New York State Department of Civil Service
Actuarial and Benefits Management Consulting Services
RFP #ABMC-2017-1

Response to Request for Proposal

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REDACTED

Section IV: Technical Proposal

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4.A. Corporate and Account Team Experience

4.A.1 Executive Summary

a. Required Submission

The Offeror must submit an Executive Summary outlining its overall program and its capacity to administer the Project Services outlined in this RFP. The Executive Summary must include

(1) The name and address of the Offeror's main and branch offices and the name of the senior officer responsible for this account;

Aon Corporation global headquarters is in London, England. Our United States headquarters is located in Chicago, Illinois. The primary consultants serving the New York State Department of Civil Service (the Department) will be located in Somerset, NJ.

Based on the requirements of the ad hoc services, Aon consultants from other offices across the country, including New York, NY; Chicago, IL; Radnor, PA; and other locations may also be involved.

Jim Christ will continue to be the officer with primary responsibility for account management. Jim will have much of the day to day interaction with the Department and will serve as the Aon Account Executive.

(2) A concise description of the Offeror's understanding of the requirements presented in the RFP, the Department's needs, approach, and how the Offeror can assist the Department in accomplishing its objectives;

Aon is excited about the possibility of continuing to work with the Department to manage its Employee Benefit Plans, covering almost 600,000 subscribers. The Department is seeking an actuarial and benefits consultant for the following services:

- Task # 1 – Premium Rate Development
- Task #2 – Quarterly Analysis
- Task #3 – GASB 75 Valuation
- Task #4 – Ad-hoc Consulting Services

Aon is particularly well qualified to provide these services as we provide top-notch advice to hundreds of public sector clients across the country and consider being client-oriented and responsive two of our highest priorities when serving our clients.

Aon's Health and Benefits Public Sector practice provides best-in-class consulting services to over 225 states, cities, counties, and public agencies around the country. Factoring in other lines of business such as retirement consulting and risk brokering, Aon has over 1,300 Public Sector clients. This allows the deepest level of benchmarking, resources and idea sharing.

Our proposal provides considerable detail on our approach and methodology to addressing the Department's consulting needs. We go beyond merely stating that we can provide a desired service; we summarize how we would conduct that project, including the tools and resources to be used – and why. We truly partner with our clients when we take on an assignment and our willingness to show our approach is reflective of that partnership mentality.

Aon is among the nation's top human resource consulting firms. We believe that continuing our relationship can offer the Department the return on investment that proves its benefit investments are sound and profitable. Aon has the expertise and extensive resources to assist the Department with the services outlined in this proposal.

Aon's proposed lead consultants are very familiar with the Department's needs and objectives, as a result of working with the Department over the past five years. In fact, in the past your account lead has worked with the Department on these very assignments both as a consultant and as a financial officer at one of your medical vendors.

The key strengths that differentiate Aon consulting in the public sector benefits consulting marketplace are:

- **Focus on cost reduction, not cost shifting**—Our consulting approach focuses on developing solutions that reduce cost with little or no impact on employees. Key to this focus is our proven ability to help clients change their benefits programs to increase efficiency, program quality, and resulting return-on-investment. For example, because public employees do not readily accept benefit cuts, we look to strategies such as value-based design, high quality networks, ACOs, and patient-centered medical homes. These programs can be a "win-win" for employees and employers and they tend to resonate well with state government constituents.
- **Highly experienced account team**—We understand that public sector employers want to know their service team has experience with helping other public sector employers solve similar problems. Your proposed service team is extensively familiar with issues facing public sector employee populations. They will combine that experience with creativity to develop viable solutions and help you navigate necessary channels as you obtain approval for benefit changes.
- **Accomplished actuarial team**—We understand the pressures of the state and the need to present complicated, detail-oriented information to oversight committees and boards. With many years of experience servicing public sector clients, our consultants and actuaries have made hundreds of presentations to committees and boards and know how to clearly articulate complicated results.
- **Significant market leverage and negotiating power**—With our scale of purchasing coverage, we can help you achieve cost savings. We use our substantial market clout with insurance carriers, TPAs, and other vendors to negotiate the best premiums, services, and associated prices for our clients. In addition, we help our clients secure the most advantageous service agreements and performance guarantees by leveraging what we have negotiated for similar public sector entities.
- **Extensive experience working with committees made up of labor, staff, management, and elected officials**—Many public sector benefit programs and vendor selections are overseen by committees. We have extensive experience presenting to and working with joint committees to achieve a positive outcome.
- **Breadth and depth of local and national resources**—We have more than 100 consultants working with public sector clients. These industry experts come from a variety of disciplines including actuarial, legal, underwriting, accounting, clinical, data analytics, pharmacy management, customer service, information technology, and management. All of our colleagues have worked in the public sector across a wide variety of roles. Many of our experts work with private sector clients as well. This diversity of experience allows for the unique opportunity to bring innovative cost management solutions from both the public and private sectors. Finally, our team's vast expertise allows us to keep the Department informed of legislative and regulatory issues that could present challenges for our public sector clients.

- **Thought leadership—**By partnering with us, you will get the benefit of top-tier thought leadership and perspectives, customized to the Department's needs. We keep our clients abreast of what is happening in Washington with our written briefs. We hold forums, in-person seminars and webinars for clients to learn, share information, and exchange ideas. We give public sector clients the opportunity to tell us about their health care plans and programs in our annual surveys, which are shared among public sector respondents. We also share our innovation with public sector clients through our game-changing points of view on the future of health care.

Other key differentiators include:

You Know Us

We have a commitment to exceptional account management. The Aon team will continue to provide a team of highly-qualified consultants and actuaries, led by Jim Christ and Jonathan Nemeth, both with extensive experience in the public sector, to deliver health and welfare consulting services to the Department. They will have access to regional and national resources, including a network of other Aon colleagues experienced in consulting on public sector benefit plans.

We Know You

Our Knowledge of the Department

Jim Christ, Mary Reilly, Jonathan Nemeth, Vince Kozlowski, Tom Vicente, and other Aon team members have a deep and intimate knowledge of the Department, and have completed various assignments for the Department. In addition to our work on the current services outlined in this RFP over the last five years, Aon has completed other ad-hoc projects for the Department and the Governor's office of Employee Relations over the last 10 years. In addition, Jim Christ was the lead financial officer responsible for the Empire Plan account at Empire BCBS between 1998 and 2005. Jim was also one of the lead consultants on the NYSHIP program prior to joining Aon.

We Know Your Data

Aon has worked closely with the Department and the Empire Plan vendors over the last five years. We know and understand the nuances and complexities in your data. As a result, there will no learning curve allowing the team to continue to provide the current level of service and ongoing projects without any interruption or delay.

We Are Confident in Our Ability to Meet Your Needs

We are so confident that we can exceed your expectations for quality, accessibility, and timeliness that we are willing to offer performance guarantees that exceed the minimum standards and put a substantial portion of our professional fees at risk.

We believe that you will find our proposal responsive to your needs and we anticipate reviewing it with you at your convenience. We look forward to continuing to work with the Department in the years ahead.

(3) A succinct statement that supports the Offeror has maintained an organization capable of performing the work specified herein this RFP, in continuous operation for at least the past three (3) years and that it has provided services comparable to the Project Services outlined in this RFP continuously during said period for the benefit of, at a minimum, three (3) governmental organizations with at least 100,000 in size;

Aon is fully capable of performing the work specified in this RFP. Aon was founded on December 12, 1979, although predecessor organizations to our firm have been in business for more than 300 years. We have decades of experience providing health and welfare consulting services to our clients.

Aon has more than 250 health care actuarial consultants and actuarial students who provide consulting services to many of our nation's state and local government entities and Fortune 500 companies. The Aon team working on this consulting assignment will have four credentialed actuaries leading the project, along with other credentialed actuaries supporting the work as needed. In addition to having a broad understanding of the dynamics within the health care industry, our health care actuaries are responsible for modeling:

- Employee contributions
- Health plan pricing
- The impact of plan design changes
- Other actuarial calculations

This combination of health knowledge and actuarial mechanics makes our actuaries a valuable resource in assisting organizations with solving their human resources and financial challenges.

We have provided services comparable to the project services outlined in this RFP for multiple governmental organizations with at least 100,000 employees, including the State of New York, the State of New Jersey, and the City of New York. Aon has been the Health and Benefits consultant and actuary for the Department over the last five years. As noted above, Aon provides health and benefits consulting advice to over 225 states, cities, counties, and public agencies around the country. Some of the Aon clients the proposed Account team has experience with include the State of New Jersey, the State of Delaware, the State of Kentucky, the State of Oklahoma, the State of Tennessee, and other public sector entities.

(4) A succinct statement explaining previous experience providing actuarial and benefits management consulting services to other governmental organizations administering health benefits programs and detail how that experience, in general and specifically in regard to the clients given as Client References in response to RFP Section III, qualifies the Offeror and, if applicable, any subcontractors, to perform the required Project Services;

Your key Aon team members Jim Christ, Jonathan Nemeth, Mary Reilly, Vince Kozlowski, and Tom Vicente all specialize in working on actuarial and benefits management consulting projects with large, complex public sector clients. We leverage this experience to ensure the Department is always apprised of industry trends. We bring our knowledge of public sector entities to every project we complete.

Aon has completed assignments similar in nature to those requested in this RFP for our two current references (the State of Tennessee and Nokia) and one former reference (the State of Delaware). The assignments included financial analyses, rate setting, and post-retirement medical valuations.

Aon's Health and Benefits public sector practice consists of over 100 consultants and actuaries around the United States who consult with states, cities, counties, municipalities, transit agencies, schools, and other public sector entities of all sizes. We understand the public sector and have a long-standing commitment to public sector consulting.

