience in other states, we know there was a significant savings opportunity for the State.

3. **Wellness Plan Design** - the lack of any comprehensive or strategic wellness plan has left the State with spiraling health risk and costs. Our cursory review of self-reported vendor engagement and disease management activities showed member engagement and participation in DM and wellness programs to be virtually non-existent. Even union leadership had expressed interest in establishing a comprehensive wellness design and said so in their meeting notes. Although there was a near-term opportunity, the long-term nature of the plans could be significant.

After our presentation to the State, we were engaged on these assignments. The pharmacy was first. We prepared a market check from our available client database and negotiated new terms with their PBM. This resulted in a substantial financial savings to the State. During our interactions with the PBM and upon review of some of the data, a few plan design changes were suggested to move them closer to the industry. Most of the changes involved the introduction of certain clinical programs.

Our next project resulted in staggering financial savings to the State. Segal first educated the State on how the Medicare Advantage program worked and more specifically, how national passive PPO plans operate in comparison to traditional medical supplement type plans. After getting buy-in from all parties – the State, Legislature, Union and Retirees, we managed the procurement. We selected one National Passive MA-PDP PPO and two local MA-PDP HMOs. The benefits were greater than the current level of benefits and premium rates are over 40% lower than the prior year's claims costs. The result is nearly \$200 million savings per year.

The third project has progressed at a more measure pace, mostly due to the longer-term nature of the impact and expected return. Due to their managed competition plan design model, the wellness strategy is more challenging to deploy. Segal conducted a comprehensive wellness strategy report that was presented to union leadership. It included various options, benchmarks to other state program and financial assessment. The initiative has been approved, but we are working through the details of a “phased-in” implementation approach. The plan has targeted savings first year of \$50 million that will likely now be achieved in the second year. The majority of the savings have come from behavior modification and enhanced compliance.

This example demonstrates that Segal will take a comprehensive look at all aspects of the program. The savings that materialized did not have any elements of cost shifting to members and should be viewed as true cost containment. There is no single solution that is best in all situations or with all organizations. We will work with ETF and the Board to identify, assess and prioritize opportunities for savings and improvements in administration and operational processes.

***7.4 Identify health care quality improvement strategies suggested for previous clients of a similar size and scope to this RFP. In your response, include two examples. For each example, describe your approaches, why you proposed them, and how you evaluated the effectiveness.***

Evaluating Quality and Performance Initiatives. Segal evaluates quality and performance at many levels. Our health management team includes a doctor of medicine, a doctor of pharmacy, and master's level registered nurse. These experts have monitored and evaluated quality metrics for care programs, and have actual experience evaluating programs such as Bridges to Excellence, Patient Centered Medical Home, and Prometheus and minimal invasive surgery.

Segal's Medical Director, Dr. Paralkar, has first-hand experience in administering the Bridges to Excellence (BTE) program while at Ingenix, a subsidiary of UnitedHealth Group, now known as OptumInsight. Dr. Paralkar and her team was responsible for creating physician specific reports on BTE certified physicians within the United Healthcare (UHC) network based on quality and performance. The qualified physicians were awarded a pre-determined bonus based on performance. Dr. Paralkar and her team were responsible for operationalizing this program for the carrier.

This work required extensive understanding of the physician quality and performance evaluation methodology using claims data, as well as a deep understanding of the complex methodology needed to attribute patients to physicians. Dr. Paralkar and others in the Segal Total Health Management (THM) team have deep expertise in new and evolving payer-provider payment models, as well as creation and evaluation of Patient Centric Medical Home (PCMH) and Accountable Care Organization (ACO).

Many of the components of our **Total Health Management approach**, described in detail in our response to 7.3, will result in improvements in the quality of care provided to patients. For example,

- Tiered, or narrow, networks and centers of excellence can direct more patients to higher quality providers and facilities
- On-site clinics can increase medication compliance, manage referrals to higher quality specialists, and reduce barriers to care access
- Member incentives to participate in disease management programs can reduce gaps in care, improve clinical metrics (HbA1c levels, cholesterol scores, etc) and improve members' long-term health
- Utilization of new and emerging provider compensation models provides an opportunity to compensate providers for keeping patients well, rather than mainly compensating for services needed when patients are not well.

Recently, for example, Segal reviewed a Patient Centered Medical Home demonstration project proposal on behalf of a large State Health Plan. While just now going into operation, the State Health Plan was concerned to examine every area in which this limited demonstration project might affect its participant population, whether those who would be invited to participate or those who live in the immediate geographic area but would not be included. Our review helped the Plan identify additional areas for discussion before final commitment to the project.

## Examples of Specific Projects

### *Example 1: Large State Health Plan*

One of our largest State accounts was looking at ways to save money while enhancing benefits and quality. This is a typical goal of many plan sponsors but very difficult to achieve if you focus only on short-term goals. The Plan and their governing Board maintains a long-term focus, as evident in their guiding principles and 5-year financial forecasts. Through our work we were able work collaboratively with staff to formulate a strategy consistent with the Board objectives.

There has been plenty of work published on quality and high performing networks, the problem is many cannot be practically applied or implemented. Many networks simply look at lower cost as their top tier network, without integrating the quality of their results. That narrow focus has plagued the health care industry since HMOs evolved some 30 years ago.

Segal proposed using a quadrant model, looking at cost vs. quality. Our initial focus was on hospital providers within the state. With about 100 hospitals currently in the network, this was a very manageable number. There was also a number of studies and approaches developed to build on. We worked with their current vendor to develop the strategy and metrics for selecting high quality/low cost providers. The Board relied heavily on their logic, since the vendor planned on rolling out to entire book of insured business. The hospitals with the highest quality while demonstrating the lowest costs were recommended as Tier 1 providers.

Segal linked the proposed network to the current experience to see what volume was currently being run through this limited network. The disruption would have been significant if the Plan replaced the network entirely. It was recommended to add a preferred tier, viewed entirely as an enhancement to their benefits. Members who use this tier receive enhanced benefits through lower cost sharing, and the plan/member benefited from enhanced quality. In addition, the Plan was able to negotiate more favorable pricing with many of the hospitals.

With the hospital network in place, the Plan wanted to take a similar approach to professionals. This is a much harder assignment and requires a significant amount of detailed claims data to be credible. At this point in time only a few specialists had enough Plan data to be tiered. Since viewed as a benefit enhancement, members who utilized these Tier 1 physicians received reduced copayments for their visits. The long term objective is to gradually increase the specialties covered and have a comprehensive physician Tier 1 network similar to the hospital structure.

The tiered network approach was implemented in 2014 and we have seen significant steerage over the first 6-months. The Plan is on track to pass our savings estimate for year 1 and in turn should see greater results longer term with reduced readmission, less costly tests, better chronic cost management, etc. We have developed metrics to track the emerging results quarterly.

## **Example 2: Large Eastern City**

The City faced rapidly escalating medical costs. Labor and management are at odds over cost allocations and formed a Joint Labor Management Committee to address medical cost challenges. The medical benefits are provided to hourly workers through four trust funds, while non-bargained workers are in one program. The goal is to work together to develop joint programs that balance fiscal needs against employee needs.

Segal was engaged in this solution in part because of our collective bargaining and Joint-Labor Management expertise. Segal was viewed as a neutral third party with the ability offer fiscal/employee balanced solutions with neither a bias toward bargaining units or administration.

Our solution was to identify the medical risk factors in the population that were attributed as driving factors in medical costs and then to develop plan design and medical management to specifically address these areas, using a combination of value-based and population management strategies to lower health risk factors and increase quality. We collected raw claims data from the five plan vendors and PBM vendors; coordinated the process of refunding data and predictive modeling with their vendor, CareAdvantage, performed the final analysis of the data identifying key indicators, developed reports, executive summaries, and assisted in the presentation of findings to the committee and other key constituents resulting in an action plan, complete with objectives and metrics.

Using a combination of value based and population management strategies to lower health risk factors in the population we:

1. Provided each plan with a detailed population health risk profile and predictive modeling analysis detailing the key cost drivers within each separate population.
2. Developed an aggregate report that focused attention on the commonality of health risk factors, chronic condition prevalence, risk stratification, and case mix adjusted cost drivers.
3. Identified opportunities to address market driven anomalies present in the local medical market delivery system.
4. Identified plan design features that are impeding benefits from being aligned with best medical practices.
5. Provided detailed review of gaps in care, unmet wellness opportunities, metrics for bench marking and tracking improvements in population health, and proposed medical management programs that would target specific needs of each population.
6. Developed the reports for each plan and presented the aggregate report to the Committee.
7. Developed an action plan complete with objectives and metrics to measure progress toward the achievement of objectives.

**7.5 Identify plan design strategies suggested to promote the efficient delivery of quality health care. In your response, include two examples. For each example, describe your approaches, why you proposed them, and how you evaluated the effectiveness.**

Plan design is probably the most controllable factor affecting health plan costs and ensure that you are efficiently delivering quality health care plans to your employees. The types and number of plan offerings are key variables. We review with our clients ways to preserve effective levels of coverage without overpaying. This includes addressing the following plan design features:

- **Establish meaningful cost sharing with participants (i.e., deductibles, copayments, coinsurance and monthly contribution levels).** Nominal copayments do little to discourage wasteful demand for questionable care. However, if the cost sharing is too high, it may deter employees from getting *essential* care.
- **Establish appropriate cost-sharing differentials among treatment options and settings so employees are encouraged to seek the most cost-effective courses of treatment and the most efficient providers.** Differences between network and non-network benefits and the coverage for brand name and generic prescriptions that are significant enough to influence behavior are important. Payment levels between competing therapies and inpatient/outpatient settings also need to differ. Plans with lower out-of-pocket costs for less expensive treatment options can change patients' behavior, benefiting both employees and employers.
- **Provide coverage incentives for support service and complementary care to motivate employees to improve their health.** Educational material about treatment options, home health aides and access to support groups are examples of support services and complementary care.
- **Enforce pre-certification and utilization review rules.** Broad-based, non-specific pre-certification rules that ultimately result in approval of all requests are a waste of time and money. To be most effective, pre-certification rules should be targeted to treatments and services that are subject to overuse or abuse. For instance, some people with minor, acute conditions improperly use narcotic painkillers on an ongoing basis (*i.e.*, potential indication of addiction). Requiring pre-certification can identify these cases and often stop the abuse.

Segal is comfortable working with large public sector clients where we must review and analyze possible benefit changes and cost effects on a rapid turnaround basis. Through our actuarial work with the State, we will develop a clear understanding of the cost drivers and factors in your program. Using that knowledge, as well as our analysis of claims and program costs for establishment of premium and cost rates, we will estimate the likely effect on the program of changes being discussed.

### **Tasks for Evaluating the Plan Design**

- Undertake a review of the plan design using Segal proprietary Wellness/Disease Management Inventory tool that incorporates over 50 recognized state of the art standards of treatment and care related to health plan design.

- Measure the current plan design against nationally recognized standards of wellness and medical management and develop a gap analysis showing areas where barriers can be lowered to improve plan participant access to recommended treatment.
- Analyze the relationship between plan design elements and the behavior that is generated in relationship to value based design and income based levers to trigger optimal health utilization.
- Develop a report that details for each plan design feature any potential gap that may exist between the current state and state of the art wellness and medical management programs.
- Develop cost estimates of the impact for remediating the gap and incorporate into the State's Ten-Year Plan.
- Develop state of the art incentive/penalty plan design recommendations that utilizes elements of value based benefit design to achieve high levels of participant participation in effective health plan utilization and healthy habits.
- Provide input about the development of a communication strategy that the State should develop to roll-out needed plan design changes to close the gaps.

### *Plan Structure & Improvement*

Based on the results of our analysis, we will recommend benefit plan design changes where appropriate. Segal evaluates benefit design alternatives in terms of anticipated results and measures them against the ETF's philosophy and program objectives. We take into account such things as:

- Competitiveness of current benefit plans to prevailing practices;
- Cost effectiveness of the current third-party administrators;
- Appropriateness of certain benefit provisions;
- Differences in plan design and operation from both the employee and employer points of view;
- Projected cost of the model benefit plan as compared to the current arrangement;
- Available funding techniques and the appropriateness of each to the ETF's strategic goals and budget, considering cost, cash-flow and risk features;
- Type of service delivery model; and
- Performance standards and guarantees that should be included in vendor contracts to administer the plan design change.

Based on our analysis, we will make recommendations to the ETF as to appropriate funding approaches and to the degree to which financial risk should be shifted, retained or shared between the ETF and the membership.

## Examples of Specific Projects

### **Example 1: Large State Health Benefit Plan (SHBP)**

The State Health Benefit Plan (SHBP) has been a long time client of Ken Vieira and Richard Ward. The plan covers over 640,000 members, including teachers, state employees and retirees (80,000 Medicare eligible). Over the last five years, they have managed a wide array of consulting and actuarial services, the most important being a redesign of their program in 2006.

Ken and Richard led a comprehensive feasibility study relating to consumer directed plans. Our approach was to create guiding principles, review performance metrics, develop a 5-year strategic plan and quantify the opportunity cost. It was a lot of work compressed into a 12-week period.

Before implementing our CDH Strategy, the SHBP had evolved into a large and difficult to manage number of plans and vendors. They had 17 medical plan options, providing members choices in HMO, PPO, Indemnity and HDHP options. There were 4 medical plan vendors: BCBS, CIGNA, Kaiser and UHC. The vendors each offered slightly different plans and options, but there was very little variation in value among the plan options – all plan options were within 5% actuarial value of each other.