Our public sector practice works with our consulting teams to develop solutions for public sector organizations as they face challenges affecting health benefits. This national group (which includes Jim Christ and Mary Reilly) connects regularly to share information on topics of particular interest in the public sector, such as techniques for reducing OPEB liabilities, strategies for addressing the Excise Tax, successful trends and designs for wellness programs, benchmarking, retiree health care strategies, and population health improvement. The goal is to share best practices with each other and with our public sector clients when appropriate, always striving to maximize the value, impact, and long-term sustainability of our clients' benefit programs for their employees and retirees.

We have extensive experience with public entities, both locally and nationally, and understand your unique challenges. Based on our public sector experience, deep expertise, and extensive understanding of public sector plans and challenges, public entities have selected Aon and have consistently scored us a "10 of 10" on our annual client satisfaction survey. Aon has a 97% retention rate with public sector clients.

(5) A concise description of the Contractor's full range benefits consulting services offering and experience addressing, at a minimum, the areas of:

- plan design consulting
- provider network access analysis
- consulting on vendor procurements
- regulatory monitoring and compliance guidance
- quality care programs
- wellness programs and disease management
- performance based contracting
- advanced primary care
- total cost of care modeling
- analytical support
- discount analysis

Aon recognizes public sector clients require an array of specialized expertise. We are committed to serving the public sector in a variety of ways through our diverse public sector practice. We offer our public sector clients customized, end-to-end solutions to health and benefits management. Our solutions are designed for impact and involve a systematic, transparent approach that includes the following:

Plan Design Consulting

A number of our proprietary actuarial tools and models are considered leading edge in the industry. These assets are used in our consulting work with hundreds of major organizations to evaluate costs, set budgets, model plan changes, and establish contribution requirements across all benefits and health plan designs for active and retired employees. The data supporting these models represents more than 1.9 million members and more than $9 billion in claims data.

Our extensive tools and databases are leveraged to benchmark current cost, plan design, employee cost sharing, and overall benefits program competitiveness. With online access to these powerful resources, our consultants can determine how your existing benefits compare with industry and market competitors. Understanding how these elements compare to other employers in both the public and private sectors is critical to determining what changes may be appropriate—when aligned with your strategy—to maintain a competitive and cost-effective health plan.

Aon's actuaries are responsible for pricing health plans (forecasting future costs), evaluating the impact of potential and actual plan design changes, and modeling employer subsidy/employee employer costs.

Provider Network Access Analysis

The GeoAccess Network Analysis tool allows us to conduct comprehensive, customized network evaluations. GeoAccess provides accessibility analyses, online directories, and simple mapping of employee or provider locations. Aon provides this service to clients to show employee access to a specific health plan's provider network by conducting accessibility analyses and creating maps and reports. Health plans compare employee files with provider files to show access based on specific standards (e.g., percent of employees with access to two primary care physicians within 10 miles).

Aon has assisted the Department in these types of analyses for several recent vendor procurement processes, including vision, mental health, and prescription drug vendor RFPs.

Consulting on Vendor Procurements

Aon provides ongoing vendor support and liaison activities for almost all of our health and benefits consulting clients; however, the level of support varies based on client needs. We can scale our support from reviewing certain sections of a proposed RFP to a more robust involvement that would include evaluation of all aspects of vendor proposals including cost and technical review. Aon worked with the Department on the development of several sections of a recent vendor RFP.

Aon has worked with and supported public entities in various manners throughout vendor RFPs and procurement processes. We understand the process, the key stakeholders, and the commitment needed for successful results.

Our consultants are uniquely qualified to assist with issues related to provider networks, claims administration, member services, account management, eligibility processing, and premium/fee payment issues. We understand the health plans' processes and limitations through daily interaction on behalf of many of our clients. Due to the large volume of health care business we manage, most of the major health plans have assigned senior regional/national account executives to manage their firms' overall relationships with us. If needed or requested, our consultants have direct access to these health plan liaisons to support the Department.

Aon has extensive experience with public sector procurement processes, including bidder protests and assisting our clients with their vendor contract issues. It is very common in the public sector for bidders not awarded contracts during procurement processes to submit formal protests that contest the award. This is especially true if incumbent vendors do not retain the business. Aon has found that “tight” and well-defined RFPs and award processes can minimize any disruption and the likelihood of successful vendor appeals of protest. We can support the Department in developing RFPs to meet these standards.

Regulatory Monitoring and Compliance Guidance

Our health and benefits legal team (H&B Legal) is composed of more than a dozen employee benefit attorneys, paralegals, and analysts with an average of 15 years of experience in employee benefits law.

H&B Legal consults with employers on compliance regarding a wide range of federal and state laws relating to health and welfare plans, including: the Patient Protection and Affordable Care Act as well as the recently emerging replacements, the Internal Revenue Code, ERISA, HIPAA, COBRA, the Americans with Disabilities Act, state and federal health care reform legislation, and state insurance laws relating to the regulation of fully-insured health care plans, such as prompt pay and any willing provider legislation. Aon's legal consultants regularly work with benefits managers, in-house attorneys, and outside counsel to draft, negotiate, and finalize contracts for self-insured health care plans and third party administrators, and conduct nondiscrimination testing on employer group health care plans. Our legal consultants also periodically submit comment letters to federal agencies on proposed regulations that could have a potential impact on employers. In the letters, Aon often suggests approaches to federal agencies to facilitate easier implementation for employers once final regulations are issued.

While Aon is not a law firm and does not provide legal advice, we work with internal and external legal counsel in designing and implementing your compliance strategy. And, while we do not lobby, we have provided data to Congressional committees and regulatory agencies on the impact of proposed changes to the employer-based health care system. We have also provided data on the advantages of maintaining a vigorous employer-based health care system serving 160 million Americans and presented the necessity of providing employers with tools for reducing the costs of health care as well as increasing access to health insurance.

Quality Care Programs, Wellness Programs and Disease Management

Aon has provided wellness and disease management consulting services for over 15 years as a discrete area of specialty. We are a recognized leader in helping entities and organizations design and implement managed health initiatives to improve health and productivity.

Aon’s Health Transformation Team (HTT) includes approximately 40 clinicians, consulting professionals, and subject matter experts. It is one of three innovation pillars under the leadership of our Chief Innovation Officer. The HTT supports 250 clients annually. Over the past 3 years we have consulted with more than 30 organizations that have been recognized by the National Business Group on Health and by the C. Everett Koop Foundation for their award-winning health and wellness initiatives.

Aon's HTT specializes in helping clients create innovative strategies and tactics to improve the health and wellbeing of their workforce, reduce the risk of chronic disease, and increase employee performance.

We assist employers in the following areas:

- **Strategic guidance** – Aon is committed to ongoing innovation and keeping our clients up to date on new and upcoming wellbeing market trends. To date, Aon has invested over $470 billion in health and benefits solutions to provide our clients with greater choice and affordability and increase employee wellbeing. Aon spends over $10 million annually to build and maintain the most comprehensive health care and general databases and analytical tools in the benefits consulting industry.
- **Total health improvement strategy** – We can help you set, refine and/or document a multiyear strategy reflecting the Department's values, the results that are most important to your success, and the employee behavior changes required to optimize those results.
- **Design** – We can help you structure benefits design, wellbeing programs, incentives, and communication messages that support healthy decisions, introduce personal responsibility for health care decisions, and reward positive behavior change.
- **Vendor review, evaluation, and selection** – Aon regularly assists in the selection, implementation, and ongoing oversight of vendors that bring your strategy to life. Aon's proprietary vendor database is updated annually and includes information on nearly 400 specialty vendors representing managed health services, disease management, high-acuity care management (including case management and utilization review), nurse line and clinical advocacy providers, wellbeing program providers, EAPs, and managed mental health providers.
- **Audits** – Aon's audit group was formed nearly 30 years ago. Having steadily built our audit expertise since that time, we complete approximately 250 audit-related projects each year. Aon provides clinical case review with physician and pharmaceutical oversight. Our clinical auditors have extensive clinical operations experience and maintain in-depth and current knowledge of vendor capabilities and performance.
- **Coordination across health and welfare benefits** – Aon guides employers in the identification of key integration points across health and welfare benefits. For example, our consultants have implemented health management initiatives and measurement approaches that link all health-related benefits (group medical, pharmacy, EAP, short- and long-term disability, and workers' compensation).

Aon's integrated approach to health and productivity helps our clients to improve the patient experience for their employees while maximizing value and ROI for the employer.

Performance Based Contracting

As part of Aon's Delivery System Transformation Initiative, there is a team of consultants working on transforming industry standards to improve healthcare delivery for all Americans. This type of contracting is part of the general move in the industry to payment for value versus payment for volume.

We address performance based contracting as two stakeholders. First, we are in the process of routinely negotiating performance based contracts with carriers and health plans. We have progressed from the traditional administrative and financial performance measures to clinical quality and outcome measures. These clinical quality and outcome measures are customized for each employer client and are designed to address health risk and conditions prevalent in their

populations. More recently we have been negotiating performance measures with ACOs and clinically-integrated health systems.

Aon uses existing measures that have been reviewed by the measurement community. They come from such validated sources as the National Quality Forum, CMS ACO and PCMH measures and the Agency for Healthcare Research and Quality (AHRQ). These measures have specific definitions and methodology approved by the agencies mentioned previously, and the carrier and health plans are already collecting them. We just ask for them to be specific to the employer. We then apply financial penalties for not meeting targeted performance measures. Typically we achieve 30% or more of administrative fees at risk in this performance based contracting. We are however exploring more shared risk type arrangements with health systems. Initially these will be shared savings arrangements with no down side risk but will progress to shared savings with upside and downside risk.

We have a number of national clients that have these performance based contracts in place with health systems through carriers in places across the country.

Advanced Primary Care

We have a number of Advanced Primary Care projects underway with employers. Many of our existing clients are exploring a continuum of options that involve refinement in health and wellbeing benefits that leverage Primary Care. The most progressive model, and what Aon believes to be best practice design, is employer(s)-sponsored health services structured as an Advanced Patient-Centered Medical Home (APCMH) coupled with a value-based payment arrangement. This structure involves holistic, person-centered, team-based care supported by advanced technology at or near the employer(s) location. The team typically includes primary care physicians, nurse practitioners/physicians assistants, social workers, behavioral health practitioners, care managers, pharmacists, and health coaches. The team is responsible and accountable for coordinating all levels of medical care and treatment and leveraging other community and employer-sponsored health and wellbeing services to improve the health of assigned members.

Historically, employer-sponsored health services have been 1) owned by a specific employer, 2) typically provided at a center operated (usually by an expert employer clinic operating partner), 3) located at an employer worksite and 4) focused on acute episodic primary care and/or occupational health. Increasingly, employers are considering an array of strategies including:

- Expansion of services to include basic primary care, lifestyle coaching and chronic condition management
- Collaboration with other employers to create shared service sites
- Delivery of services at a nearby, convenient off-site location(s)
- Engagement of alternative clinical operating partners such as a direct primary care provider groups, Patient-Centered Medical Homes, concierge physician practices and local health systems as well as the more conventional clinic operators
- Value-based rather than fee-for-services payment arrangements to align interests among all parties

When the APCMH model is adopted as a replacement for a local medical/health plan available to employees, we have negotiated a capitated arrangement for primary care services and fee-for-

service for specialty and hospital referrals. We have two national clients with this model in Illinois and Colorado. The APCMH is run by a local health system, chosen through a competitive proposal process and is paid a capitated fee. When specialty or facility-based care is necessary, members are referred to providers that are part of that system and are designated as in-network. The plan design supporting this model has favorable steerage into the system network of assets. We have three clients exploring this model in Atlanta and Texas.

Some clients are considering expansion or replacement of their existing onsite or near site clinics with a more advanced form of primary care, similar to that provided in a PCMH, integrating the services and providers into their existing medical plan network. For others we are working to promote effective use of primary care and to advocate and negotiate for inclusion of an Advanced Primary Care model into existing networks.

There is a number of emerging integrated primary care networks that have large numbers of PCPs covering large geographic areas (Health Catalyst in Dallas, for example). These primary care networks often have multiple assets, like pharmacy or physical therapy, as part of their network. We are working with the carriers and health plans to include these networks in a custom narrow network for some employers. We are also working with some new private primary care organizations like One Medical, Iora, and Privia as well as more conventional employer clinic operators that are amenable to adopting a PCMH model and welcome value-based payment arrangements.

Under these Advanced Primary Care models the teams are committed to health and wellbeing and managing health risk. They measure performance and recognize and reward the primary care teams for improved outcomes (including clinical quality and efficiency as well as productivity and quality of life). While limited geographically, most Advanced Primary Care Provider organizations are requesting value-based payment arrangements, which is where the industry is headed.

Total Cost of Care Modeling

Over a decade ago, Aon pioneered a holistic approach to measuring the relative impact of carrier-negotiated provider discounts. Our model and methodology soon became the industry standard. Over time, as carriers sought to differentiate themselves via care management programs, we set out to enhance our discount analysis model to measure the true total cost of care by carrier. With this new model, we are able to measure both the effectiveness of the carrier negotiation model as well as the relative impact on cost of the care management services included. To execute on this model, we have been working with all the major carriers to fully understand their various network composition and care management products and to develop a quantitative evaluation/measurement approach that all parties will find credible. The result of this work, currently being piloted on behalf of a half dozen clients, is a vendor comparison analysis that will be the industry standard measurement for employers as they seek a more sophisticated assessment of the next generation of payment and care management models.

Analytical Support

Aon's health and benefits actuarial practice consists of over 250 credentialed health actuaries and actuarial students. Our strategic financial consultants provide health and benefits consulting services to clients of all sizes and in all industries, in both the public and private sector.

The practice has a number of specialty sub-practices with colleagues who primarily consult to states on their Medicaid plans, state and local government groups on their benefits offerings, and employers on their retiree healthcare plans. Our consultants and actuaries are considered experts in a broad range of healthcare topics and are often asked to present at industry conferences.

Internal teams of actuaries focus on developing actuarial guidance and models that are used across the practice. These efforts are done while ensuring we are being operationally efficient. We use consistent approaches and deliver the highest quality advice to our clients. Many of our colleagues serve clients and are involved in R&D efforts, which results in an ability to offer consulting advice to clients in a unique and powerful way.

The actuarial practice is always prepared to look nationwide to find the best resource for a given project. Our client teams are structured to ensure both clients and colleagues have the right level of support. Peer review is an integral component of our work product. We have peer review guidelines and a structure in place to ensure we minimize potential errors so our clients can feel comfortable and secure with the work we deliver.

Our actuaries provide the following financial management and modeling services:

- Project future health care costs, including total budget rates, employee and retiree cost sharing, and aggregate budgets
- Develop IBNR claim reserve estimates
- Provide medical plan design and cost benchmarking
- Support healthcare strategy projects for active employees and retirees with extensive modeling
- Project the cost impact of health care legislation changes
- Assist with analysis of the various health care marketplaces (exchanges), including private (e.g., Aon Active Health Exchange) and public (federal/state marketplaces)
- Conduct discount analyses, total cost of care analyses, and support vendor selection
- Provide union negotiation support, including onsite presence at negotiations, as appropriate
- Help with carrier negotiations
- Prepare periodic experience reports to track emerging claims experience
- Deliver health cost trend analyses
- Support wellness ROI modeling
- Conduct Medicare Part D Attestation testing (Actuarial Equivalence), and Creditable Coverage Testing

Discount Analysis

Many of our competitors rely on carrier self-reported responses to specialized RFIs for selected CPT and/or DRG codes to estimate potential savings or re-pricing of historical claims. Aon pioneered the Network Discount Analysis capability methodology and has more history and more experience than anyone else in the industry with this nationally recognized product. Every 6 months, Aon receives over $650 billion in claims detail (by zip code) from 14 different health plans. This data provides detailed information on the discounts they have negotiated for every medical procedure, including more than 300 CPT codes (split out by professional charges and outpatient

charges) and all DRG codes for the 25 Major Diagnostic Categories (MDCs) for IP Facility admissions.

By leveraging the actual claims and negotiated discounts, we are better able to utilize this data to help the Department choose a health plan that best meets its employees' unique needs. The model calculates a net discount based on each vendor's hospital and physician contracted rates for in and out-of-network providers and the client's specific claim utilization in a given market. This claims data analysis will encompass utilization information by provider type (physician and hospital), procedure type for physicians (CPT based), and geographic location (three-digit ZIP Code level). This tool enables the Department to better evaluate the financial arrangement each health plan is proposing, and specifically evaluates the portion of the agreement that is 80 to 90 percent of the total expense. The tool is based on total claims book of business data collection and actuarial methodology, with weightings for population and credibility, to accurately measure the underlying financial savings that could be available to an employer on a consistent basis.

Aon can create Department-specific reporting on the value of the potential underlying financial arrangement available from each carrier network. This gives the Department a broad perspective to plan performance evaluation, and a dimension not available in such specificity otherwise.

Our team will be able to provide network price arrangements for current participating carriers, which includes all the major national carriers, as well as many regional carriers. The Aon national team can help coordinate client specific carrier submissions not included with our current carrier group by sharing the current RFI request or working with that regional carrier to provide a similar summarized submission.

(6) A description of the activities the Offeror is proposing to undertake to begin or, in the case of the incumbent contractor should they choose to submit a Proposal, continue serving the Department as a client on January 1, 2018;

Aon has been the consultant and actuary for the Department for the last five years. In addition, the account team for this work has only minimally changed during this period. Based on this, and the fact that the Aon Account Executive has known and worked with the Department for more than 20 years, there will be no transition or ramp-up period. Aon will continue with the work without missing a beat.

(7) An explanation as to how the Offeror proposes to handle administrative responsibilities, such as the billing and invoicing of charges for services to the Department, including a description of how the Offeror will ensure only accurate and complete billing of charges are submitted to the Department;

Each Aon employee tracks the time spent working on client projects using our Time & Expense system. We record time in 15 minute increments to separate billing codes for different client projects. We have our time charged to clients on a monthly basis.

An invoice is generated out of our time and expense system and the account manager reviews the time charges for accuracy. The account manager will prepare a document to the client detailing the services that are being billed in this monthly invoice.

We plan to continue with the current process we have now. We will also be pleased to make any changes to the process as requested to meet your requirements.

(8) A description of the qualifications and experience of staff assigned to provide IT services in support of the Project Management Team's delivery of the required services and how they will interface with the Project Management Team to complete assignments and reports;

Aon's Health and Benefits practice organizations possess an embedded, thoroughly integrated and dedicated programming and data analysis team of IT professionals. This data-knowledgeable team of professionals mutually supports other Aon consultant staff working with very large clients such as the Department. Aon's proposed team members for the Department routinely handle files that are of the double digit gigabyte size.

Besides being skilled in IT, Aon's programmers and analysts are knowledgeable in the nuances of health & benefits – a quality assurance, early anomaly noticing, and error avoidance capability.

The programming team is skilled in data handling, data screening, data warehousing, data analysis, and data prediction. The team possesses the valuation and planning experience to easily adapt to the Department's needs. The programming team works hand-in-glove with the client team. Together these people have the expertise to assist in designing, quality cost effective plans that maintain past promises, are attractive to retain talented workers, and minimize future liabilities.

Aon's IT team for the Department is led by an IT professional, Gerry Smit. Gerry has with more than 20 years of experience in the benefits field.

(9) An overview of the Offeror's IT system and programming capabilities and its capacity to accept data from and exchange data with the Department and Empire Plan vendors/contractors, including a description of security measures used to ensure privacy and confidentiality of data is maintained; and

Data Exchange

Aon reviews all data communications methods to ensure that they meet or exceed all regulatory, legislative, and Aon internal business policy security, privacy and reliability requirements (hereinafter, "Aon Standards"). Moreover, while striving to be above industry standards in security, privacy, and reliability, Aon has balanced these qualities with cost effectiveness.

As the incumbent, Aon already has these exchanges and interfaces in place, so no additional work, or resources would be required to continue this.