Most of their active membership was enrolled in the HMOs and most of the rest was in the PPO. There was less than 1% in their pilot HRA. The indemnity plan was essentially a retiree plan where members paid a substantial premium for the coverage. Their premium structure was only two tier (single/family) and they had surcharges for Tobacco users and those with spousal coverage available elsewhere. There was no strategic plan in place and costs were escalating at double digit trends. Given projected revenue shortfalls the trends were not sustainable.

We managed a very systematic approach and worked with the management team at SHBP, as well as key stakeholder in the legislature, to put together a benefit package that made sense for their population. Our team recommended the plan options be reduced from 17 plans to 8, essentially 4 plans with 2 vendors. The strategic analysis resulted in a governor's directive to introduce a consumer health plan with incentives to encourage enrollment in HRA plans over time through employee contribution and plan design steerage. In the process, all plans were going to institute elements of consumerism. We recommended the active contribution structure be changed to four tiers and there was a large emphasis on wellness/DM incentives. Our strategy was gradual, implementing small steps each year. After meeting and getting approval from the Governor we began the process in 2007 for the 2008 plan year.

In 2008, only small steps were practical. One of the vendors was removed, enrollment was frozen in the indemnity plan, plan design and contribution changes were implemented and the CDHP was rolled out Statewide, resulting in 4% enrollment.

The SHBP made more substantial progress in 2009. A large component was a vendor marketing that resulted in selection of two Statewide vendors. Kaiser members were granted a one year extension due to disruption issues. There were some additional plan design and contribution changes to the non-HRA products. Active contributions were changed to four tiers and a wellness incentive program was implemented. The final changes were to default new employees into the HRA. HRA enrollment increased to 16%

Lastly, in the 2010 all elements of the strategic plan were implemented. They eliminated Kaiser and were down to two vendors – United & Cigna. All Medicare retirees moved to Medicare Advantage and we got HRA enrollment to 28% that year – ultimately it climbed to over 40%.

The financial results were significant and as projected. With the plans expected to trend between 8-10%, the SHBP trended at a 4% rate over the same period. That has resulted in FY10 total savings of \$220 million from the original baseline. The plan was put in as a win/win for both the State and its membership. Of the \$220 million savings, \$114 million or about 50% was returned to employees through reduced contributions and incentives. Not only was there substantial cost savings, there has been an increased awareness of member health and satisfaction with the program.

Segal was engaged to assist SHBP with a reprocurement of their carrier and administrator contracts, to be effective 2014. Under the prior contracts, two vendors provided comprehensive services on an integrated basis: Medical TPA, MA-PD, PBM, wellness and medical management. The procurement was structured so that SHBP will contract in 2014 on a best-in-class approach, which has resulted in the top vendor in each service category being contracted for 2014. The new contracts are expected to reduce costs by more than 10% annually.

### ***Example 2: Large Southern City***

Segal serves as the consultant and actuary to this large Southern City with more than 50,000 covered members. **Richard Ward, FSA, FCA, MAAA** leads the engagement and **Kirsten Schatten, ASA, MAAA** is the lead actuary.

The City utilizes a modified ACO arrangement with a large local provider group in one of its plan options. In this plan option, 100% of professional services are capitated to this provider group and members are restricted to utilize this provider group for all non-emergency professional services.

The City provides modest premium and plan design incentives for employees to enroll in this option (the Limited Plan). Other options include an open access PPO and a HDHP. In these options members can utilize this same provider group, but are not required to and have the choice of other network and non-network providers. Approximately 75% of the membership is covered in the Limited Plan, which receives high scores in annual member satisfaction surveys.

Within the capitated arrangement, providers are compensated for higher generic prescribing rates, in-person wellness coaching, improved membership biometrics (BMI and blood pressure reductions), and care gap reductions.

A recent study was performed to compare the costs and utilization of the Limited and PPO plan memberships. The Limited Plan has approximately 37,000 members and the PPO has approximately 10,000 – so both groups are reasonably credible in size. There are no significant differences in demographic or health risk profiles for the two groups. However, the Limited Plan membership has:

- A higher generic dispensing rate
- Lower rates of hospital admissions, and readmissions
- Lower emergency room utilization rates

➤ Lower urgent care utilization rates

Additionally, the average cost per hospital admission (and readmission) and ER/urgent care visit are 10-20% lower for the Limited Plan. Data is currently being collected to determine the impact on biometric and care gaps. But City's health plan trend has averaged to 1% annually since the program was implemented.

The PPO members primarily utilize the same providers for professional services as the Limited Plan members. In the PPO, providers are compensated under a largely Fee-for-Service pay structure, while under the Limited Plan these (mostly) same providers participate in the previously described capitation program.

Based on the utilization differences between the two groups and the overall favorable trend, it seems reasonable to conclude the ACO-like Limited Plan is resulting in the delivery of higher quality care to patients and lower costs to the City.

In 2013, this program was reproduced with the encounter data from the Limited Plan evaluated and repriced under several alternatives in the market, most of which are FFS based, and it was confirmed that the current approach is an appropriate strategy for the City.

***7.6 The Contractor will be expected to use data from a variety of sources. Identify examples where your company reviewed multiple sources of data for a client and made recommendations about data gaps and needs. In your answer, include two examples. For each example, describe your recommendations, why you proposed them, how your client(s) acted on your recommendations, and how you evaluated the effectiveness.***

We currently work with a large number of clients in collecting and analyzing data concerning their health benefit programs, providing a full data integration and warehousing approach. Your Segal Consulting and Technical Team is willing to create models and tools for the ETF which reflect our actuarial and/or financial methodology/approach used to accomplish the technical objective of each task — and have experience doing so.

The challenge for many employers who may already have access to risk and population data, as well as many brokers and consultants without our in-depth experience and expertise with data analytics is in making that data meaningful and actionable. Segal brings our expertise work on behalf of the State of Wisconsin.

We provide data analytics as a tool for data driven recommendations, actions, reporting and benchmarks. Segal has the tools and resources to help the State of Wisconsin integrate the data that you already have, including participation data from the *Well Wisconsin* program, data from each carrier or third party administrator, or even encounter data from on-site clinics that the State may wish to consider in the future.

Many firms have recently purchased or may have access to data warehouse and integration tools through proprietary arrangements. Many of our competitors may have these tools, but not all of our competitors have their own data analytics professionals or the experience that Segal has in health related data analytics.

Segal will offer a menu of recommendations that will help address challenges or leverage opportunities presented within your data. We explain the alternatives as well as potential impacts or even unintended consequence as possible safeguards as you consider methods for address behaviors and health trends, with the ability to integrate solutions throughout your health plans and organization. Segal's actuaries are among the best in the industry. However, we are differentiated in the industry and in the team proposed for ETF by our significant clinical experience and consulting provided by data analytics experts and clinical experts who are doctors of medicine and pharmacy.

Segal can customize the data warehouse that is consistent with the elements that will allow consistent data collection. We are well qualified and prepared to assist ETF is setting up SQL database to append monthly claim and enrollment data into the historical database, in addition to monthly medical, pharmacy, dental claims and other information that is captured and desired. Examples may include health risk assessment questions and biometric benchmarks.

Our work will be carried out through a secure data transfer in accordance with ePHI and PHI standards regarding de-identification.

## Examples of Specific Projects

### **Example 1: Eastern State Health Benefit Plan**

In 2012, Segal was named the Consultant and Actuary to the State Health Plan, which provides medical, drug, dental, vision and life insurance benefits for 110,000 current and retired State employees. The total membership of the Plan is 220,000.

The Plan offers three plan options – EPO, PPO, POS - from three different carriers – Aetna, BCBS and UHC. Aetna offers the EPO and the POS, and UHC and BCBS each offer all three options. The result is that the Plan provides a total of eight medical plan options. A separate drug plan is administered by ExpressScripts (ESI) and the dental is provided on an insured basis by United Concordia (UCCI). Mental Health benefits are carved-out and are provided by APS.

As part of our engagement as the Plan's actuary and consultant, we provide complete data warehousing and reporting services. On a monthly basis we receive the following detailed claims data feeds:

- Aetna (medical)
- BCBS (medical)
- UHC (medical)
- ESI (Rx)
- UCCI (dental)
- APS (mental health)

The data includes all fields, including diagnostic codes, service codes, provider/pharmacy, provider type and location, etc and all financial fields, including submitted and allowed charges, plus plan and member paid amounts.

Additionally, we receive a detailed eligibility file directly from the State that includes full demographic detail, benefit elections, and coverage effective dates.

On a monthly basis, Segal analysts process the six different claims data feeds and, utilizing a custom designed crosswalk, load the data into a single database so that it can be cross-referenced to the eligibility data. Utilizing this robust database, we produce detailed monthly and quarterly reporting and analytics that enable the Plan's management to monitor experience and identify underlying trends and utilization patterns.

Additionally, we utilize this database to access detailed claims, utilization and cost data for all of our routine actuarial analysis, including rate setting, budget setting and forecasting, GASB/OPEB and IBNR reserve analysis. Having the data readily available at this level of detail also enables us to utilize it as a basis for a variety of ad-hoc analysis, including:

- Proposed legislation
- RFP and bid package data
- Evaluation of wellness and health management programs
- ACA related analysis
- Costs by tiers (single, family, etc)

- Large claims analysis
- Comparison of costs across different member classes (active, retired, COBRA, satellite agencies, etc)

We have also utilized the data to measure and benchmark the prevalence of chronic conditions and identify gaps in care and member compliance with recommended treatment and maintenance regimens.

For example, we identified that the prevalence of certain chronic conditions, such as diabetes is much higher than should be expected in population with similar demographics (currently 12% compared to a norm of 6%), and the rate of diabetics that had two Hemoglobin A1c tests in the last year was 31% compared to NCQA norms of 87% for PPOs and 90% for HMOs.

Therefore it was concluded that an opportunity existed to incent participation among diabetics in disease management (to increase testing compliance) and for the general population to utilize wellness programs to improve diet and exercise in order to reduce the prevalence of diabetes, or at least Type II diabetes. Similar conclusions were reached for asthma, hypertension, COPD, hyperlipidemia and heart disease.

We assisted the State in designing a value based benefit design with incentives to increase health education (biometric screenings, risk assessments, etc.) for everyone and increase DM participation for those with chronic conditions. Segal also assisted with an RFP that is resulting in vendor contracts with meaningful performance guarantees that are aligned with the gaps and opportunities identified in our analysis. For example, vendors will be required to increase the number of diabetics with HbA1c levels below 8.0 annually in order to avoid paying an assessment. There are similar performance metrics associated with other conditions.

Please see our report in **Appendix 5 – Additional Presentations.**

### Example 2: Western State

The Segal Company has the ability to collect and warehouse data from multiple sources, medical plan, pharmacy, health risk assessment, disability, workers compensation, and clinical care. We also integrate the information into patient centered predictive models, health-tracking tools, as well as aggregated employer reports that provide a holistic view of member care, gaps, and health improvements.

Plan Type	Plan Cost	Member
Medical Plan Paid	\$130,647,236	-
Pharmacy Plan Paid	\$26,229,142	-
Total Plan Paid	\$156,876,378	-
Total % Employee Paid	13.9	22.8
Medical Plan Paid PPO	\$554.89	\$474.19
Pharmacy Plan Paid PPO	\$99.37	\$104.98
Medical Plan Paid HMO	\$259.43	\$227.74
Pharmacy Plan Paid HMO	\$39.82	\$94.49
Emergency Room Plan Paid	\$140.89	\$160.81
Outpatient Hospital Plan Paid	\$76.38	\$133.81
Office Plan Paid	\$46.33	\$107.82
Emergency Room Plan Paid	\$28.60	\$24.35
Outpatient Hospital Plan Paid	\$96.53	\$76.19
Office Plan Paid	\$38.04	\$84.37
Emergency Room Plan Paid	\$21.87	\$44.78
Pharmacy Plan Paid	\$12.59	\$17.87
Current Employees	9,976	-
Current Retirees	21,497	-
Employee Months	234,121	-
Member Age	\$40,348	-
Average Age	35.42	34.8
% State	49.8	49.8

## Sample Executive Summary and Cost Trending

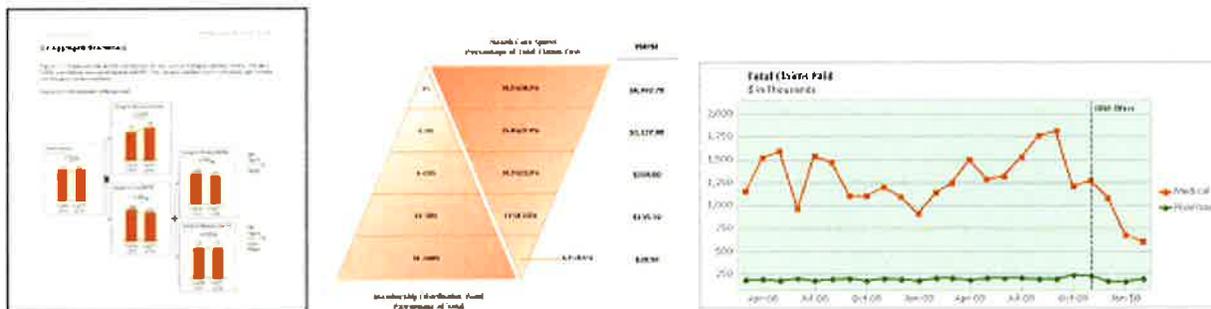
A complete overview of reports and capabilities are available upon request.

Segal delivers a robust assessment of cost, utilization, and clinical trends and opportunities, with the capability to compile any desired set of reports into the Executive Summary for this state.

**Medical Economics:** Including an analysis of medical expense trends by business segmentation and service.

**Pharmacy Economics:** PBM and Non-PBM drug spend and understanding of Rx cost avoidance opportunities and other opportunities for cost improvement:

- Clinical Disease Fingerprint and Catastrophic member analysis.
- Sample Executive Dashboard Views—Expense Distribution, Gaps in Care



**Executive Dashboard Reports** include predictive models, which examine eligibility, medical, and pharmacy claims and compares each individual record with evidence-based medical guidelines to model clinical and financial risk. This information is used to set budgets and prioritize care management interventions.