When Aon is required to transmit or receive sensitive customer data via a public network, industry–standard methods are used to protect the data in transit from eavesdropping. Aon provides an Internet–facing FTP service where Aon can act as either a client or a server. We require the use of either PGP (Pretty Good Privacy) or VPN (Virtual Private Network) to exchange files with our clients and providers over the Internet. Only known IP addresses are allowed by Aon firewalls to access the FTP server environment from the internet.

Aon Standards also offer SFTP SSH using certificates to exchange data via the internet. When appropriate, data exchange partners (DEPs) can also use their web browser with HTTPS to drop off or pick up files for ad hoc file transmissions.

Aon's internet–accessible mail transfer agent servers are configured by default to use border–to–border encryption of electronic mail messages between Aon and its clients through the use of TLS (transport layer security). Finally, we use Microsoft Exchange as our email software.

All Aon colleagues are subject to our Code of Business Conduct and internal policies, including a Privacy Policy and Information Security Policy, which include obligations for data confidentiality and privacy, and the potential disciplinary consequences of non-compliance. We also have confidentiality obligations in contracts of employment, and perform pre-employment screening checks.

HIPAA Compliance

We are compliant with all HIPAA requirements and regulations, as they are applicable to Aon. When providing services to benefit plans covered under HIPAA, Aon complies with HIPAA rules and standards for security and privacy, as well as file transmission as applicable.

In addition to a global privacy policy that addresses Aon's commitment to the protection of personal information, including any protected health information we might hold, we also have a global security policy for our services that addresses our confidentiality and security practices, deviations from these practices and the consequences of violating these practices.

Aon employees are educated on security policies during their orientation and are required to complete a training program focused on HIPAA privacy and security regulations as well as other compliance related issues. Employees are also informed that violations of our privacy and security policies are a violation of Aon's Code of Conduct, which can result in disciplinary action up to and including separation from the firm.

Aon has also established a privacy committee to address issues of security and privacy within the firm, as well as a mandatory global privacy training program to augment security training for each of our lines of business. We continually evaluate services that we provide to determine the nature and scope of personal information that we may collect, use, or disclose, and review safeguards and processes that address the security and privacy of personal information. For example, we require that authenticators be entered or verified before we permit access to confidential information.

Aon recognizes that it has new obligations as a business associate under HITECH and, accordingly, has taken numerous steps to meet those obligations. Actions include:

- Creating enterprise-wide compliance project led by the privacy office
- Forming a task force with leaders from across the business (e.g. consulting, IT)
- Conducting gap analysis
- Communicating HIPAA policies and procedures
- Training all U.S., Puerto Rico, and India colleagues who handle or who have access to PHI
- Reviewing and updating breach notification response process for HITECH requirements
- Amending business associate agreements

Gramm-Leach-Bliley (GLB)

Aon understands that the Department's use and/or disclosure of personal information may be governed by the federal Gramm-Leach-Bliley Act ("GLB"). We support that obligation. Aon maintains a comprehensive data security program that includes reasonable and appropriate technical, organizational, administrative, and other security measures against the destruction, loss, unauthorized access to, or unauthorized alteration of personal data in the possession of Aon. Aon also maintains an information security policy and data privacy policy, which outline those technical, organizational, administrative, and security measures.

Security Measures

Protecting the personal and confidential data of our clients and our colleagues through technical, administrative, and physical safeguards is a top priority for Aon. As a rule, personal data is stored within our secure environment on extremely limited access repositories according to Aon Standards. Our standards discourage the use of hard drives, diskettes, or mobile media. These are used only if necessary and only for the minimum amount of time necessary to perform the required job.

Our policy directs users to store personal data within the Aon secure environment (e.g., restricted and policed data repositories), as opposed to local hard drives or other devices. Therefore, access to restricted and protected information is managed within secure, access-controlled physical environments. Also, role-based logic controls are used to limit access to data on a business-need-to-know basis.

When there is a business need to remove personal data from the Aon environment, that data is encrypted using Aon industry-standard encryption methods. The hard drives of Aon laptops are automatically configured with full-disk encryption from SafeBoot. Mobile media (including CDs, DVDs, flash drives, and portable hard drives) are required by policy to be encrypted. We provide all colleagues with a variety of tools to facilitate compliance, including encryption-capable zip utilities and PGP-compatible tools. Failure to comply with the mobile media policy may result in disciplinary action up to and including separation.

(10) A description of any additional services/benefits that the Offeror provides its customers, including the Department if the Offeror is selected, at no additional charge, e.g., newsletter, white papers, etc.

Keeping the Department Informed

Publications

Aon provides several publications to keep our clients informed, many of which are available via email subscription, including Aon Bulletins and our Washington Report. Examples of our publications as well as thought leadership (white papers and survey results) are found at the following link: http://tinyurl.com/Aon-Thought-Leadership.

A sampling of this material includes:

- **Aon Bulletins**—Aon bulletins provide clients with the latest updates on relevant legislative and regulatory developments in the United States, as well as key human resource trends. Periodically, we feature trends reports that highlight emerging issues in human resources and

benefits. Our special reports provide in-depth analysis on specific legislative or regulatory developments that could have an impact on our clients.

- **Washington Report**—This weekly email newsletter captures the key human resources-related developments in Washington from the previous week.
- **Aon Alerts**—These alerts are emailed directly to subscribers when late breaking human resources and business developments occur.
- **Health and Benefits Legal Alert**—These alerts are emailed directly to subscribers when changes in law or policy related to benefit plans occur. The emails contain a summary of the change or proposed issue and its potential impact on employer-sponsored benefit plans.

Aon publishes our *Public Sector Advisor*, a weekly newsletter for public sector clients. We also frequently create and publish a version of our various survey reports specific to the public sector—such as our public sector data cut of the renowned Health Care Survey—and whitepapers such as *2018 Excise Tax: Hard Choices Facing the Public Sector.*

Aon will continue to provide the Department with up-to-date information and innovative ideas as they emerge.

Webcasts and Other Events

We also host annual national teleconferences, in-person conferences, local breakfast seminars, and roundtables. We use these forums to share information with our clients and provide an opportunity to leverage our knowledge and experience. Events are held throughout the country, at different times of the year. Some examples of these types of events and meetings in 2016 and early 2017 include:

- Local Compliance Breakfast: Health Care Compliance Update and Best Practices as a Plan Sponsor
- 2016 Health Forum: Navigating at the Speed of Health – various locations throughout the country
- Webinar Series: An Employer's Guide to ACA Reporting
- Total Wellbeing & Improving Outcomes (webinar) – June 22, 2016
- Create Choice, Empower Consumers: Hold People Accountable and Fully Support Them (webinar) – May 25, 2016
- Specialty Pharmacy Seminar – Dallas, TX, March 24, 2016
- Innovative and Local Provider Network Solutions – Irving, TX, May 19, 2015
- 2016 Compliance Update and Best Practices as a Plan Sponsor – Albuquerque, NM, August 31, 2016
- Full Picture Webinar – Brexit: Understanding the Timeline and Anticipating Business Implications – June 30, 2016
- 2017 Health Forum – New York, NY, April 25, 2017

Direct From Your Aon Team

In addition to routine updates, we will call or email you with any items that require immediate attention or which may be of particular interest. This process will be ongoing and proactive throughout our relationship with the Department.

4.A.2 Account Team

The Department expects the successful Offeror to have in place a proactive, experienced Project Manager and an experienced team who have the authority to coordinate the appropriate resources to implement and administer Project Services.

b. Required Submission

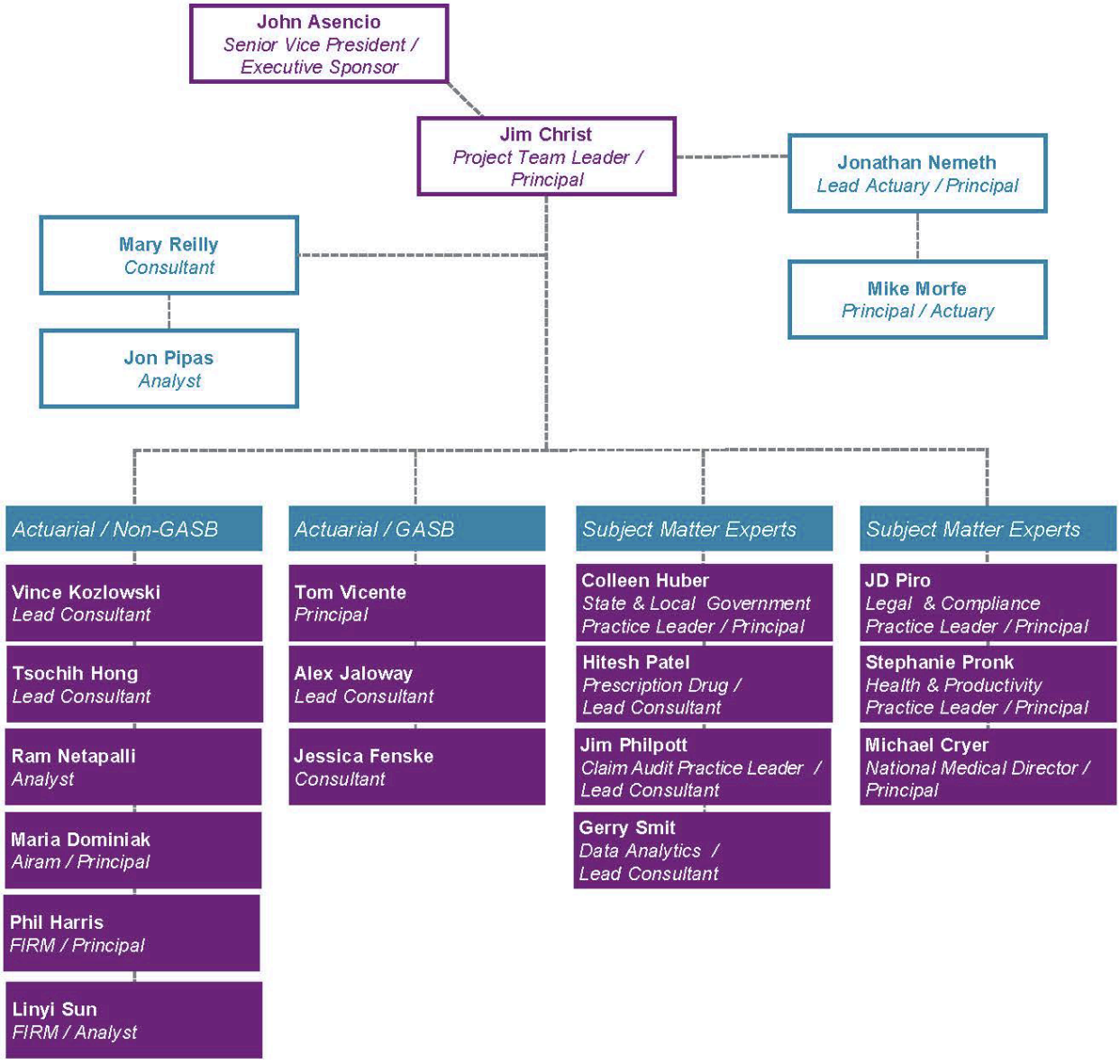
(1)	Provide an organizational chart and narrative description illustrating how the Offeror proposes to administer, manage, and oversee all aspects of the Projects. Complete RFP Exhibit III.A entitled Project Team Roster listing the Offeror's proposed key project management team members, including Key Subcontractors, if any. The Offeror should also complete and submit RFP Exhibit I.B, entitled, "Biographical Sketch Form" for each proposed key project management team member.