**Analytic Reporting** areas include drill down in demographic, expense distribution, healthcare metrics that includes over 30 healthcare utilization metrics from aggregate data representing actual claim experience, as well, as how a population compares to normative values. Metrics include inpatient, outpatient, high- cost procedures, and pharmacy fill rates, network utilization, medication compliance, identification and measurement of gaps in care, and quality.

**Risk Measures** modules contains more than 700 Quality and Risk Measures to identify specific gaps in care.

**Disease Manager.** Segal's individual view is effectively used to stratify the risk of a population and determine what acute risk trigger conditions contribute to cost. By filtering on Risk Scores and Care Gap Index (CGI), allowing analysts to target which members and disease are good opportunities for targeted intervention. Our platform supports top down, aggregate analysis as well as bottom up analysis from the member level.

**Risk Solutions** is a suite of Segal's sophisticated risk adjustment and predictive modeling products full integrated within the Segal data platform that enables the Segal to analyze, predict, manage, and minimize healthcare risk and costs on behalf of the State.

**7.7 Describe one specific example of work your company has performed aligning health insurance program efforts amongst multiple purchasers/employers. In your answer, describe your recommendations, why you proposed them, how your client(s) acted on your recommendations, and how you evaluated the effectiveness.**

Through our consulting work in a number of states we routinely work with multiple purchasers. Over time we have dealt with a wide array of projects. Below are a few:

- North Carolina State Health Plan - evaluate counties and school systems entering the plan. We have also developed rates for individual groups, like the national guard and firefighters.
- State of Tennessee - has a local government plan, requiring different rates and plan designs
- Illinois Central Management Services – has a local plan with different rates and negotiated plans
- In New York, there are about 850 school districts, many of them quite small. The average district is has about 400 employees and that includes the biggest 10 that have from 2,500 to 130,000. In any event, there are 32 consortia that have joined together for purchasing health care. Some of these have one pool with one plan of benefits; some have multiple pools with many benefit plans.

## **Example of a Specific Project**

### **Example 1: Commonwealth of Virginia**

Segal consulted to the Commonwealth of Virginia in developing a pooled medical plan option for smaller local jurisdictions that were having difficulty obtaining cost-effective health insurance on their own. The study involved a broad array of data gathering and market analysis to identify possible solutions that could be sponsored at the state level with limited additional staffing.

At the beginning of the project, we surveyed approximately 600 local jurisdictions across the Commonwealth, including both large and small city and county government entities, school districts and many small public instrumentalities and authorities such as utilities, housing districts, transportation units, and mental health agencies. The purpose of the survey was to obtain current health plan and cost information and to more closely define the real needs across local governments that could be filled by a consolidated program. In addition, Segal conducted outreach to all the major health insurance companies, including not only the Blue Cross Blue Shield organizations typically providing coverage, but also all major HMOs operating at that time in the state to determine their primary market development intentions and identify factors that might help them offer more competitive products and pricing to these governmental groups. We also conducted numerous interviews with both the State government agency that would be charged with administering the program, and with a selected array of different sized municipal governments, to learn about the obstacles and opportunities that might be available.

Segal also compared the current plan designs for the local governments in the survey to both the Commonwealth benefit package and to other state employee plans in Segal's periodic State Health Plan Survey. We also reviewed the benefit plans for a selected group of large Virginia

jurisdictions that would not be the primary targets for this consolidated pool and factored those designs into our analysis as examples of competitive programs within the state already.

Based on the survey, interviews, market analysis and benchmarking spade work, we then developed a proposed program design for review and discussion. The program design at this point did not identify specific carriers, but laid out a reasonable array of recommended plan types (e.g., PPO, HMO, etc.) and general benefit design options that would provide both solid coverage and some choice to small jurisdictions. Our initial plan also described how the local government pool would need to be organized and managed separately from the state employee health plan, but with a similar structure to avoid confusion and claims of lesser options for local governments.

We recommended providing a geographically sensitive selection of both PPO and HMO alternatives, since different carriers were stronger in different parts of the state and only a couple of reasonable alternatives existed for state-wide offering. We also recommended that the pool be constructed to take individual employer experience into account at a low threshold of covered employees (rating would move from fully insured rates to majority self-funded rates by 200 employees). The pool would allow jurisdictions to apply for entry at any point, not just at the implementation of the program. Withdrawal from the program would also be allowed, but the jurisdiction leaving would have to pay any experience loss to make the pool whole.

Segal's recommendations also took into consideration efficient administration of the program. For example, we recommended having the same department and state committee that oversee the state employee plans expand their existing operations to handle the pooled municipal program. We also suggested having the state's actuary determine the reserve needs for these programs and that competitive bids to be coordinated with bids for the state employee health plan.

The client adopted Segal's recommendations with minimal adjustments and drafted legislation that was approved by the State Legislature implementing the Virginia Local Choice program. The Local Choice program continues to serve several hundred small governmental entities across the state and participation has been highly stable. While most participating groups are small, the program has also attracted a number of medium sized school districts across the state.

**7.8 Describe one specific example of work your company has performed auditing health care claims information for payment accuracy. In your answer, describe your recommendations, why you proposed them, how your client(s) acted on your recommendations, and how you evaluated the effectiveness.**

Our Administration and Technology practice has been assisting clients since 1973 through onsite and desktop audits of insured and self-funded plans administered by carriers and third party administrators nationwide. Our National Health Practice supports these auditors with clinical consultants, including a physician, a dentist, nurses and a doctor of pharmacy.

Segal consultants in this practice were previously employed as claims payers and subsequently have had specialized training to conduct health care claim audits. Because these individuals devote their time to conducting claim audits, they have a level of experience and expertise that is unequalled in the industry. Because of this approach, as well as the fact that our audit services are fee based, rather than contingent, we obtain a level of cooperation from carriers, TPA firms and pharmacy benefits managers that is critical to obtaining optimal outcomes for our clients.

Segal maintains an array of audit tools to assist clients in monitoring vendor service levels and validating their achievement. The project scope, defined by the plan's objectives and/or specific areas of concern, may include:

- Periodic claim audits to meet fiduciary responsibilities, validate plan costs, enforce or implement performance guarantees, in comparison to industry standards, address benefit concerns, and/or increase employee satisfaction.
- Post-implementation assessments of plan set-up, adjudication procedures, and automated system capabilities are conducted within 60 to 90 days of an administrator transition, following a major benefit modification, or change in automated systems.
- Desktop or electronic audits that lend themselves to reviews of pharmacy benefit programs administered through a pharmacy benefit manager (PBM) or analysis of claims data to determine utilization trends and comparisons to contractual compliance.
- Dependent eligibility verifications to identify, report, and disenroll ineligible dependents from one or more benefit plans. Our project management role assists client's in finding a vendor that will modify their verification procedures to work within the client's guidelines to provide efficiencies and minimize employee complaints and appeals.

We view an audit as a constructive process in which all parties work in concert to ensure that proper control measures are in place for efficient administration of plan benefits. The unique aspects of administering medical and prescription drug benefits requires individual scopes of services to effectively assess the respective vendor's performance. Medical claims, which include multiple benefit variables and a significant amount of human intervention, are addressed through statistical and target claim samples. Prescriptions that are electronically captured and adjudicated at the point of sale lend themselves to 100% electronic analysis.

## **Example of a Specific Project**

### ***Example 1: Northeastern State Health Plan***

In 2004, Segal's Claims Audit team proposed a comprehensive audit including the review of day-to-day operational procedures and statistical sampling of claim payments; we proposed two statistical samples to distinguish between active and retiree claims that were processed on separate systems. Our review recommended improvements in the enrollment process, coordination of claims data with the behavioral health vendor, overpayment recovery procedures, and processing timeliness; plan provisions requiring clarification of intent or discussion for automated processing were also addressed. Sampled errors were classified to distinguish between manual and automated deficiencies, and to identify any patterns that required further review for financial impact (i.e., potential duplicate payments). This initial audit offered a baseline for future performance measurements; a list of reports to monitor administrative performance throughout the year was also provided to the Client.

A subsequent audit provided the opportunity to confirm corrective actions had been properly managed. Administrative details learned through the audits also assisted in the Client's preparation of a Request for Proposal and contract negotiations with their next administrator. In 2007, the Client's internal audit division requested Segal's assistance in supporting in-house staff in their TPA audit planning, development, statistical sampling, evaluation of TPA operational procedures, and assessment of medical claims accuracy. Segal coordinated each audit task and provided documents to the Client's auditors for review and input; Client auditors received onsite training for manual review of claims to ensure compliance with established administrative procedures and plan provisions from receipt of the claim to final disposition.

Following a second annual review with Client auditor's, Segal was endorsed to conduct annual audits and assisted in preparing an audit plan that addressed each of the Client's vendors. Medical claims are reviewed annually due to the magnitude of expense and potential financial risk; dental and vision audits are conducted every 2 to 3 years following satisfactory audit results and minimal changes in plan design.

Segal's constructive relationship with administrative staff effectively confirmed the Client's confidence in our procedures and fostered continued relationship on future projects. Segal continues to assist the Client in modifying their annual audit plans to meet changes in plan benefits or vendors, addresses issues raised through vendor reports or member complaints, and confirm the status of prior recommendations and findings.

**7.9 Describe one specific example of actuarial analysis your company has performed that were incorporated into plan design recommendations. In your answer, describe your recommendations, why you proposed them, how your client(s) acted on your recommendations, and how you evaluated the effectiveness.**

Our firm was built on an actuarial foundation and currently has over 150 credentialed actuaries. Our proposed account team includes several well-seasoned actuaries that will bring to this engagement extensive experience with state health plans and public sector entities. We understand the importance of having our top technical and consulting specialists knowledgeable with the ETF's benefit structure and programs in order to develop and recommend effective strategic options that are based on data-driven analysis and are actuarially sound.

Members of the team have worked with many large state and county jurisdictions in the Midwest, most recently including the Illinois Central Management Services – Bureau of Benefits, State of Michigan, State of Colorado, State of Minnesota, State of Ohio, and South and North Dakota.

Your senior team also serves a number of other large eastern and southern states, including the North Carolina State Health Plan, Alabama Public Education Employees Health Insurance Plan, Georgia Department of Community Health – State Health Benefit Plan, Pennsylvania Public School Employees' Retirement System – Health Options Program, the State of Delaware, the State of New Hampshire, Large Eastern State, and the Texas Group Benefit Plan for State Employees.

Actuarial analysis and support runs through nearly every component of a strategic plan redesign. Our actuaries are involved in analysis of the data analytics, clinical benchmarks, plan design alternatives, quality initiatives, on-site clinic reviews, wellness opportunities, etc. ETF should feel comfortable knowing that your proposed team has worked together on a number of these projects and understand the importance of a multi-disciplined project team with varied viewpoints.

### **Tools and Technology Resources**

Segal's Actuarial Team utilizes several analytical tools to measure, monitor, and predict the costs of health and welfare benefit programs. We customize our array of technical resources for your specific needs, ensuring that we provide the high level of quality consulting that our clients expect. Segal is on the cutting edge of health care industry trends and relevant legislation, and we update and revise our tools as needed to provide maximum value to our clients. These tools are used in various capacities, depending on the plan feature under consideration.

Below are some examples of the wide range of tools available to our team and indirectly to the ETF.

<b>Health Analytical Tools and Resources</b>		<b>Health Underwriting, Fees, Benchmarking, Reserving, Premium calculation</b>	APEX, Stop Loss Deductible Modeler, Comprehensive Medicare Coordination Model, Multiemployer Health Plan Design Norms, Claims Cost Application, IBNR Model, Physician Fee Modeler, Employee Cost Share Benchmarking Tool
		<b>Prescription Drug Benchmarking, Auditing Underwriting</b>	Rx Omni Pricer, Prescription Drug Program Analysis (PDPA), Medicare Part D Calculator, Prescription Drug Benchmarks, Medi-Span, Rx Claims Database
		<b>Health Data Analysis, Health Claims Auditing</b>	Health Benefit Report (HBR), Verisk Health, DxCG risk models, Interactive Projections Modeler, Claim Audit Software, Ingenix Encoder Pro
		<b>Electronic Request for Proposal Services (eRFP)</b>	Proposal Tech
		<b>Dental Underwriting, Fees and Benchmarking</b>	Dental Pricer, NDAS Pricing
		<b>Health Provider Accessibility, Quality Assessment</b>	Q-Val, Verisk Health; Wellness and Disease Management Performance Dashboard
		<b>Utilization Management Program Assessment</b>	Verisk Health

## Example of a Specific Project

### Example 1: State Health Plan (“Plan”)

Your Account Manager has been the lead actuary on this state level plan since 1995. The Plan is one of Segal’s largest accounts, covering approximately 670,000 members. Segal is currently the Plan’s Consultant and Actuary, where we provide a broad range of services. We deliver comprehensive actuarial support, including the following projects over the last 12-months:

- Providing ongoing actuarial analyses and financial projections over 5-years
- Calculation of participant and employer rates
- Data mining, warehousing and in depth utilization claims analysis, including dashboards
- Clinical risk group analysis
- Medicare Part D actuarial attestations
- IBNR analysis and reserve recommendations
- Analysis of return on investment of contracted disease management vendor
- Alternative plan design, including incentives, penalties, and value based features
- Wellness program review and consulting
- ACA program consulting, including the evaluation of the financial and compliance implications of upcoming legislation

- Medicare Advantage, PDP and EGWP consulting

We provide below some additional details on a couple complex actuarial assignment that have resulted in plan design changes to the plan.

1. **Consumer Directed Plan Design** – In late 2012 we performed a detailed analysis of the current plan design options available. During that review we quantified selection patterns currently present in each of the programs, modeled alternative designs and prepared a detailed actuarial report. As part of our analysis, we prepared winners/losers analysis to demonstrate the value of the plan, noting that over half the population would be better off in this program. As a result of our recommendations, the Plan introduced a CDHP plan design for 2014. Initial enrollment and financial results have been positive.
2. **Medical Management Return on Investment** – Over the past two contract years Segal has prepared a ROI calculation based on the parameters of the Vendor contract. The method in the contract produces ROIs well over expectations and industry norms. The method was built from a population health model and determines savings from actual utilization versus expected. The problem is that the plan made a number of programmatic changes that influenced utilization as well, resulting in nearly flat trends. With the current contract structure, the Vendor gets nearly full credit for changes implemented by the Plan.

Over the last 6-months Segal has worked to develop a cohort analysis as a new process for determining the ROI. A participating group's risk factor will be compared to a similarly diagnosed group with identical risk profiles. The return would then be the difference in non-participant trends versus participant trends. Those with similar risk participating should experience lower trends and result in savings from the Vendor. This recommended method was presented to the Vendor and is to be implemented for the 2014 ROI calculation.

3. **Medicare Advantage Plan Design** – This was a very complicated project that Segal undertook in 2012-2013. We pulled the claims data for Medicare eligible members and prepared data book from with the MA plans to bid on. There were a number of complications, the most significant being the lack of information from their current provider on what Medicare paid for each claim. This is not uncommon for supplemental type plans to have difficulty tracking original claims payments in their system since they only process what is not paid by Medicare.

Utilizing the Plan's utilization and cost data we designed an MA passive PPO plan that is actuarially equivalent to what members were currently paying. We also took the baseline data and modeled out what we expected the insured bids to be, including reimbursement from CMS, managed care utilization changes, pricing, etc. As rates were received we had the information available to best negotiate for our client. When it was all complete, the plan was able to save over \$200 million per year or more than \$150 per member per month.

4. **Benefit Savings Grid** – Over the past 10-years, Ken Vieira has produced a report to the Plan showing the savings/costs of making a wide variety of plan changes. In more financially stressful years this report was used a "menu" to get to necessary expenditure level. The grid included a wide variety of components, such as:

- Cost Sharing Changes – copay, deductible, coinsurance, OOP max

- Pharmacy Changes – adding deductible, tier changes, specialty drugs, day supply, mail-order, maintenance medications
- Plan structure – eliminate plans, add new plan designs
- Premium structure – buy-up strategy, salary based, dependents
- Provider contracting – hospital reductions, physician fee schedule changes
- Wellness – plan changes, premium changes

Every year the components of the grid would change but required a large amount of actuarial analysis to prepare. As a result of the grid, the Executive Administrator and staff would select an alternative to best meet there needs.

*These are just of small subset of the actuarial work we do for this client. The Plan relies heavily on our actuarial analysis to develop and consider strategic options, manage costs, modify benefits, compile disclosure exhibits, manage vendors, value the impract of proposed legislation, and monitor member health risk. This approach has resulted in relatively low stable trends and enabled Plan staff and the Board to measure and monitor and report on the success of new initiatives after implementation.*

***7.10 Describe one specific example of work your company has performed assisting an employer in analyzing and/or developing plan design strategies relating to requirements of the Affordable Care Act. In your answer, describe your recommendations, why you proposed them, how your client(s) acted on your recommendations, and how you evaluated the effectiveness.***

Segal is a leader in helping clients in educational settings navigate the current and future impacts of the Affordable Care Act (ACA).

Segal has been at the forefront in reviewing and anticipating the developments relating to health care reform as the legislation was being crafted and as the agencies are issuing regulations and guidance. The federal government and other regulatory entities frequently call on Segal's expertise to understand how new laws and developing regulations can affect public and multi-employer plans. By no means do we take credit for the final drafted language, but our presence in the development stage enables our clients to be as current as possible with emerging regulatory and compliance requirements.

Segal's website serves as a central resource of valuable information and tools for our clients. Webinars and events featuring timely topics, trends, and legislation are listed on our site. Segal publishes an array of newsletters, surveys and other informative publications on a variety of topics. These publications, including archives, and articles by Segal experts, are available to our clients through the website. Our website also contains Segal's Health Care Reform Guide, which provides updates on the latest legislative developments and guidance on how health care reform will affect your plan, at <http://www.segalco.com/publications-and-resources/health-care-reform/>

Our Compliance Specialists will be involved in the ongoing work performed, providing input from the compliance perspective. In addition, we encourage our clients to work directly with our Compliance Specialist whenever a question arises about an issue that can affect their plan. When legal issues arise, we do advise our clients to supplement the information and observations that we offer by looking to their attorneys for authoritative legal advice.

We will also look more deeply into the following areas to determine how they fit into the overall strategy and how you can address them.

### **Health Insurance Exchange**

The advent of the Health Insurance Exchange starting in 2014 and expanding through 2018 is being addressed today, at least based on the current understanding of how those market delivery vehicles will work. The State will need to identify the groups that will be attracted to the Exchange and why they will be attracted, including such factors as low cost for minimal benefit coverage, consistency of coverage when changing jobs, and other factors. You will need to determine the factors that will be important to employees and dependents who will have the option of migrating to the Exchange and what impact that potential migration could have on the Plan. We expect that State policy makers will be interested in identifying the value of federal subsidies to the State employees' health plans.

## Expansion of Medicaid

The expansion of Medicaid to provide benefits for a greater range of recipients directly affects a contingent of the persons covered under the CHIP and Medicaid programs. This change in the dividing line between employee benefits and recipient benefits needs to be explored carefully and continually to help the State understand the dynamics that will drive choice of program and source of subsidy in the future. We will work with the State to determine more specifically how these participants should be handled and whether this change at the federal level requires an adjustment in benefits philosophy and plan availability at the State level.

## Minimum Contribution and Benefit Levels

The State provides many benefit designs aimed at keeping premiums at a low cost. We will look at the impact of compliance with the contribution and benefit requirements is likely to have on the plan in terms of participation, cost and continuity. We will also examine the cost impacts in the contribution analysis part of our review, and will coordinate those results with the broader review as part of this segment.

## Shared Responsibility

The proposed consulting team speaks frequently on the ACA topics and has also assisted many states in modeling a number of hour conversion scenarios and have also identified the exact job classifications and exact employees who based on historical data would met the ACA definition of a full time employee, those who may be misclassified, and those that currently receive benefits that are not required under the Employer's Shared Responsibility provisions of PPACA.

While other firms took an ultra-conservative approach and assisted their clients in only understanding look back and stability periods, Segal, went further to search for complaint alternatives that could be considered by our clients. In addition, to showing our clients the potential cost and benefits of each look back and stability period that would be available, Segal called upon our resources in Washington D.C. to research alternatives such as "skinny plans" and "minimum value plans" that some clients may wish to consider, in addition, or instead of, safe harbors suggested by the Affordable Care to protect employers from penalties that could be imposed.

**Hours Worked Analysis** — Our work will produce a detailed report that will drill down to number of employees and hours worked by month and by job classification (with supporting person by person detail) that are identified as eligible for benefits under ACA, but not currently offered coverage, may be misclassified, may require coverage or result in a penalty including the cost or impact of each.

This work includes an in-person meeting to present our findings and discussion of options for managing liabilities and managing reporting obligations. The detail that would be included in the report and discussed as a part of follow-up and conclusion is as follows:

- Review of ongoing employees, new, variable hour, and seasonal employees to determine if they are reasonably expected to work on average at least 30 hours per week.
- Crediting method of analysis during academic breaks as required of educational setting.

- Alternative factors including the voluntary safe harbor of 2.25 hours for counting all hours for adjuncts.
- Apply tests for various measurement periods. This will include ongoing, new employees and new hire tests, as well as new monthly measurement method for variable hour, seasonal or temporary employees. A variety of look-back and stability periods (12 months, 9 months, 6 months as well as currently monthly measurement) will be modeled.
  - Standard Measurement Period
  - Initial Measurement Period
  - Administrative Period
  - Stability Period
  - New Monthly Measurement Method
- Affordability analysis to determine the population of employees for whom their share of cost would exceed ACA guidelines and result in a potential 4980H (b) penalty.
- Overview of minimum 90-day waiting periods and minimum value coverage.

### **Additional ACA Considerations**

Our work also includes a similar analysis of affordability, projections of current excise tax such as the transitional reinsurance and comparative effectiveness fees, as well as which plan offering are likely to penetrate to the 2018 tax on high cost plans (Cadillac tax) as costs are trended forward.

For those clients that offer programs or may consider an offer of Health Reimbursement Arrangements we have also assisted in revising the HRA design, documents and employee communications. Model notices such as new COBRA event notices, the availability of the Exchange, and revised HIPAA notices are also prepared by our national compliance team and disseminated to each of our clients.

We work with our clients to ensure that other provisions such as limits on waiting periods, and accumulation of deductibles, co-insurance and co-payments are not only in place, but that cost impacts and alternatives that may be available to balance budgets are considered.

Segal provides employer education and data analysis to help our clients assess their exposure to

- 4980H(a) and 4980H(b) Penalties
- Full-Time Employment
- Counting Hours in an Educational Setting
- Counting Hours for Breaks in Service
- Minimum Value Coverage
- Affordable Coverage
- Dependent Coverage

- Premium Tax Credit Subsidies and Impacts for Employee and Employers
- Safe Harbors and Look Back Periods
- Misclassifications
- Employee Value Proposition
- Overview of Alternatives:
  - Minimum Value Plans
  - Skinny Plans
  - Penalty in Lieu of Benefits
  - Private Exchanges

## **Example of a Specific Project**

### ***Example 1: Western State Health Plan***

Segal is currently assisting the State in determining which employee classes and job categories would be considered full-time and require reporting and an offer of coverage under the ACA. Particularly challenging in this analysis are certain seasonal positions, adjunct professors, resident and graduate assistants and certain public health workers, long-term contractual workers that do not have predictable schedules.

Our analysis for the State aggregated hours for employees holding multiple positions with different departments, converted University contract pay to hours, credited hours during academic breaks for their higher education institutions and provided an analysis of employee and job classifications that could create an exposure to penalties or new liabilities for coverage. The State provides coverage to any employee who works at least eight hours in month, so they were surprised to find a fair number of employees working more than 30 hours per week on average and not offered benefits.

A problem area for The State was the large number of full time temporary workers. The State has previously believed that temporary employees would not require an offer of benefits. While that belief would have held true for any employee working less than 90 days, this was not a correct interpretation. The State currently offers four benefit plan choices to their employees. Segal was asked to provide a “thin” plan option offering that would avoid both the 4980h(a) and 4980(b) penalties, and compare the costs of extending coverage to include this option to associated penalties, or coverage under the current plan options. The thin plan modeled by Segal that met the needs of the State was a high deductible health plan, featuring a \$6,350 deductible / \$6,350 out of pocket plan design.

The governor is currently evaluating the alternative proposals, which includes the addition of “thin” plan offering, providing an offer of benefit under the existing four plan choices, or exposure to potential 4980(b) penalties. Even though is the most costly option, the Division of Personnel and Administration favors a change in the temporary definition to less than 90 days, clean-up of number if misclassified records into either part time or full time, with extension of

benefits of the four current benefit plan offering to employees expected to work 30 hours or more per for 90 days of longer.

Additionally, we have modeled and projected benefit costs and compared against the projected thresholds for the “Cadillac Tax”. This analysis was performed under a variety of trend scenarios and we identified the “break even trend” – if costs increase at a rate below this rate, then the State will not be subject to the Cadillac tax in 2018. We also performed the analysis separately for retirees and certain public safety groups that could be eligible for higher thresholds and, therefore reducing the State’s exposure.

This is one aspect of the ACA that is still largely undefined, or at least it is undefined how the Tax will be calculated. For example, there are different thresholds for employees electing single and non-single coverage but it is unclear exactly how a plan with 3 or 4 tiers would be valued. At the request of the State, we performed this analysis using the most conservative approach so that as additional guidance is provided, then the State’s exposure would be more likely to be reduced over time.

We projected out several years past 2018 to model the potential exposure to the State and identified that, as things stand currently, exposure to the Tax is fairly minor.

### Summary of Section 7 Client Experience

The questions in this section ask for specific examples of our experience in providing strategic guidance in very targeted and focused settings. The reality, however, is that strategic options and considerations are generally developed utilizing multiple tools and encompass multiple components simultaneously.

In our responses, we provide the examples we feel are best aligned with the specific application called for in each specific question. However, with most of our clients, we reviewed, analyzed, and considered strategic options from multiple angles.

Below is a table illustrating our experience in providing strategic guidance to other state level clients and main components that were used as a basis for our analysis and recommendations. We have worked with many of the clients for over 10 years and, in the case of Hawaii, for over 50 years.

Requested Experience	NC	GA	PA	ES*	IL	DE	WV	NH	AL	HI	NM	TN	CO
Data Analytics (7.1)	X	X	X	X	X			X	X		X	X	X
Administrative Process (7.2)	X	X	X	X	X	X	X	X		X		X	X
Cost Containment (7.3)	X	X	X	X	X	X	X	X	X	X	X	X	X
Quality of Care (7.4)	X	X		X	X	X		X	X	X	X	X	X
Plan Design (7.5)	X	X	X	X	X	X		X	X	X	X	X	X
Data Management (7.6)	X	X	X	X	X			X		X	X	X	X
Multiple Employers (7.7)	X			X	X			X	X		X	X	X
Claims Audits (7.8)	X		X	X				X		X	X		X
Actuarial Services (7.9)	X	X	X	X	X	X		X	X	X	X	X	X
Affordable Care Act (7.10)	X		X	X		X	X	X	X	X	X		X
Has Bargained Membership				X	X			X		X			

\*Due to contractual obligations, Segal is not able to release the name of the above listed state client.