With Aon as your partner, the Department will have the best of both worlds—local expertise with knowledge and familiarity with your health plans and a team of national experts. The Department will be served by consultants who know you and understand your local environment and market and programs. They bring the power of expert national resources to solve a broad range of issues.

We have selected Jim Christ to be the Account Executive and Project Team Leader. As the team lead, Jim will act as the project manager for all health and benefit projects for the Department. Jim will be the primary day-to-day contact for Department staff. He will be supported by a team that assists with day-to-day questions, projects, and reporting/deliverables. Jim is also responsible for organizing the resources for the Department through additional Aon team members in the areas that include compliance, legal, pharmacy, wellbeing, worker's compensation, safety, and MBE partners. Jim will be supported by Mary Reilly who has deep experience with the Department and knowledge of all of the NYSHIP programs.

Jonathan Nemeth, FSA will be the Lead Actuary and review and sign-off on all actuarial-related projects.

Aon Team Organizational Chart for New York State Department of Civil Service



Note:
The organizational chart above includes the key staff we anticipate would be involved in this work. There would be other more junior members completing the work as well. In addition, depending on the project, other staff from Aon or MWBE's could also be involved in this work.

How Aon Will Manage the Project

Aon's objective is to provide you world-class support through many of our credentialed subject matter experts, leading to peace-of-mind, which ultimately allows you to effectively focus your resources on delivering superior benefit programs to your employees. Exhibit I.B includes detailed information on the credentials of the team noted in the organizational chart above.

Within the past few years, Aon implemented periodic ongoing status calls with the Department to give us an opportunity to discuss completed work and activities as well as to plan for upcoming activities. At the close of each meeting, we are left with a clear understanding of items such as specific issues, project plan milestones, key deliverable dates, and a clear definition of a satisfactorily completed project task.

We establish project plans for all activities, and we manage our team closely to deadlines without compromising the quality of deliverables. In addition, we provide regular communication (primarily via email) on developments in the health and benefits industry and relevant federal legislation.

Exhibit I.B - Biographical Sketch Form

INSTRUCTION: Prepare this form for each key staff individual, including subcontractor provided key staff, if any.

Name: John Asencio

Job Title: Regional Practice Leader

Relationship to Project: Executive Sponsor

[redacted]

Exhibit I.B - Biographical Sketch Form

INSTRUCTION: Prepare this form for each key staff individual, including subcontractor provided key staff, if any.

Name: James A. Christ, CEBS

Job Title: Vice President

Relationship to Project: Principal/Account Executive (Project Team Leader)

[redacted]

Exhibit I.B - Biographical Sketch Form

INSTRUCTION: Prepare this form for each key staff individual, including subcontractor provided key staff, if any.

Name: Michael Cryer, MD

Job Title: Senior Vice President/National Medical Director

Relationship to Project: National Medical Director/Subject Matter Expert

[redacted]

Exhibit I.B - Biographical Sketch Form

INSTRUCTION: Prepare this form for each key staff individual, including subcontractor provided key staff, if any.

Name: Jessica Fenske, ASA

Job Title: Associate

Relationship to Project: Consultant

[redacted]

Exhibit I.B - Biographical Sketch Form

INSTRUCTION: Prepare this form for each key staff individual, including subcontractor provided key staff, if any.

Name: Tsochih Hong, FSA

Job Title: Vice President

Relationship to Project: Lead Consultant/Actuary

[redacted]

Exhibit I.B - Biographical Sketch Form

INSTRUCTION: Prepare this form for each key staff individual, including subcontractor provided key staff, if any.

Name: Colleen Huber, FSA

Job Title: Senior Vice President

Relationship to Project: Principal/State and Local Government Subject Matter Expert

[redacted]

Exhibit I.B - Biographical Sketch Form

INSTRUCTION: Prepare this form for each key staff individual, including subcontractor provided key staff, if any.

Name: Alex Jaloway, FSA

Job Title: Vice President

Relationship to Project: Lead Consultant/Actuary

[redacted]

Exhibit I.B - Biographical Sketch Form

INSTRUCTION: Prepare this form for each key staff individual, including subcontractor provided key staff, if any.

Name: Vince Kozlowski, FSA

Job Title: Vice President

Relationship to Project: Lead Consultant/Actuary

[redacted]

Exhibit I.B - Biographical Sketch Form

INSTRUCTION: Prepare this form for each key staff individual, including subcontractor provided key staff, if any.

Name: Michael Morfe, ASA

Job Title: Senior Vice President

Relationship to Project: Principal/Actuarial Subject Matter Expert

[redacted]

Exhibit I.B - Biographical Sketch Form

INSTRUCTION: Prepare this form for each key staff individual, including subcontractor provided key staff, if any.

Name: Jonathan Nemeth, FSA

Job Title: Senior Vice President

Relationship to Project: Principal/Lead Actuary

[redacted]

Exhibit I.B - Biographical Sketch Form

INSTRUCTION: Prepare this form for each key staff individual, including subcontractor provided key staff, if any.

Name: Ram Netapalli

Job Title: Consulting Actuary

Relationship to Project: Analyst

Exhibit I.B - Biographical Sketch Form

INSTRUCTION: Prepare this form for each key staff individual, including subcontractor provided key staff, if any.

Name: Hitesh Patel, RPh

Job Title: Vice President

Relationship to Project: Lead Consultant/Pharmacy Subject Matter Expert

[redacted]

Exhibit I.B - Biographical Sketch Form

INSTRUCTION: Prepare this form for each key staff individual, including subcontractor provided key staff, if any.

Name: Jim Philpott

Job Title: Vice President

Relationship to Project: Lead Consultant/Audit Practice Leader

[redacted]

Exhibit I.B - Biographical Sketch Form

INSTRUCTION: Prepare this form for each key staff individual, including subcontractor provided key staff, if any.

Name: Jon Pipas

Job Title: Health and Benefits Specialist

Relationship to Project: Analyst

[redacted]

Exhibit I.B - Biographical Sketch Form

INSTRUCTION: Prepare this form for each key staff individual, including subcontractor provided key staff, if any.

Name: J.D. Piro, JD

Job Title: Senior Vice President

Relationship to Project: Principal/Compliance Subject Matter Expert

[redacted]

Exhibit I.B - Biographical Sketch Form

INSTRUCTION: Prepare this form for each key staff individual, including subcontractor provided key staff, if any.

Name: Stephanie Pronk

Job Title: Senior Vice President

Relationship to Project: Principal/Innovation Group and Health Transformation Team Leader

[redacted]

Exhibit I.B - Biographical Sketch Form

INSTRUCTION: Prepare this form for each key staff individual, including subcontractor provided key staff, if any.

Name: Mary Reilly

Job Title: Senior Consultant

Relationship to Project: Consultant/Project Manager

[redacted]

Exhibit I.B - Biographical Sketch Form

INSTRUCTION: Prepare this form for each key staff individual, including subcontractor provided key staff, if any.

Name: Gerry Smit

Job Title: Lead Consultant/Data Analytics Subject Matter Expert

Relationship to Project: Lead Consultant/Data Analytics Subject Matter Expert

Exhibit I.B - Biographical Sketch Form

INSTRUCTION: Prepare this form for each key staff individual, including subcontractor provided key staff, if any.

Name: Tom Vicente, FSA

Job Title: Partner

Relationship to Project: Principal/Lead Actuarial Consultant for GASB

[redacted]

Exhibit I.B - Biographical Sketch Form

INSTRUCTION: Prepare this form for each key staff individual, including subcontractor provided key staff, if any.

Name: Philip M. Harris

Job Title: President and CEO, FIRM

Relationship to Project: Principal/MBE Partner

[redacted]

Exhibit I.B - Biographical Sketch Form

INSTRUCTION: Prepare this form for each key staff individual, including subcontractor provided key staff, if any.

Name: Linyi Sun

Job Title: Actuarial Analyst, FIRM

Relationship to Project: Analyst/MBE

[redacted]

Exhibit I.B - Biographical Sketch Form

INSTRUCTION: Prepare this form for each key staff individual, including subcontractor provided key staff, if any.

Name: Maria C. Dominiak, FSA

Job Title: Senior Consultant, Airam

Relationship to Project: Principal/WBE

[redacted]

Exhibit III.A - Project Team Roster

Project Team Member's Name [1]	Position Title	Subcontractor (Y/N)	Employer
John Asencio	Principal	N	Aon
Jim Christ	Principal	N	Aon
Michael Cryer	Principal	N	Aon
Jessica Fenske	Consultant	N	Aon
Tsochih Hong	Lead Consultant	N	Aon
Colleen Huber	Principal	N	Aon
Alex Jaloway	Lead Consultant	N	Aon
Vince Kozlowski	Lead Consultant	N	Aon
Mike Morfe	Principal	N	Aon
Jonathan Nemeth	Principal	N	Aon
Ram Netapalli	Analyst	N	Aon
Hitesh Patel	Lead Consultant	N	Aon
Jim Philpott	Lead Consultant	N	Aon
Jon Pipas	Analyst	N	Aon
JD Piro	Principal	N	Aon
Stephanie Pronk	Principal	N	Aon
Mary Reilly	Consultant	N	Aon
Gerry Smit	Lead Consultant	N	Aon
Tom Vicente	Principal	N	Aon
Phillip Harris	Principal	Y	FIRM
Linyi Sun	Analyst	Y	FIRM
Maria Dominiak	Principal	Y	Airam

NOTE:

[1] Employers are required by Federal law to verify that all employees are legally entitled to work in the United States. Accordingly, the Department reserves the right to request legally mandated employer-held documentation attesting to the same for each individual assigned work under the Contract. In accordance with such laws, the Department does not discriminate against individuals on the basis of national origin or citizenship.

(2) Describe the experience of the individual who will assume the role of Project Team Leader. Include a description of the individual's experience with clients similar in size and scope of the Department.

Jim Christ will be the Project Team Leader. His office is located in Somerset, NJ. Jim has more than 30 years of experience in the employee benefits field and has worked for both consulting firms and group insurers over his career. Jim has worked with the Department for more than 20 years (which includes experience at a prior consulting firm). He was also the financial officer responsible for the Empire Plan while at an insurer utilized under the Empire Plan. Jim has also worked with other large state government plans located in the Northeast over his career.

(3) Confirm that the Project Team will be readily accessible to the Department. Describe where the Project Team will be located.

The Aon team is readily accessible via phone or email and will continue to respond to all inquiries rapidly. The project team will be located in Somerset, NJ, as well as around the country as needed. The key team members will be located in the NY/NJ Metropolitan area.

(4) Provide a description of how the Offeror proposes that the Project Management Team will successfully handle the four (4) tasks (including an indication of the percentage of time, by team member, dedicated to the project and a task(s), manage the Department's account; and interface with the Department in its delivery of Project Services; a description of the process by which the Offeror proposes to provide notification to the Department of actual or anticipated events impacting the delivery of Project Services and the presentation of options available to minimize or eliminate the impact of those events on the delivery of Project Services; a description of how the Offeror proposes to provide additional resources, should the need arise, from within the organization and/or from a third party; for those positions for which an individual(s) has not been named at time of Proposal submission; a description of how the Offeror proposes to recruit the person(s) to fill the position; a description of how the Offeror proposes to recruit replacement personnel, should one or more Project Management Team members leave during the term of the Contract; and a description of the steps that will be taken to ensure the continuity of Project Management Team members throughout the term of the Agreement.

Aon has a robust and experienced project team to handle the four tasks included in this proposal. In addition to the current Aon team working on these projects now, Aon will be supported going forward by two MWBE firms in the work, Airam and FIRM. These two firms are certified by the State of New York. Aon has worked with them in the past on prior projects.

The work related to Task #1 Premium Rate Development and Task #2 Quarterly Analysis occurs at different times of the year; this does not present any obstacles to timely completion of the projects. This work will primarily be led by Jonathan Nemeth, Vince Kozlowski, and Tsochih Hong. For the period leading up to completion of these projects, these team members, and key actuarial junior staff, would likely dedicate 50-75% of their time to these projects. For Task #3 GASB 75 Valuation, the key team members are Tom Vicente and Jessica Fenske. For times when these reports are due to the State, they would also likely devote 50-75% of their time to this work. Task #4 Ad-Hoc Projects are completely dependent on the scope of services and timing.

For all of these services, Jim Christ and Mary Reilly will interact with the Department and manage the work. We should note that over the term of the current contract Aon has with the Department, there was not one deadline missed. To the extent it becomes clear to Aon that the delivery of certain work-products will be negatively impacted by actual or anticipated events, Aon will immediately contact the Department and offer alternative arrangements to minimize impact.

Because of the breadth and depth of Aon and our MWBE partners, we do not anticipate a significant change in the project team. To the extent that a key Aon team member would need to be changed over the term of this contract, Aon will notify the Department and gain approval of any personnel changes before a change is made.

We should note that Aon's Health and Benefits group has had low turnover, in general and specifically as it relates to the current NYSHIP team. We expect that turnover will continue to be low going forward.

(5) Provide reporting relationships and the responsibilities of each key position of the account management team; and how the team will interact with other business units or functional areas within the Offeror's organization. The Offeror must include the percentage of time (by position) dedicated to the Program and reporting relationships. Describe how the account management team interfaces with senior management and ultimate decision makers within the Offeror's organization;

Jim Christ will serve as the Project Team leader and will be responsible for delivery of all assignments to the Department. Jim will work closely with Mary Reilly who will act as Project Manager for certain assignments. Jon Pipas will work with Mary and Jim in the successful delivery of all core and ad-hoc projects required. At this point, based on the work required under the core recurring tasks (#1 Premium Rate Development, #2 Quarterly Reports, and #3 GASB 75 Valuation) we estimate that Jim, Mary, and Jon will spend approximately 10% of their overall time on this work. Of course, when deliverables for Tasks #1, #2, and #3 are due we would expect that a greater percentage of time would be required.

Jim, Mary, and Jon will work closely with subject matter experts, as well as our MBE/WBE partners in bringing the correct resources and expertise to any and all core and ad-hoc tasks.

Jonathan Nemeth FSA, Vince Kozlowski FSA, and Tom Vicente FSA, will serve as the lead actuaries for this work and will oversee all actuarial work resulting from this proposal. They will work closely with Tsochih Hong, FSA on the actuarial work. We estimate that Jonathan, Vince, Tsochih, and Tom will spend approximately 10% of their time on the core tasks in this proposal. They will work closely with actuarial analysts in completing the work.

Jim and Jonathan will have direct access to John Asencio, who is responsible for all Health and Benefits Consulting work done for Aon in the Northeast United States.

4.B. Project Services

The Offeror must demonstrate its capacity to deliver the required Project Services described in Section IV of this RFP.

4.B.1 Task #1 - Premium Rate Development

b. Required Submission

Submit a work plan that demonstrates your ability to deliver Task #1 Project Services as described in the Duties and Responsibilities above. The outline should include the following:

(1) A detailed description of the steps, factors, and required staff resources.

Step # 1 – Submit Work Plan

This process will start on or about June 1st of every year with a detailed work plan submitted to the Department prior to July 1st.

Step # 2 – Develop Independent Premium Rate Estimates

After submission of the work plan on July 1st, Aon will begin developing the independent premium rate estimates. This process will include the following steps:

- Review and assess claims and other relevant data provided by the State and its vendors
- Complete claim lag analyses, based on data provided by the vendors, to develop appropriate actuarial completion factors
- Develop projected paid and incurred claims based on the data provided by the vendors and various assumptions
- Evaluate enrollment (actual and projected), trend factors (national and local), administrative expenses, extraordinary liabilities or recoveries (actual and projected), benefit design changes, and other factors that materially impact appropriate renewal projections and rate setting
- Project prior plan year net gains and losses for each of the four Empire Plan programs
- Develop Incurred But Not Reported Reserves for each of the four Empire Plan programs as of the end of the prior plan year
- Develop Aon's independent premium rate estimates for each of the four Empire Plan programs, which will be delivered to the Department not later than August 31st each year

Step # 3 – Review Vendor Rate Renewal Projections

Aon assumes that the Department will continue to require the Empire Plan vendors to develop renewal projections for each of the programs they administer and expect that these projections will be due by September 1st. These renewal projections will reflect projected claims, prescription drug rebates and EGWP credits, development of trend and reserves, and any requests for increases in the vendor's fees. Upon receipt of the vendor renewal projections, Aon will perform the following tasks:

- Review all components of the vendor renewal projections and identify issues and questions for preparatory discussions with the Department and ultimate discussions with the vendors
- Once Aon and the Department finalizes the key discussion issues (expected to be approximately 1 to 2 weeks after the vendor renewal projections have been submitted), Aon and the Department will meet with the vendors to review their projections and fee increase requests

- Shortly after these meetings, Aon will provide comments (verbal or written if required) to the Department on the renewal projections reflecting any additional information provided during the vendor meetings
- To the extent necessary, Aon will develop updated required funding projections for the current plan year to reflect any changes necessitated by a review of the Empire Plan vendors' renewal projections and submit updated required funding projections to the Department

We expect the above steps will be completed by the end of September.

Step # 4 –Present results to the Joint Labor Management Committee (JLMC) and provide Final Report

In early October, the Department and Aon will brief the Joint Labor Management Committee (JLMC) on the rate proposals for the four Empire Plan programs. Approximately one to two weeks after the meeting with the JLMC, Aon will submit our final written rate recommendation to the Department.

The balance of the rate renewal process, which includes submission of final rates and their approval, will be handled by the Department, without involvement by Aon.

The required staff resources are described in #2 below.

(2) The number of individuals per title and total number of hours per title using the Position Titles set forth in RFP Section V– Assumption #6 in your work plan. Please note that the projected total number of hours per Position Title per year as set forth in the Offeror's work plan must match the total number of hours per Position Title per year as set forth in the Offeror's Exhibit V.A Form 1 submission.

Personnel and Hours for Task #1		
Position/Title	**Anticipated Number of Personnel**	**# Hours Per Year**
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]

(3) A timeline with specified start dates based on number of Business Days, of the major milestones and interim activities for completion of the Task and related activities (e.g. attendance at meetings with the vendors).

Below is the work plan that Aon will use for the Plan Year 2018 renewal process.