## Tab 7 – State of Wisconsin Terms and Conditions

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*The terms and conditions shall govern this Proposal and subsequent award. The Proposer shall submit any exceptions per the instructions in Section 10.0.*

*The State of Wisconsin reserves the right to incorporate standard State contract provisions into any contract negotiated with any Proposal submitted responding to this RFP [Standard Terms and Conditions (DOA-3054) and Supplemental Standard Terms and Conditions for Procurements for Services (DOA-3681)]. Failure of the successful Proposer to accept these obligations in a contractual agreement may result in cancellation of the award.*

Segal was recently awarded the Consulting Actuarial Contract for the State's Health Insurance Programs.

We are currently in the process of finalizing the terms and conditions with the appropriate State staff. We would therefor propose providing the new services under the same terms and conditions that have been accepted by ETF General Counsel.

As we are doing with that contract, we will be glad to discuss with the ETF and to agree on mutually acceptable language to reach a final contract. Please let us know if you desire to discuss our proposal and we will immediately schedule a conference call with our General Counsel at your convenience.

# Appendix 1 – Segal Team Resumes

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## **Expertise**

Mr. Vieira is a Senior Vice President and Consulting Actuary in Segal's Atlanta office with nearly 25 years of experience as an account manager, actuary and consultant. He serves as East Region Public Sector Market Leader and is a member of the Public Sector Leadership Group and the East Management Team. Ken joined Segal in January 2012.

Mr. Vieira brings a full complement of actuarial and consulting expertise to his clients. He has extensive experience in strategic consulting, benefit plan design and evaluation, financial forecasting, trend analysis, risk profiling, new product design, plan rating, premium rate development, data analytics, retiree medical, statistical modeling, and other medical management programs.

Mr. Vieira's public sector clients include:

- North Carolina State Health Plan
- Alabama Public Education Employees Health Insurance Plan
- Metropolitan Atlanta Rapid Transit Authority
- Georgia State Health Benefit Plan
- Illinois Central Management Services
- State of Minnesota
- State of Wisconsin (new contract)

Mr. Vieira's clients have spanned a variety of public sector entities. He has worked for Medicaid agencies, school systems, community health departments, medical affairs, state health plans, CMS, etc.

In addition to his specialty in the governmental sector, Mr. Vieira has worked with large employers, healthcare providers and health plans. His varied projects have included packaging and pricing medical services, developing claims data reporting, utilizing risk management software, developing HMO rates and renewal support, and developing prospective payment systems.

## **Professional Background**

Prior to joining Segal, Mr. Vieira was the head of the Government Programs Health Practice at a large consulting firm in Atlanta. He has worked extensively with states and other large governmental employers on state health plans, Medicaid programs and a broad range of actuarial issues. With many of these states, Mr. Vieira served as both the account manager and actuary, and provided a wide array of strategic consulting.

## **Education/Professional Designations**

Mr. Vieira received a BS in Software Engineering from Syracuse University. He is a Fellow of the Society of Actuaries, a Member of the American Academy of Actuaries, a Fellow of the Conference of Consulting Actuaries, and a retired Enrolled Actuary. He is also a licensed Life and Health Insurance Consultant in Georgia, Tennessee, North Carolina and other states.

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## **Expertise**

Mr. Johnson is a Senior Vice President and serves both as the National Public Sector Health Practice Leader and as the East Region Public Sector Market Co-Leader in Segal's Washington, DC office. Mr. Johnson has over 30 years of experience in all phases of state and local government health benefit programs, pension and deferred compensation benefit plans, executive benefits, and strategic benefit planning. He has advised clients on plan design, funding, administration, human resource systems and employee communications.

Mr. Johnson's specialized expertise includes developing direct contract employer/union prescription drug plans (PDPs), consulting on retiree health benefit programs, and analyzing income replacement, retirement benefit sufficiency, benefit administration practices, and 457, 403(b), and 401(k) programs. He has also developed employer and system strategies for compliance with the Affordable Care Act (ACA), pre-funding of GASB OPEB, strategic plans for benefit programs and regional healthcare plans for numerous public sector clients.

Mr. Johnson's public sector clients include the Pennsylvania Public School Employees' Retirement System Health Options Program and the North Carolina State Health Plan for Teachers and State Employees, as well as a number of large state systems, county governments and school systems.

## **Professional Background**

Prior to Segal, Mr. Johnson worked at the trust and investment group of a large regional bank where he managed the research, development, and administration of benefits and investment related services and electronic systems.

## **Education/Professional Designations**

Mr. Johnson received a BA with Honors from Hendrix College (Conway, AR) and an MA in Speech and Communication from Louisiana State University. He is licensed as a Life and Health Insurance Consultant.

## **Publications/Speeches**

Mr. Johnson frequently writes and speaks on employee benefit issues in the public sector. Recent speech and webinar topics have included ACA-specific requirements, employer and health system strategic reaction to health reform, how state employers can control health costs, federal and state health policy initiatives, and the future of public sector health benefits. He was recently honored as the State and Local Government Benefits Associations' Associate Member of the Year.

Recent publications and webinars include:

- "Affordable Care Act and the Employee Shared Responsibility Penalty," by Rick Johnson and Kathryn L. Bakich, Segal webinar, May 2014
- "This is a Good Time to Expand Your Wellness Program" By Sadhna Paralkar, Ed Kaplan and Rick Johnson, April 2014, IPMA HR News
- "The Affordable Care Act: What Public Sector Employers Need to do Now ... Later This Year ... and Beyond" By J. Richard Johnson, January 2014, IPMA HR News
- "Knowledge is Power: Key Findings from Segal's Latest Study of State Employee Health Benefits" By Rick Johnson and Elliot R. Susseles, September 2013, HR News Magazine

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## **Expertise**

Mr. Ward is a Senior Vice President and the Health Practice Leader in Segal's Atlanta office. He has approximately 20 years of experience in working with employee benefit programs for the public sector. He has a broad range of expertise in the strategic design, administration, and funding of public employee and retiree benefit plans. Richard joined Segal in January 2012.

His experience includes all aspects of employee benefit programs, including vendor selection and management, financial management and reporting (rate development, budget projections, reserving, etc.), evaluation of alternative service models (tiered networks, on-site clinics, etc.), and benefits enrollment/administrative services.

Mr. Ward's current clients include:

- Georgia State Health Benefit Plan
- North Carolina State Health Plan
- Texas Employees Group Benefit Plan
- Illinois Central Management Services
- Alabama Public Education Employees Health Insurance Plan
- City of Houston

## **Education/Professional Designations**

Mr. Ward received a BS in Mathematics from George Mason University. He is a Fellow of the Society of Actuaries, a Fellow of the Conference of Consulting Actuaries and a Member of the American Academy of Actuaries.

## **Published Work/Speeches**

Mr. Ward is a frequent speaker on benefits design, health management, and employee and retiree benefits strategies for public plans and employers. Organizations and events he has presented to include the Public Sector Healthcare Roundtable, The World Congress (Strategic Leadership for the Health Care Industry) and the Governmental Finance Officers Association.

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## **Expertise**

Mr. Mathews is a Vice President and Senior Health Consultant in Segal's Washington, DC office. He has 25 years of health and welfare benefits consulting experience advising both public and private sector organizations. Mr. Mathews leads the total health management consulting initiatives for Segal nationally.

His expertise includes:

- Developing innovative health care management strategies
- Evaluating managed care organizations and high performance networks
- Strategic benefit planning and the design of quality medical care delivery systems
- Designing health care cost management plans
- Managing the interfacing of third party health and welfare vendors with data management vendors
- Applying technology to solve data management and patient management challenges
- Understanding the issues of compliance in an outsourced environment

## **Professional Background**

Prior to joining Segal, Mr. Mathews served as the Atlantic Area Client Service and Client Delivery Leader for another major national consulting firm. He has served on the faculty of the International Foundation of Employee Benefit Plans since 1986 and has lectured on Future Trends in Benefits at American University's school of business.

## **Education/Professional Designations**

Mr. Mathews received a BA and an MBA in Economics from the University of Utah.

## **Published Work/Speeches**

Mr. Mathews is a frequent speaker on benefits design, and total health management, and has been quoted in the Baltimore Sun, Benefits & Compensation Solutions, Health Leaders, The Washington Post, and several trade journals.

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## **Expertise**

Mr. Gingell is a Senior Vice President and Benefits Consultant in the Chicago office with over 25 years of benefits consulting experience. As Midwest Regional Leader, he is responsible for overseeing Segal's clients in the Chicago, Cleveland, Minneapolis and Detroit offices. Mr. Gingell is a member of Segal's Multiemployer Leadership Group, and has previously served as Head of the Cleveland office.

Mr. Gingell provides health care and pension consulting advice to clients and specializes in developing strategic, customized solutions to help manage rising health care costs. His expertise includes claims data mining, aggressively managing vendor contracts, plan design, and incentivized wellness and disease management alternatives. Mr. Gingell also works to minimize employee dissatisfaction through carefully crafted communications. He helps clients address the short-term pension funding issues they are facing due to investment market activity while also maintaining focus on the appropriate long-term strategy for retirement income fund design. Mr. Gingell is passionate about staff development and encourages a collaborative environment in an effort to improve the quality and depth of client work.

## **Professional Background**

Prior to joining The Segal Company, Mr. Gingell gained nine years of experience in employee benefits with a major insurance carrier; managing claim processing, customer service and client relationships in two claim processing centers. Towards the end of his service, Mr. Gingell managed and sold large group health care accounts.

## **Education/Professional Designations**

Mr. Gingell received a BS in Business Administration at The Citadel (Charleston, SC). He has taken numerous management, health care, and strategy courses at a variety of institutions and attended the Harvard Business School's Executive Education Program. Mr. Gingell is active in The Executives Club of Chicago and other HR groups, and is a past chair of a Society for Human Resource Management (SHRM) Board. He is President of the Foundation Board at Northeastern Illinois University and Chairman of its Finance Committee. Mr. Gingell is also the Chairman of the Board of the Arts and Business Council in Chicago. He actively participates in human resources, benefits and charity associations in the Midwest, holds various board and committee positions, and speaks frequently on health care and pension issues at benefit conferences and other events.

## Expertise

Dr. Paralkar's areas of expertise include health care informatics, medical management program design, clinical operations, benefit plan design and network management strategies to optimize health improvement while containing costs, and evaluation and implementation of disease management and wellness programs based on evidence based medicine (EBM) protocols.

A sample of recent client work includes:

- North Carolina State Health Plan
- State of South Dakota
- City of Philadelphia, PA
- City of San Bernadino, CA
- City of Chicago, IL

## Professional Background

Dr. Paralkar's extensive experience in health care operations, informatics, and consulting includes positions at UnitedHealth Group (UHG) and Ingenix, where she provided clinical expertise to clients in the payer, provider, public sector, and employer markets. Prior to Ingenix, Dr. Paralkar was at Optum, another UHG company, where she served as Director of Product Development for the Care Management suite of products and was also responsible for the Care Management ROI model.

Prior to joining UHG, Dr. Paralkar worked at a Fortune 500 company, International Truck and Engine Corporation (Navistar, formerly known as International Harvester), in various capacities for six years. The last position Dr. Paralkar held at Navistar was Associate Medical Director, responsible for occupational health and disability, on-site wellness programs, health benefits plan design, and health care purchasing.

## Education/Professional Designations

A native of Mumbai (Bombay), India, Dr. Paralkar completed her medical internship in 1992 at L.T.M. General Hospital of University of Bombay, India after earning her baccalaureate degree in Medicine and Surgery from the same institution in 1990.

As a licensed family practitioner, some of Dr. Paralkar's public health achievements include implementation and evaluation of immunization programs in rural India. In 1995, she completed a Master of Science degree in Public Health from the University of Illinois at Urbana-Champaign focusing on health data analysis and epidemiology. Part of her analytic research on health communications in the mass media was funded by the National Institutes of Health. Dr. Paralkar also completed an MBA with a focus on Health Industry Management and Marketing from the prestigious Kellogg School of Management of Northwestern University in 2003.

Dr. Paralkar is a member of the American Public Health Association, American College of Occupational and Environmental Medicine, The Institute of Medicine of Chicago, American Association of Physicians from India, and Women Business Leaders of the U.S. Health Care Industry Foundation

### **Published Work/Speeches**

Dr. Paralkar has published several articles on Health and Productivity in peer-reviewed journals and is a frequent speaker at national conferences concerning health care. Past speaking engagements include the Society of Actuaries conference and the ACOEM (American College of Occupational and Environmental Medicine) conference.

Examples of Dr. Paralkar's recent publications include:

- “Genetic Testing: An Ever-Evolving Health Field Raises Complex Coverage Issues,”  
By Dr. Sadhna Paralkar and Joanne Husted, *Benefits Law Journal*, Spring 2011
- “Why Health Care Costs Keep Rising—And What to Do About It,” *SHRM Online*,  
May 1, 2009
- “While We’re Waiting for Health Care Reform... Things We Can Do Now to Control Rising  
Costs,” *Employersweb*, June 11, 2009

## **Expertise**

Ms. Hakes is a Vice President and Health Care Benefits Consultant in Segal's Phoenix office. She is the Company's technical expert on operational issues regarding managed care. Ms. Hakes provides detailed research on specific health care issues pertinent to medical coverage, plan design, and quality of care, including disability; workers' compensation; wellness and associated incentive programs; EAP and behavioral health; prescription drugs; disease management; telephonic nurse triage programs; and utilization management. She is skilled in analyzing the effectiveness of health care delivery systems that guide managed care organizations. Ms. Hakes leads the development and maintenance of a proprietary Segal program, Q-ValSM, which allows plan sponsors to assess the extent to which managed care organizations (such as PPOs, POS and HMO plans) oversee and assure the delivery of quality health care to their plan participants.