	Business Days Required	Plan Year 2018 Due Dates
Step #1 – Submit Work Plan		
- Complete work plan and submit to Department	10	6/30/2017
Step #2 – Develop Cost Projections for Renewal Year		
- Aon obtains updated claim and enrollment information from vendors	10	7/14/2017
- Aon obtains Quarterly and Trend Reports from vendors	5	7/21/2017
- Aon resolves any open data issues with vendors	5	7/28/2017
- Develop current year incurred claims adjusted for plan changes, if any, based on historical and projected completion factors for each vendor	10	8/4/2017
- Develop projected future trend rate based on (a) historical data, (b) data provided by vendors, and (c) Aon's knowledge and database of similar vendors and plans	5	8/11/2017
- Develop projections for pharma revenue and EGWP credits	2	8/14/2017
- Develop projected retention based on input from vendors and the Department	2	8/16/2017
- Develop rate actions by vendor	2	8/18/2017
- Complete written analysis of report	5	8/25/2017
- Submit Independent Rate Requirements Estimate document to the Department	3	8/31/2017
Step #3 – Review Vendor Plan Year Projections		
- Aon reviews vendor rate reports (assumes vendor reports are provided by September 1)	4	9/8/2017
- The Department and Aon meet with vendors to discuss rate renewal requests, ASO fee increase requests, and cost projections	2	9/13/2017 & 9/14/2017
- Aon provides verbal comments to the Department on vendor renewals, ASO fee increases and cost projections	3	9/18/2017
- Aon submits updated funding requirement for self-insured plans, if necessary	4	9/22/2017
Step #4 – Present results to JLMC and provide Final Report		
- The Department and Aon meet the JLMC to review cost projections	1	10/5/2017
- Aon provides final rate renewal report to the Department	10	10/20/2017

(4) A description of the steps the Offeror will take to ensure that due dates and deadlines for Task #1 are met; and

Aon's focus on client and project management along with developing a detailed work plan with steps and milestones ensures that due dates and deadlines are met.

Aon will meet the time frames, deadlines and due dates for all steps and processes involved in Task #1. Aon has worked with large governmental clients in the past in meeting similar timeframes. In addition, Jim Christ, as Aon Account Executive, will be intimately involved in the work and will provide weekly updates to the Department on the status of the work to ensure deadlines are met.

(5) A description of the quality assurance process to be used to ensure Task #1 reports, documents and services are complete, accurate and of the quality required by the Department.

All work produced by Aon checked and peer reviewed. The peer review procedure is completed by a consultant responsible for reviewing the final product, process, and assumptions utilized in producing the final product. The peer review procedure checks:

- Clarity of presentation
- Reasonability of final results
- Appropriateness and reasonableness of assumptions
- Sufficiency of scope and detail in the analysis and presentation

Aon senior management requires that all colleagues abide by our formal peer review process. Failure to comply may be addressed with disciplinary action, up to and including termination of employment.

Within the core team for the Department, there are four credentialed actuaries specializing in health and benefits. This ensures that all actuarial work will be reviewed by credentialed professionals. In addition, and as required, Aon will always have at least one credentialed actuary at all necessary in-person meetings.

(6) A detailed description that illustrates how you will independently project experience and premium requirements for each of the Empire Plan vendors.

The process that Aon undergoes to develop independent projections for the Empire Plan for the current year and following year includes:

- Gathering vendor data, reviewing vendor reports for the four Empire Plan programs, and performing an overall check for reasonableness
- Developing year-end claim reserves for each of the four Empire Plan programs
- Establishing annual trend assumptions, based on a combination of Aon national trend guidance, historical trend levels, carrier trend surveys and other influencing factors

- Reviewing credit receivables under the Empire Plan (Rx rebates and EGWP subsidies) as provided by the vendors and determining if magnitude and timing is appropriate, based on historical patterns and other factors
- Reviewing administrative costs as provided by the vendors to ensure that they are in line with expectations
- Compiling all projection results into exhibits that reflect a detailed breakout of the projection in order to arrive at the required level funding amount, which is compared to the current level funding amount to determine either the current year's loss ratio for that program or the projected required increase for the following year
- Comparing Aon and vendor results to understand and articulate the drivers of the difference
- Providing a comprehensive report for the State of New York that includes discussion of results, projection exhibits, description of the drivers of the difference between Aon and the vendors, and a documentation of primary assumptions and methods

(7) An example of a Final Report and Recommendations of Plan Funding Requirements.

Aon has included a sample of a final report and recommendations of plan funding requirements table of contents below, as well as description of each section of the report:

Table of Contents

Section 1: Executive Summary

- Shows a summary of the projected financial gain/loss for current plan year for each of the four Empire Plan programs from Aon and the vendors
- Shows a summary of historical and projected incurred claims increases per contract for each of the four Empire Plan programs
- Shows a summary of the recommended level funding percentage increase for the next Plan year for each of the four Empire Plan programs from Aon and the vendors

Section 2: Introduction

- Describes basic program information and any recent plan changes for each of the four Empire Plan programs

Section 3: Hospital Program

- Describes the difference between Aon projections and Empire Blue Cross Blue Shield (EBCBS) projections for the Hospital program
- Includes exhibits that show an item by item comparison for the projected rate increases from Aon and EBCBS

Section 4: Medical Program

- Describes the differences between Aon projections and UnitedHealthcare (UHC) projections for the Medical program
- Includes exhibits to show item by item comparison for the projected rate increases from Aon and UHC

Section 5: Behavioral Program

- Describes the differences between Aon projections and Beacon Health Options for the behavioral program
- Includes exhibits to show item by item comparison for the projected rate increases from Aon and Beacon Health

Section 6: Prescription Drug Program

- Describes the differences between Aon projections and CVS Health for the prescription drug program
- Includes exhibits to show item by item comparison for the projected rate increases from Aon and CVS Health

Section 7: Primary Assumptions and Methodology

- Describes the primary assumptions and methods that Aon used to develop the independent financial analysis included in the report for each of the four Empire Plan programs

Section 8: Actuarial Certification

- Actuary provides a signature that certifies, to the best of Aon's knowledge, that the assumptions and methods used in the report are consistent with generally accepted actuarial principles, as promulgated by relevant Actuarial Standards of Practice

4.B.2 Task #2 – Quarterly Analysis

b. Required Submission

Submit a work plan which outlines the proposed process to be followed in order to deliver Task #2 Project Services as described in the Duties and Responsibilities above. The outline should include:

(1) A detailed description of the steps, factors, required staff resources.

Step #1 – Data Gathering

Aon will receive quarterly vendors' reports and additional data from the Department regarding plan enrollment. Ideally, the enrollment file should include information about all NYSHIP members such as Benefit Option, employee age, employee coverage (single/family), employee group (Participating Agency, Participating Employer, Student Employee Health Plan), and employee status (active, early retiree, Medicare retiree). In addition, the first quarter enrollment file should also include both the current Benefit Option and the Benefit Option from the prior year.

Step #2 – Trend Analysis

In order to analyze historical trend patterns, we need to also review various changes that have an impact on claim cost increases:

Open Enrollment Results (First Quarter Report only)

NYSHIP offers State employees a choice of the Empire Plan or one of several HMOs. Participating Agencies may offer their employees a choice of HMOs in addition to the NYSHIP Empire Plan. Employees will choose the plan that best meets their needs based on its perceived value and perceived cost to the employee, factoring in other variables such as name recognition and reputation, and network adequacy. The result of employee choice can impact the cost of the different plan options, so the first quarter report of each calendar year will reflect the results of the Benefits Options transfer period based on any large shifts in enrollment between benefit plans and coverage tiers (single versus family).

Enrollment Analysis

Changes in enrollment can also occur as a result of NY State employment decisions (hiring freeze, early retirement option, new state programs, etc.) or as a result of changes in NYSHIP Participating Employers/Agencies. The enrollment analysis will compare current quarter enrollment with prior quarters, both in terms of aggregate numbers of covered lives, as well as average age, geographic location, and family status. Any anticipated employment/retiree changes will also be reflected in the projected enrollment for the remainder of the current calendar year and for the subsequent calendar year.

Incurred Claim Factors

Aon's analysis will use incurred claims estimates since using incurred claims filters out any payment systems issues, and allows the actuary to isolate the value of enrollment changes due to the Benefit Option transfer period or other significant events. Aon will use the claim triangle files included in the quarterly reports to calculate appropriate claim completion factors to develop incurred claims. This analysis will be performed separately for each of the four vendors.

Incurred Claims per Member

Incurred claims through the end of the current quarter will be developed from the incurred claim factors for each of the four vendors. Annual incurred claims per member will be calculated for the most recent two to three years of experience.

Increase in Incurred Claims per Member

Aon will provide trend recommendations with each report, based on the most up-to-date information available. The increase in incurred claims per member, normalized for any items that would have impacted trend (enrollment changes, benefit changes, vendor changes, etc.), will be used to develop historical and future trends. Aon will also review the vendor quarterly experience reports to help identify factors that may impact both historical and future trends. The trend analysis will be completed for each of the four vendors.

Step #3 - Develop Current Year Experience

Current year experience requires projections of aggregate current year expenses for incurred claims, administrative expenses, and premiums:

Current Year Incurred Claims

For the fourth quarter report, we will apply the incurred claim factors to paid claims to developed calendar year incurred claims. For the first quarter report, we will apply incurred claim factors to paid claims to develop first quarter incurred claims. Incurred claims for the remainder of the calendar year will be calculated by taking the most recent 12 months of incurred claims per member per month (PMPM), adjusting for any benefit changes or demographic changes, and trending to each month of the remainder of the calendar year. The trended claims PMPM will be multiplied by our enrollment projections to calculate aggregate claims. This calculation will be done separately for each of the four vendors, as well as for different employee/retiree groups.

Incurred prescription drug costs will be reduced for projected prescription drug rebates and other manufacturers' payments. Projected rebates will be developed based on input from the prescription drug vendor, historical rebate experience, and Aon's knowledge of changes in the drug marketplace (such as increased availability of generic drugs) that impact rebate payments.