Ms. Hakes assists employers in the creation and interpretation of technical medical health care coverage language, the design of employee educational information, and the implementation of specific managed care techniques engineered to control health care costs. Additionally, as Health Compliance Manager for the West Region, she researches employee benefit laws and their impact on clients, creates plan amendments and writes plan documents. Ms. Hakes was instrumental in designing the medical text of the Segal Master Plan Document/Summary Plan Description for use with self-funded clients nationwide. Using her past experience as Chief Operating Officer of a nationwide managed health care review organization, she has developed techniques for assessing the comprehensiveness, effectiveness, progressiveness and quality of medical management organizations.

Ms. Hakes performs analyses of medical records as part of her research of complex claims appeals. She additionally conducts assessments of operations and savings assumptions by medical management organizations nationwide, and reviews health records for issues involving cost and quality of care. Ms. Hakes has also customized return-to-work programs and performance guarantees for clients. She is experienced in complex case management and in designing reports that help detail the effectiveness of managed care organizations.

## **Professional Background**

Prior to her 20 years with Segal, Ms. Hakes' background as Director of Health Services and Quality Control for the Arizona division of a national HMO provided her with the expertise to assist Segal clients in the design, implementation, and analysis of unique risk-sharing arrangements for control of medical costs.

## **Education/Professional Designations**

After graduating from the University of Arizona with a BS in Nursing and with an MS from the University of San Diego, Ms. Hakes spent over 10 years providing direct patient care as well as overall nursing unit management in a 650-bed teaching hospital in Southern California. She maintains licensure as a Registered Nurse in Arizona and, until 2004, worked in an urgent care center on weekends.

## **Published Work/Speeches**

Recent articles by Ms. Hakes include:

➤ “Thank You for Not Smoking,” Christopher Calvert and Nancy R. Hakes, *Compensation & Benefits*, December 2009

“Is Your Wellness Program a Scattershot Effort...or on Target to Serve Employees and the Organization?” Chris Calvert and Nancy R. Hakes, *Perspectives*, Volume 16, Issue 3, June 2008

## Expertise

Dr. Malhotra is a Vice President and the National Pharmacy Benefits Practice Leader in Segal's Chicago office. She leads Segal's PBM technical team and the prescription drug consulting groups. She also serves as an expert regarding prescription drug benefit design, cost savings strategies, clinical management strategies, practice development and market trends. Dr. Malhotra provides clinical consulting, analysis, support and strategic direction for clients nationally. She focuses on assisting Segal clients in vendor selection and implementation, contract negotiation, clinical program development. She has extensive experience with the integration of clinical expertise in multiple managed care settings.

Dr. Malhotra is a Vice President and Clinical Pharmacy Consultant in Segal's Chicago office. She is a member of the firm's National Pharmacy Benefits Consulting Practice. Dr. Malhotra provides clinical consulting, analysis, support and strategic direction for clients nationally. She has extensive experience with the integration of clinical expertise in multiple managed care settings.

A sample of Ms. Malhotra's clients are:

- Public School Employees Retirement System (PA)
- New Jersey Transit System
- New Mexico Public Schools Insurance Authority
- Alabama Public Education Employees Health Insurance Plan
- Illinois Central Management Services

## Professional Background

Prior to joining Segal, Dr. Malhotra served as East Region Pharmacy Consulting Practice Leader and Consultant for Hewitt, where she leveraged her consulting and clinical expertise to develop strategies for employers to optimize their prescription drug benefits. Her additional responsibilities included assisting clients in plan design strategy, contract benchmarking and negotiation, vendor selection and management, and auditing. Prior to that, she worked in Aon's pharmacy practice and as a Staff Pharmacist for CVS. Dr. Malhotra's wide range of experience within the managed care industry includes hospital-sponsored health plans, PBM, Medicaid health plans, and employee benefits consulting.

Dr. Malhotra has several years of pharmacy consulting experience. Most recently, she served as East Region Pharmacy Consulting Practice Leader and Consultant for Hewitt, where she leveraged her consulting and clinical expertise to develop strategies for employers to optimize their prescription drug benefit. Her additional responsibilities included assisting clients in plan design strategy, contract benchmarking and negotiation, vendor selection and management, and auditing. Prior to that, she worked in Aon's pharmacy practice and as a Staff Pharmacist for CVS. Dr. Malhotra's varied experience within the managed care industry includes hospital-sponsored health plans, PBM, Medicaid health plans, and employee benefits consulting.

## **Education/Professional Designations**

Dr. Malhotra holds a Doctor of Pharmacy degree from the University of the Sciences in Philadelphia, Philadelphia College of Pharmacy, and a BA in Biology from Lehigh University (Bethlehem, PA). She is a registered Pharmacist and is licensed as a Life, Accident & Health Producer. Dr. Malhotra is an active member of the Academy of Managed Care Pharmacy (AMCP), where she serves on the Program Planning & Development Committee.

## **Published Work/Speeches**

Dr. Malhotra has spoken on a variety of prescription drug benefits topics at national healthcare conferences, local benefits association meetings, and client meetings.

Dr. Malhotra has spoken on a variety of prescription drug benefits topics at national healthcare conferences, local benefits association meetings, and client meetings. Her most recent publication appears in the July 2011 issue of *Benefits Magazine*, "Are You Controlling Fraud and Abuse in Your Prescription Drug Program?"

## **Expertise**

Dr. Vyas is a Clinical Pharmacy Consultant in Segal's Chicago office. He is a member of Segal's National Pharmacy Consulting practice and assists clients in optimizing benefit design and drug mix. He provides consulting services that incorporate the latest best-practice guidelines for clinical pharmacy. Dr. Vyas is a national resource for the firm and has experience working with a wide variety of plan sponsors and Pharmacy Benefit Managers.

Some of Mr. Vyas' clients include:

- City of Houston
- City of Milwaukee
- Cook County
- State of Delaware
- State of North Carolina
- New Jersey Transit
- WisconsinRx/National CooperativeRx
- Alabama Public Education Employees Health Insurance Plan
- Illinois Central Management Services

## **Professional Background**

Prior to joining Segal, Dr. Vyas completed a post-doctoral residency-training program in pharmacy benefits consulting under Segal's National Pharmacy Practice Leader. He has also worked for Astellas Pharmaceuticals in their Scientific Affairs department and has several years of experience working in a community setting with Walgreens Pharmacy.

## **Education/Professional Designations**

Dr. Vyas received both his Doctor of Pharmacy and his BS in Biochemistry from the University of Illinois at Chicago. Dr. Vyas is a licensed pharmacist in the state of Illinois and is a certified immunizer through the American Pharmacist Association (APhA). Dr. Vyas' clinical experience is concentrated in the field of Oncology and the management of disease states requiring complex medication regimens. Dr. Vyas is also an active member of the Academy of Managed Care Pharmacy (AMCP).

## **Expertise**

Ms. Flick joined The Segal Company's New York office in 1993 as a Health Consultant. She transferred to the National Health Services Practice in 1997 as Director of Health Technology Systems and was named Vice President in 1999.

Ms. Flick has special expertise in assisting clients with developing health care cost containment strategies, with an emphasis on pricing and plan design. In her capacity as Director of Health Technology Systems, she has managed the development of claims models for retiree health valuations, rate manuals for medical, prescription drug and dental programs, and health care benchmark database systems.

Ms. Flick was instrumental in helping the firm select a data management software partner to enable Segal to effectively analyze key data elements to help decision-makers take action to improve plan performance. Additionally, she has also actively project-managed a number of client engagements in utilizing this data mining software to determine underlying cost drivers, develop strategies for engaging participants in their own care, contain costs and improve patient outcomes.

Ms. Flick's current and previous clients include:

- North Carolina State Health Plan
- Public School Employees Retirement System (PA)
- State of New Hampshire
- City of Chicago
- City of Philadelphia
- New Mexico Retiree Health Care Authority
- City of New York
- State of Vermont  
New York City Department of Health and Mental Hygiene (Take Care NY)

## **Professional Background**

Prior to joining The Segal Company, Ms. Flick worked as a Benefits Consultant for a major accounting firm.

## **Education/Professional Designations**

Ms. Flick received a BS in Mathematics and Statistics from the State University of New York at Stony Brook.

## **Published Work/Speeches**

Ms. Flick created the Segal *Health Plan Trend Cost Survey* in 1996, now a standard in the industry. Other publications she has authored and project-managed include TRENDS, Segal's *Survey of Dental Coverages* and Segal's *State Health Benefit Survey*. Ms. Flick has been widely quoted in the benefits press, including *Employee Benefit News* and *Capitation Rates & Data*. She provided testimony to the Department of Labor (DOL) ERISA Advisory Council's Working Group on Health Information Technology.

## **Expertise**

Mr. Searles is a Vice President and Consultant in Segal's New York office with over 20 years of experience working with health technology systems. He serves as the project leader for several key health practice initiative, including Segal's medical data mining and pricing tools and analytics. Mr. Searles works with clients to provide technical assistance for network discount analysis, pricing, wellness and disease management program effectiveness, and plan design analysis. Over the last year, Mr. Searles has consulted on the North Carolina State Health Plan.

## **Professional Background**

Prior to joining Segal, Mr. Searles was an Assistant Vice President with Berkley Accident and Health, a direct-writer for a broad range of accident and health insurance products and services including stop loss insurance, HMO reinsurance for health plans and clinical management services to support claim management. Prior to that, Mr. Searles worked for Apex Management Group (owned by Arthur J. Gallagher, Inc.), where he developed their proprietary health care pricing software - Apex.HRM - as well as an online data warehouse and a predictive modeling system.

## **Education/Professional Designations**

Mr. Searles received a BBA from Rutgers University and is a Certified Employee Benefits Specialist (CEBS).

## Expertise

Mr. Williams is a Health Actuary in The Segal Company's Chicago office and has been with the firm since 2002. He is responsible for performing health underwriting, procurement, and managed care projects.

Mr. Williams' responsibilities at Segal have included pricing medical and prescription drug benefits, preparing health plan financial projections, conducting retrospective analysis of claims, developing and setting strategy for contribution rates, analysis of fee schedules, and renewal negotiation. He became the primary analyst for a block of seventeen clients ranging in size from 700 to 20,000+ employees. During this time, Mr. Williams also became familiar with the related areas of retiree health (plan design, funding, and valuation of liabilities) and the vendor procurement process.

Mr. Williams then transitioned his focus to working with corporate and public sector clients in managing their health and productivity programs. He has since performed electronic procurement in several areas of employee benefits, managed vendor renewals, performed analysis of plan cost drivers, and helped clients determine the feasibility of transition to both consumer-driven health and paid time off programs. Mr. Williams has also performed valuation of disability benefits for clients, wellness program return-on-investment calculations, prescription drug fraud/abuse analysis, prescription drug auditing, and continued preparing health plan financial projections and assisting clients in setting strategy for and developing contribution rates.

His clients and services include or have included:

- University of Oklahoma
- Allied Pilots Association
- Regis
- Labor Management Cooperation Committee – City of Chicago Employees / Chicago Public Schools Employees
- City of Philadelphia
- Purdue University
- Chicago Teachers Pension Fund

## Education/Professional Designations

Mr. Williams graduated from Wheaton College (Wheaton, IL) with a BS in Mathematics and a Concentration in Secondary Education in 2000. He is an active volunteer in the Society of Actuaries, and is also on the steering committee of WEB Chicago West, a networking organization of employee benefits professionals.

## **Expertise**

Mr. Kaplan joined The Segal Company's National Health Practice as a Managed Care Consultant in 1993. He was promoted to Vice President in 1996 and became National Health Practice Leader in 2001. Mr. Kaplan has worked with managed care programs since 1986, with special emphasis on pricing and plan design strategies for managed medical, dental, and prescription drug programs. He works with national and local corporations, governments, and collectively-bargained plans. In 1996, Mr. Kaplan created the Segal Health Plan Trend Cost Survey, now a standard in the industry, and client appreciation and use of the survey has contributed to Segal's national reputation as a leader in prescription drug plan benefit consulting and pharmacy benefits management consulting.

Some of Ed's clients include the following:

- Public Schools Employees Retirement System (PA)
- NYC United Federation of Teachers
- Amtrak

## **Professional Background**

Prior to joining Segal, Mr. Kaplan served as an Associate Manager of Underwriting for a major insurance carrier, where he helped to develop managed care plan designs, pricing techniques, and financial risk sharing arrangements. He also served as a Health Consultant for a major consulting firm, where he assisted in the development of rate manuals for managed medical, dental, and prescription drug programs and was involved in several special studies related to managed care, including studies on the prescription drug "shoebox" effect, HMO "skimming," and other issues.

## **Education/Professional Designations**

Mr. Kaplan received a BA in Economics from Rutgers University.

## **Published Work/Speeches**

Mr. Kaplan is often quoted in general business and employee benefit publications on managed care issues. He has authored articles and book chapters for several trade journals and publications, including Employee Benefits Handbook, published by WG&L, Trustees Handbook, published by the International Foundation of Employee Benefits, and Workspan magazine.

## **Expertise**

Ms. Finch is a Benefits Consultant in Segal's Chicago office with over 15 years of experience in the health benefits industry. She helps clients develop, implement and manage their health and pension and communications strategies. She helps clients strategize on benefit design, leads complex projects involving multiple benefit plan changes and carriers to a successful implementation, and assists in the development and execution of communications strategies. Ms. Finch works primarily with small and large government entities and national union groups.

Ms. Finch has assisted clients in lowering annual trend in health care costs, implementing disease management programs (resulting in high participation rates) and identifying key plan design changes for promoting improved member awareness. She has conducted comprehensive reviews of disability and health benefit processes, developed procedures and identified communications improvements for more effectively managing administration and costs, and is experienced in the creation of employee handbooks, benefit brochures, newsletters and employee or retiree meetings. Ms. Finch has also developed in-depth web content for pension, health and disability benefits programs.

Ms. Finch supports the Midwest division of Segal as a subject matter expert on retiree healthcare.

A sample of Ms. Finch's clients are as follows:

- Illinois Central Management Services (State IL)
- Chicago Transit Authority
- International Association of Sheet Metal, Air, Rail and Transportation Workers Union (SMART)

## **Professional Background**

Prior to joining Segal, Ms. Finch was the Chief Operating Officer and Director of Health Benefits for the Cook County Pension Fund in Chicago, IL. Her responsibilities included the strategic day to day operations of a \$7B Pension Fund & \$78M Health Benefit to ensure compliance with Illinois statute. Such duties included policy and procedure development, budget and the administration of the Pension, Health and Disability Benefits. .

Ms. Finch has also worked for Hewitt Associates, a national consulting firm and Caremark, a pharmacy benefit management (PBM) company.

Prior to moving to the United States, Penny was a Social Worker in England; working on a national program to rehabilitate adults with multiple levels of developmental disability from institutional establishments back into their communities and also volunteered in a program that provided respite to parents of children with dual sensory disabilities.

## **Education/Professional Designations**

Ms. Finch received a BS degree from Brookes University in Oxford, England.

## **Expertise**

Mr. Wohl joined The Segal Company in 1988 as part of the Health Actuarial practice in the New York office and transferred to the Washington, DC office as a Benefits Consultant in 1994. He became a Vice President in 1996 and a Senior Vice President in 2005. He specializes in active and retiree health and life benefits and is involved in health actuarial services both nationally and in the East Region. Mr. Wohl is a recognized expert on retiree health benefits and retiree health valuations and served as a technical resource to the Governmental Accounting Standards Board in its deliberations prior to the issuance of GASB 43 and GASB 45. He has been called as an expert witness regarding retiree health benefits and retiree health valuations.

Mr. Wohl serves as Consultant to numerous trust funds that provide health and/or life benefits to retirees and their dependents typically resulting from bankruptcy, collective bargaining or litigation. In many of these situations, Mr. Wohl led the Segal team that helped establish these plans, work that included providing assistance in drafting trust and plan documents, hiring plan and claim administrators, developing compliance policies, plan design decisions and communications. These trust funds provide benefits to certain retirees of Pan American Airways, Fairchild, Dana Corporation, General Motors, Unisys, Campbell Soup, Ford, Northwest Airlines and other retiree groups.

As Regional Health Practice Leader, Mr. Wohl leads a team that provides health consulting, analytical and actuarial expertise to all of Segal's East Region public sector, multiemployer, union and corporate clients. The team provides core services including but not limited to budget projections, rate setting, renewal analysis, procurements, retiree health valuations and reserve setting. The team provides specialized prescription drug consulting and total health management, and has introduced wellness and chronic care management to numerous clients.

Along with being an expert in retiree life and health valuations, Mr. Wohl also has extensive knowledge in developing client specified actuarial systems and the computer programs to implement those systems. He is part of the Segal team assigned to assess the value of health actuarial tools and processes, helping to determine what tools are needed and how best to develop such tools. He also practices in other areas including the development of HMO rates, reserve calculations, plan design, and all facets of health, life and disability benefits.

## **Professional Background**

Prior to joining Segal, Mr. Wohl served in an actuarial management position with a major health and insurance company. He has also has experience in group insurance underwriting.

## **Education/Professional Designations**

Mr. Wohl received a BA in Mathematics from Trenton State College (Ewing, NJ) and an MS in Operations Research from Baruch College of the City University of New York. He is a licensed Life and Health Insurance Consultant in Maryland, Virginia, Washington, DC and other states.

## **Expertise**

Ms. Schatten is a Vice President and consulting actuary in our Atlanta office. She has 20 years of experience in working with public sector plans and employers. Kirsten joined Segal in January 2014.

Kirsten has conferred with many clients to develop innovative benefit designs and pricing strategies to meet unique requests. Most recently, she has assisted plans with consumerism strategies, population health education needs, quality of care initiatives, and drivers of health costs (including drivers of disease prevalence).

She has developed pricing for unprecedented models of care management programs, developed studies to quantify savings from consumer and wellness initiatives, negotiated reimbursement and risk sharing scenarios for managed payers and providers, performed market valuations of health plans for mergers and acquisitions, approved rate filings for DOIs and helped to develop strategies with legal counsel for public rate hearings.

Her experience also includes the analysis and implementation of Retiree medical and prescription drug strategies including coordination of Medicare Advantage plans and Medicare Part D and working extensively with Medicare Advantage plans providing development of business strategies, claims analysis, network strategies, and pricing.

Ms. Schatten's current and recent clients include:

- Georgia State Health Benefit Plan
- North Carolina State Health Plan
- Alabama Public Education Employees Health Insurance Plan
- Illinois Central Management Services
- Bureau of TennCare
- Commonwealth of Virginia
- Kentucky Employees Benefit Plan
- Kentucky Retirement System

## **Education/Professional Designations**

Kirsten is an Associate of the Society of Actuaries and a Member of the American Academy of Actuaries. She holds a Bachelor of Business Administration degree in Risk Management/Insurance from the University of Georgia, and a Master of Actuarial Science degree from Georgia State University.

## **Expertise**

Mr. Heppner joined The Segal Company's Chicago office in 2002 with extensive retiree health knowledge, and began working as a Health Actuary with clients in the Corporate and Public Sector markets to develop rating and contribution strategies. Since then, he has developed an expertise in the multiemployer market as well.

Mr. Heppner has been involved in a variety of projects that include flex plan pricing, PPO and prescription drug pricing, renewal negotiations, contribution strategy, plan design analysis, disability plans and valuations, Medicare Part D attestations, and reserve calculations. He also provides litigation support as a resident expert.

Since his promotion to Vice President in 2005, Mr. Heppner has developed and reviewed Segal's health actuarial guidelines while managing the Midwest Health Practice.

In a recent project, Mr. Heppner assisted clients in understanding their current cost components so that effective decisions could be made to manage those costs. He has also developed interactive budget projection models to address client-specific interests, as well as engaged in successful negotiations with insurers to keep renewal increases consistently below trend. Mr. Heppner has also developed techniques to test and determine actuarial equivalents for unique plan designs.

Two of Mr. Heppner's clients are listed below:

- Alabama Public Education Employees Health Insurance Plan
- Illinois Central Management Services

## **Professional Background**

Prior to joining Segal, Mr. Heppner worked for a major medical insurance company conducting individual health insurance pricing and plan design analysis. He began his career at another international human resources and benefits consulting firm.

## **Education/Professional Designations**

Mr. Heppner received a BS in Business Administration from the University of Illinois in 1991. He is an Associate of the Society of Actuaries and a Member of the American Academy of Actuaries.

## Expertise

Mr. Wang is an Assistant Actuary in Segal's Atlanta office with over 11 years of actuarial consulting experience. He provides retiree health and related consulting services (including SOP 92-6 valuations and GASB OPEB valuations) to clients.

A sample of recent client work includes:

- Alabama Public Education Employees Health Insurance Plan
- City of Houston
- Metropolitan Atlanta Rapid Transit Authority
- Fulton County
- Illinois Central Management Services
- North Carolina State Health Plan

## Professional Background

Prior to joining The Segal Company, Mr. Wang served as a Consulting Actuary for Cuni, Rust and Strenk, where he was responsible for reviewing and co-signing valuation reports for single employer and multiemployer pension and health and welfare funds (including both funding and accounting reports). In addition, he was responsible for signing government forms. Mr. Wang also served as a Consulting Actuary for United Actuarial Services, Inc. where he was responsible for the firm's post-retirement medical valuation practice and worked with several multiemployer pension funds.

## Education/Professional Designations

Mr. Wang received a BS in Mathematics from Fudan University (Shanghai, China). He received a PhD in Statistics from Purdue University. Mr. Wang is an Associate of the Society of Actuaries (ASA), a Member of the American Academy of Actuaries (MAAA) and an Enrolled Actuary (EA).

## Expertise

Ms. Ronsini joined is an Actuarial Analyst in Segal's Atlanta office. Her past, and current, responsibilities include performing technical work and review for actuarial valuations, actuarial assumptions studies and related projects, including:

- Retiree Medical (OPEB) Valuations;
- Expense and revenue projections for self-funded health plans;
- Estimating IBNR reserves;
- Quarterly and monthly reports;
- Conducting Actuarial Attestations in support of Retiree Drug Subsidy applications; and
- Processing and analyzing health claims data.

Her current clients include:

- Georgia State Health Benefit Plan
- Large Eastern State (cannot be named)
- City of Houston
- Illinois Central Management Services
- Alabama Public Education Employees Health Insurance Plan
- City of Atlanta
- North Carolina State Health Plan
- Gwinnett County (GA)
- Fulton County (GA)

## Professional Background

Prior to joining Segal, Ms. Ronsini was a Sales Coordinator at Gallaher Liggett-Ducat (Russia), where she provided operational support for a local branch of an international tobacco company.

## Education/Professional Designations

Ms. Ronsini graduated with an MA in Applied Mathematics from Yaroslavl State University (Russia).

Ms. Ronsini received her Actuarial Society of America (ASA) designation last year.

## **Expertise**

Mr. Wohl joined The Segal Company in 1988 as part of the Health Actuarial practice in the New York office and transferred to the Washington, DC office as a Benefits Consultant in 1994. He became a Vice President in 1996 and a Senior Vice President in 2005. He specializes in active and retiree health and life benefits and is involved in health actuarial services both nationally and in the East Region. Mr. Wohl is a recognized expert on retiree health benefits and retiree health valuations and served as a technical resource to the Governmental Accounting Standards Board in its deliberations prior to the issuance of GASB 43 and GASB 45. He has been called as an expert witness regarding retiree health benefits and retiree health valuations.

Mr. Wohl serves as Consultant to numerous trust funds that provide health and/or life benefits to retirees and their dependents typically resulting from bankruptcy, collective bargaining or litigation. In many of these situations, Mr. Wohl led the Segal team that helped establish these plans, work that included providing assistance in drafting trust and plan documents, hiring plan and claim administrators, developing compliance policies, plan design decisions and communications. These trust funds provide benefits to certain retirees of Pan American Airways, Fairchild, Dana Corporation, General Motors, Unisys, Campbell Soup, Ford, Northwest Airlines and other retiree groups.

As Regional Health Practice Leader, Mr. Wohl leads a team that provides health consulting, analytical and actuarial expertise to all of Segal's East Region public sector, multiemployer, union and corporate clients. The team provides core services including but not limited to budget projections, rate setting, renewal analysis, procurements, retiree health valuations and reserve setting. The team provides specialized prescription drug consulting and total health management, and has introduced wellness and chronic care management to numerous clients.

Along with being an expert in retiree life and health valuations, Mr. Wohl also has extensive knowledge in developing client specified actuarial systems and the computer programs to implement those systems. He is part of the Segal team assigned to assess the value of health actuarial tools and processes, helping to determine what tools are needed and how best to develop such tools. He also practices in other areas including the development of HMO rates, reserve calculations, plan design, and all facets of health, life and disability benefits.

## **Professional Background**

Prior to joining Segal, Mr. Wohl served in an actuarial management position with a major health and insurance company. He has also has experience in group insurance underwriting.

## **Education/Professional Designations**

Mr. Wohl received a BA in Mathematics from Trenton State College (Ewing, NJ) and an MS in Operations Research from Baruch College of the City University of New York. He is a licensed Life and Health Insurance Consultant in Maryland, Virginia, Washington, DC and other states.

## Expertise

Mr. Kaplan joined The Segal Company's National Health Practice as a Managed Care Consultant in 1993. He was promoted to Vice President in 1996 and became National Health Practice Leader in 2001. Mr. Kaplan has worked with managed care programs since 1986, with special emphasis on pricing and plan design strategies for managed medical, dental, and prescription drug programs. He works with national and local corporations, governments, and collectively-bargained plans. In 1996, Mr. Kaplan created the Segal *Health Plan Trend Cost Survey*, now a standard in the industry, and client appreciation and use of the survey has contributed to Segal's national reputation as a leader in prescription drug plan benefit consulting and pharmacy benefits management consulting.

Some of Ed's clients include the following:

- Public Schools Employees Retirement System (PA) – 75,000
- NYC United Federation of Teachers
- Amtrak

## Professional Background

Prior to joining Segal, Mr. Kaplan served as an Associate Manager of Underwriting for a major insurance carrier, where he helped to develop managed care plan designs, pricing techniques, and financial risk sharing arrangements. He also served as a Health Consultant for a major consulting firm, where he assisted in the development of rate manuals for managed medical, dental, and prescription drug programs and was involved in several special studies related to managed care, including studies on the prescription drug "shoebox" effect, HMO "skimming," and other issues.

## Education/Professional Designations

Mr. Kaplan received a BA in Economics from Rutgers University.

Mr. Kaplan is often quoted in general business and employee benefit publications on managed care issues. He has authored articles and book chapters for several trade journals and publications, including *Employee Benefits Handbook*, published by WG&L, *Trustees Handbook*, published by the International Foundation of Employee Benefits, and *Workspan* magazine.

## Expertise

Ms. Ingle is a Health Consultant in Segal's Atlanta office with nearly 16 years of industry experience in Project Management and Human Resource Management. Her responsibilities include the strategic design and supervision of many different areas for health benefit plans, including health plan strategy, vendor evaluation and selection, implementation of new programs, and plan performance management.

She has directed implementations and assisted in the plan design and development of a broad scope of projects, including Intensive Case Management, Disease Management and Integrated Health and Productivity Management. Additionally, Laine has experience in serving as the day-to-day contact for public sector clients focusing on project management, vendor management, benchmarking of benefit plans and renewal marketing.

Ms. Ingle's public sector clients include:

- Georgia State Health Benefit Plan
- Alabama Public Education Employees Health Insurance Plan
- Illinois Central Management Services
- City of Houston
- Texas Employees Group Benefit Plan

## Professional Background

Prior to joining Segal, Ms. Ingle was a Senior Consultant in the Government Programs Health Practice at a large consulting firm in Atlanta. She has worked extensively with states and other large governmental employers on the evaluation, design and operation of state health plans, on-site healthcare clinics, integrated health promotion and absence management programs as well as Specialty Disease Management and Care Management Programs.

## Education/Professional Designations

Ms. Ingle received a BS in Broadcast Communications from Kennesaw State University. She has been a Georgia licensed agent since 2000, as well as holds licenses in Tennessee and Mississippi. She is an ISSA Certified Fitness Trainer and a student of the Certified Employee Benefits Specialist program.

## **Expertise**

Ms. Slutzky is an Associate Health Consultant in Segal's Atlanta office with over 15 years of experience in the employee benefits field. She currently consults on and evaluates retiree health options, Medicare Advantage and Prescription Drug Plan solutions and assists with valuating medical management programs and health plan strategies.

Ms. Slutzky works with clients across Segal's multiemployer, public sector and corporate markets. She performs PBM RFP analyses as well as reviews and assessments of PBM contract terms to determine areas that can be improved to better meet a plan's needs, enhance performance, reduce costs and improve quality. She has also performed RFP analysis for stop loss, life and AD+D insurance, dental, vision and independent review organization coverages to assist clients in selecting vendors. Ms. Slutzky's expertise includes training and development, managed care analysis and assessment, Health Insurance Portability and Accountability Act (HIPAA) privacy and security compliance assessment, and Pharmacy Benefit Manager (PBM) consulting services.

A sample of recent client work includes:

- Alabama Public Education Employees Health Insurance Plan
- Illinois Central Management Services
- Metro Atlanta Rapid Transit Authority
- City of Atlanta, GA
- Georgia State Health Benefit Plan
- City of Houston, TX

## **Professional Background**

Ms. Slutzky has contributed to several company initiatives that provided value for our clients. She designed, managed, and served as a coach for the company's health training program curricula for over 250 health practitioners. She also researched various health care topics and their relevance to plan sponsors.

Ms. Slutzky's past roles at Segal included streamlining Segal's national template of Preferred Provider Organization (PPO) bid specifications, which assisted clients in gathering effective information in order to select the most optimal vendor for their plan. She also developed report templates to facilitate consulting on emerging health issues under Affordable Care Act (ACA), provided technical and consulting assistance for select client projects, and created and updated health benefit benchmarks.

## **Education/Professional Designations**

Ms. Slutzky received a BS degree from Emory University and a Masters of Public Health degree in Health Policy and Management from Emory University's Rollins School of Public Health.

## **Published Work/Speeches**

Ms. Slutzky has contributed to several company surveys and reports, including the *Segal Health Plan Cost Trend Survey*, which captures average forecasted changes in health plans' per capita claims costs for medical, dental, prescription drug, and vision coverages, and *TRENDS*, an e-publication that offers a periodic snapshot of newsworthy health coverage developments for plan sponsors.

## **Expertise**

Ms. Bakich is a Senior Vice President in Segal's Washington, DC office with over 20 years of experience in health care compliance. She is the firm's National Health Compliance Practice Leader.

Ms. Bakich is one of the country's leading experts on employer sponsored health coverage. She specializes in providing research and analysis on federal laws and regulations affecting health coverage, including: ERISA, Medicare, HIPAA, COBRA, the Newborns' and Mothers' Health Protection Act, the Mental Health Parity Act, and the Women's Health and Cancer Rights Act.

Ms. Bakich is a recognized expert on the Patient Protection and Affordable Care Act passed in 2010. She speaks regularly about the law, helps plan sponsors understand its short and long term effects on their plans, and assists clients with preparing comments on the legislation for submission to regulatory Departments (Treasury, Labor, and Health & Human Services). Some of Ms. Bakich's clients include the State of Michigan, Public School Employees Retirement System (PA), Alabama Public Education Employees Health Insurance Plan, Illinois Central Management Services, UAW retiree medical trust, and NCCMP.

Ms. Bakich leads the Segal team responsible for publishing information about new health care laws and regulations, and trains internal staff on all legislation and related developments. She and her staff disseminate health compliance information, monitor federal and state laws and regulations, and prepare amendments for health plans and summary plan descriptions based on national models.

## **Professional Background**

Prior to joining Segal, Ms. Bakich was an attorney in private practice representing multiemployer health plans and an appellate administrative law judge.

## **Education/Professional Designations**

Ms. Bakich graduated in 1979 with a BA in Political Science, in 1982 with an MA in Public Policy, and in 1985 with a JD from the University of Missouri. She has been admitted to the Bar in the District of Columbia, United States Supreme Court, and multiple federal district and appellate courts.

Ms. Bakich is a member of the Working Committee of the National Coordinating Committee for Multiemployer Plans (NCCMP), the Health Technical Issues Taskforce of the American Benefits Council (ABC), the Employers Council on Flexible Compensation (ECFC) Flex Advisory Council, and the American Bar Association (ABA). Ms. Bakich is co-chair of the ABA Joint Committee on Employee Benefits Subcommittee on Welfare Plan Regulation. She was also appointed to the Government Liaison Committee of the International Foundation of Employee Benefit Plans (IFEPP). Ms. Bakich was named a Fellow of the American College of Employee Benefits Counsel in 2012.

## **Published Works/Speeches**

Ms. Bakich has published multiple articles about employee health and welfare benefits, including a series of articles discussing HIPAA Administrative Simplification, EDI, and Privacy in the *Benefits Law Journal*. She is a co-author of the *Employers' Guide to HIPAA Privacy Requirements*, published by Thompson Publishing Group, and a chapter editor of *Employee Benefits Law*. Ms. Bakich speaks regularly on issues related to group health plans.

## **Expertise**

Mr. Kaplan is a Vice President and Senior Consultant in Segal's Communications practice. He has over 20 years of consulting experience in the development and management of employee-focused communications strategy, tactics, and message creation. His consulting approach emphasizes the importance of using audience research (e.g., surveys, focus groups, one-on-one interviews) to gather the information needed to create targeted messages and content that raise awareness, influence thinking and change behavior.

Mr. Kaplan provides strategic counsel to clients on a wide range of employee communications issues and develops content for a broad array of media channels, including online/interactive, print, and face-to-face. His clients include Ball State University; Illinois Central Management Services; Yale-New Haven Health System; Dana-Farber Cancer Institute; The Ohio State University; Skidmore College; and the University of Arkansas System.

## **Professional Background**

Prior to joining Segal, Mr. Kaplan provided employee communications counsel to clients with two other nationally known human capital consulting firms.

## **Education/Professional Designations**

Mr. Kaplan received a BA in Psychology from Stony Brook University and an MA in Industrial/Organizational Psychology from the University of New Haven.

## **Published Works/Speeches**

Mr. Kaplan's speaking engagements have included addresses to: the Council on Employee Benefits on increasing savings plan participation; the International Society of Certified Employee Benefit Specialists (Northern New Jersey Chapter) on "Communicating Tough Messages in Tough Times"; the New England Employee Benefits Council on "Communicating Health Care with Employees: From Need to Know to Full Disclosure"; and, the International Foundation of Employee Benefits Plans and the Association of Benefit Administrators (ABA) on "From 'Required' to 'Inspired': Moving Beyond the PPA'06 rules of Participant Communications." He has also published an article based on the latter speech in the ABA's quarterly newsletter.

## **Expertise**

Ms. Rosenthal is a Vice President and Senior Consultant in Segal's Communications Practice. She is located in the firm's Boston office and has over 25 years of experience in communications consulting and business administration. Ms. Rosenthal develops and implements communications strategies that align with an organization's vision and culture, often in a difficult and changing environment. Her experience and technical knowledge cover a broad range of human resources topics, including benefits, compensation and organizational change.

Ms. Rosenthal serves clients in all of Segal's markets (public sector, corporate and multiemployer). Major public sector clients include the State of Tennessee, the Pennsylvania Public School Employees' Retirement System, North Carolina State Health Plan, and the State of New Hampshire. Other clients include Avis Budget, Realogy and the national benefits funds for an entertainment industry labor union.

## **Professional Background**

Prior to joining Segal in 2002, Ms. Rosenthal served as President of her own firm, MCR Communications. She also previously worked in executive positions for CBS, HBO, and Winstar Communications, where she oversaw financial, human resources, and communications departments.

## **Education/Professional Designations**

Ms. Rosenthal received a BA in Psychology from Tufts University and an MBA in Finance and Marketing from Columbia University. Her work has been recognized with ACE Awards from the International Association of Business Communicators (IABC) and MarCom Creative Awards from the Association of Marketing and Communication Professionals.

## **Published Works/Speeches**

Ms. Rosenthal's speaking engagements have included addresses to the State and Local Government Benefits Association ("Total Rewards—Going Beyond Benefits and Compensation"), the New England Employee Benefits Council ("Communicating Health Care with Employees: From Need to Know to Full Disclosure") and the Airline Human Resource Association ("Go First Class with Your HR Communications"). She has conducted webinars on a number of topics, including "Sharing Responsibility for Health Care: A Case Study for Implementing Changes in Tennessee, which she co-presented with the Executive Director, Benefits Administration for the State of Tennessee. Her article: "When They Tell You the Sky Is Falling... How to Guide Employees through Economic Uncertainty," was published in IPMA HR News.



## **Expertise**

Ms. Watson is a Vice President and Senior Consultant in Segal's Phoenix office and has over 39 years of claims administration and audit experience. She is responsible for overseeing all aspects of Segal's claims auditing services, and provides assistance with operational/organizational reviews, technology application assessments, and TPA searches. Ms. Watson's experience as a group benefit analyst and auditor for The Segal Company, combined with her prior experience as a claims examiner, enables her to provide clients with a clear understanding of employee benefits and an administrative office's responsibilities and workflow.

## **Professional Background**

Ms. Watson entered the employee benefits field in 1972 working with insured and self-funded groups on both manual and computerized claims adjudication systems. Her experience includes the supervision of a large claims payment staff and working with major group insurance carriers.

## **Education/Professional Designations**

Ms. Watson attended Glendale Community College. She has received the designation of Health Insurance Associate (HIA) and Managed Healthcare Professional (MHP) for completion of the America's Health Insurance Plans (AHIP) Insurance Education Programs, a certificate of completion from the Insurance Educational Association (IEA) in Workers' Compensation Claims Administration and completed training as a Forensic Medical Fraud Investigator.

## **Expertise**

Ms. Sheldon is a Consultant in Segal's Phoenix office and has over 30 years of experience in claims administration and auditing. In addition to claims auditing services, her responsibilities include reviewing detailed financial and claims data for various health, dental, vision, disability, life, and alternate provider benefit programs.

## **Professional Background**

Prior to joining The Segal Company, Ms. Sheldon was employed for 17 years by a national third-party administrator working with insured and self-funded groups on both manual and computerized claims adjudication systems. She is experienced in customer service, claims processing, staff training, the coordination of third-party subrogation recoveries, producing and reviewing carrier and network reports, the performance of internal audits, and the maintenance of provider profiles and federal tax reports.

## **Education/Professional Designations**

Ms. Sheldon attended Phoenix Community College. She has received the designation of Health Insurance Associate (HIA) for completion of the America's Health Insurance Plans (AHIP) Insurance Education Program and a certificate of completion from the Insurance Educational

# Appendix 2 – Business Transaction Authority

United States of America

State of Wisconsin

DEPARTMENT OF FINANCIAL INSTITUTIONS



## CERTIFICATE OF AUTHORITY or REGISTRATION

Issued to

**THE SEGAL COMPANY (MIDWEST), INC.**

an organization formed under the laws of **Illinois**,

authorizing the organization to transact business in this state, effective **July 24, 2006**,

as a

- Foreign limited liability partnership, under sec. 178.45, Wis. Stats.
- Foreign limited partnership, under sec. 179.82, Wis. Stats.
- Foreign corporation, under sec. 180.1503, 180.1504, 181.1503 or 181.1504, Wis. Stats.
- Foreign limited liability company, under sec. 183.1004 or 183.1006, Wis. Stats.

Date of Issue: **July 26, 2006.**



A handwritten signature in black ink, appearing to read "Ray Allen".

RAY ALLEN, Deputy Administrator  
Division of Corporate & Consumer Services  
Department of Financial Institutions

See reverse for more information

DFI/CORP/22(R 2/00)

# **Appendix 3 – Mandatory Requirement (WHIO) Data Use Agreement Contract & Non-Disclosure Agreement**

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# Appendix 4 – Sample Reports

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Please find attached the work samples below:

1. State of North Carolina – Report on State Health Plan’s Next Generation Health*Smart* Ten-Year Plan and Strategy
2. State of Tennessee – A Health Benefit Plan Strategy for the Public Sector Plans

# Appendix 5 – Additional Presentations

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Please find attached the additional work samples below:

1. Quarterly Dashboard Report
2. Wellness Performance Metrics