The trends used to project PMPM claims will be developed in the trend analysis report (see Step #2 above).

Administrative Expenses

In formulating rates, non-claim expenses for the rating period must be added to the expected claims to make appropriate provision for all revenue required in the rating period. Non-claim expenses will consist of at least the following:

- Administrative expenses for the claim payment vendors
- Fulfillment and other non-claim payment expenses not covered above
- Any surplus management additions or subtractions

Current Year Aggregate Premiums

Aggregate premiums will be developed for the current year by multiplying the current year premium tables by the current year enrollment developed in Step #1 above to compare with results shown in each vendor's report.

Step # 4 - Project Rates for Subsequent Year

Incurred claims per member will be projected using the following factors:

- Expected claim trend
- NYSHIP anticipated changes that impact claim costs
- Anticipated benefit changes (based on input from the Department)
- Any items identified in the assessment of current year experience that are expected to impact subsequent year claim costs.
- Prescription drugs claims per member will be adjusted for any anticipated changes in prescription drug rebates as a percentage of incurred claims.

Administrative costs per member will be projected by increasing the current year administrative costs per member and increasing it for any expected changes in non-claim expense. This increase will reflect anticipated administrative cost increases provided by the vendors and can be expected to be much lower than claim trends.

The sum of projected claims and administrative costs per member will be compared to the current year premium rates per member to determine the premium increase necessary to cover projected expenses. The required increase will be further adjusted to reflect any margins or deficit recovery amounts that may be necessary based on NYSHIP prior experience, vendor requirements, and required reserve levels for the claim stabilization reserve on the self-insured plans.

Step #5 – Review Vendor Reports

Aon will compare our projections and trend analyses to those in the vendor reports, and work with the vendors to understand the differences. We will adjust our projections to reflect any new information uncovered in this process.

Step #6 – Produce Quarterly Reports

Aon will send the Department a final summary report that contains all the items described in this section.

The required staff resources are described in #2 below.

(2) The number of individuals per title and total number of hours per title using the Position Titles set forth in RFP Section V – Assumption #6 in your work plan. Please note that the projected total number of hours per Position Title per year as set forth in the Offeror's work plan must match the total number of hours per Position Title per year as set forth in the Offeror's Exhibit V.A Form 2 submission.

Personnel and Hours for Task #2		
Position/Title	**Anticipated Number of Personnel**	**# Hours Per Year**
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]

(3) A timeline with specified start dates based on the number of Business Days, of the major milestones and interim activities for completion of the Task and related activities.

	Business Days Required	4th Quarter 2017 Report Due Dates
Step #1- Data Gathering - NYSHIP sends enrollment data and data dictionaries to Aon. Aon process data and performs reasonability checks on the data. - Aon receives quarterly reports from the vendors	5 1	1/15/2018 1/22/2018
Step #2 - Trend Analysis - Open enrollment results analysis (First Quarter only) - Enrollment analysis - Incurred claim factor development - Historical increase in claims per member - Projected increases in claims per member	1	1/26/2018
Step #3 - Develop Current Year Experience - Project current year claims - Project current year administrative expenses - Compare loss ratio with renewal report loss ratios	1	1/29/2018

	Business Days Required	4th Quarter 2017 Report Due Dates
Step #4 - Project Rates for Subsequent Year - Projected incurred claims - Project administrative expenses and surplus/margins - Compare projected costs to current year premiums - Compare projected premiums with renewal report projections	1	1/30/2018
Step #5 - Review Vendor Reports - Compare vendor and Aon projections - Reconcile differences - Adjust Aon projections as necessary	6	2/7/2018
Step #6 - Final Report - Submit final report	1	2/15/2018

(4) A description of the steps the Offeror will take to ensure that due dates and deadlines for Task #2 are met, and

Aon's focus on client and project management along with developing a detailed work plan with steps and milestones ensures that due dates and deadlines are met.

Aon will meet the time frames, deadlines, and due dates for all steps and processes involved in Task #2. Aon has worked with large governmental clients in the past in meeting similar timeframes. In addition, Jim Christ, Aon Account Executive, will be intimately involved in the work and will provide periodic updates to the Department on the status of the work to ensure that deadlines are met.

(5) A description of the quality assurance process used to ensure Task #2 reports, documents and services are complete, accurate and of the quality required by the Department.

All work produced by Aon checked and peer reviewed. The peer review procedure is completed by a consultant responsible for reviewing the final product as well as the process and assumptions utilized in producing the final product. The peer review procedure checks:

- Clarity of presentation
- Reasonability of final results
- Appropriateness and reasonableness of assumptions
- Sufficiency of scope and detail in the analysis and presentation

As an additional step to assure the quality of our final reports, we plan to send the Department a preliminary report about a week before the final report is due. We will ask the Department to review the preliminary report to make sure that it meets their expectations.

Aon's senior management requires that all colleagues abide by our formal peer review process. Failure to comply may be addressed with disciplinary action up to and including termination of employment.

(6) A comprehensive outline of the information to be provided in the "Benefits Management Consultant Review of Empire Plan Vendors' Quarterly Reports" for each of the Empire Plan vendors, and a justification for inclusion of each of the subject areas.

The following describes sections of the report that Aon will produce.

Trend Analysis

The Trend Analysis Report will compare NYSHIP historical trends with industry norms to develop an assumption of future NYSHIP trends compared to industry trend expectations. Aon will develop two sets of trend factors. The first set will reflect the underlying claim trends and will vary based on type of claim: hospital, medical, prescription drugs, and mental health/ substance abuse. The second set of projection factors will be NYSHIP specific and will reflect anticipated changes due to NYSHIP factors such as enrollment changes or NYSHIP patterns identified by the vendors in their experience reports.

Assessment of Current Year Experience

Using the projected claims, administrative expenses, and aggregate premiums developed in Step #3, we will calculate the current year loss ratio and compare it to the ratios projected in the renewal report. To the extent that the current year loss ratios differ from the loss ratios projected in the renewal report, we will review different vendor reports, as well as NYSHIP claim experience to identify factors that have impacted the current year loss ratios. This will identify such factors and describe their anticipated impact on NYSHIP experience

Projected Rates for Subsequent Years

This report will compare renewal report projections with the quarterly projections developed in Step 4 for expected claims, administrative expenses, margins, and deficit recovery amounts. Any significant differences from the renewal report will be identified and quantified.

4.B 3. Task #3 – GASB 75 Valuation

b. Required Submission

In regard to Task #3, at this part of its Technical Proposal, provide the information sought in 1 through 4, below.

(1) GASB 75 Prior Experience:

Describe the Offeror's prior experience in providing GASB 75 valuation and reporting services for other governmental organizations. The Offeror should demonstrate its understanding of the scope and purpose of the project in its response.

The valuation of OPEB liabilities became a core part of our service in 1985, shortly after the Financial Accounting Standards Board (FASB) issued Statement No. 81, which was its first official pronouncement dedicated to accounting requirements for post-retirement health care and life insurance benefits. When FASB Statement No. 106 replaced Statement No. 81 in 1990, the volume of our actuarial OPEB work increased substantially. It has increased again as public entities have begun grappling with similar issues under GASB Statement Nos. 43 and 45 and reporting OPEB costs and liabilities on their balance sheet.

Aon performs valuations for a large number of governmental enterprises across the country, from small enterprises to exceptionally complicated state valuations. Performing the valuations for a significant number of states, counties, cities, authorities and school systems (well over 100 valuations), including one of the largest valuations in the country (New Jersey, with over 400,000 active and retired participants covering multiple pension plans) demonstrates our expertise and experience. We are well-qualified to assist the Department with their valuation process.

GASB 75 is just becoming applicable starting with fiscal 2018 for many employers (including SUNY). As a result, GASB 75 work has been limited to providing transition information and detail at this point. Our team has been very active in assisting employers to understand what GASB 75 requires and to prepare for it. We have developed new computation and modeling tools and have been using them extensively in the period before the effective date of the standard. This includes discount rate modeling tools, new report formats, measurement date/valuation date decision discussions and analysis, and prior year reporting information. We have held several calls with NYS and SUNY on the impact of GASB 75 and kept the team abreast of news and changes.

(2) Task #3 Work Plan:

Submit two work plans which outline the proposed process to be followed in order to deliver Task #3 Project Services as set forth in the Duties and Responsibilities above. The first work plan should clearly identify the steps related to the actuarial valuation component of the Task (i.e., Valuation) and the second work plan should clearly identify the steps related to the annual trending component (i.e., Year Two Roll Forward). Both work plans should include:

(a) A detailed description of the steps, factors, required staff resources.

Please note that the Q&A responses from New York State were revised to clarify that only one workplan was needed.

Aon will complete the scope of services in six primary phases, which are outlined below. This disciplined approach has been successful in many similar projects and is designed to ensure that the NYS/SUNY achieves its objectives and meets its project schedule. We will schedule the first phase immediately upon being notified of the acceptance of our bid.

Phase 1 – Planning Meeting with the NYS/SUNY representatives

At the beginning of the project, Aon will meet with representatives of NYS/SUNY to achieve several important objectives, including:

- Discussion of the high-level project plan for the entire project (as contained in this document)
- Introduction of key team members
- Clarifications of plan provisions, including eligibility requirements, benefit options, retiree contribution levels, etc.
- Discussion and selection of the actuarial assumptions and methods, including actuarial cost methods, which will be used to calculate the OPEB obligations and Annual Required Contribution amounts
- Discussion of the transference of employee and claims data; clarification of the format and content of data to be transferred
- Clarification of expectations regarding project scope, deliverables, and any special needs

This initial meeting is an excellent opportunity to gain a mutual understanding of the key steps in the valuation process, and the way Aon and NYS/SUNY will work together to achieve the objectives.

Phase 2 – Employee Data Collection, Review, and Analysis

The accuracy of employee data is very important because valuation results are only as reliable as the underlying data. Aon will load the employee data provided onto our OPEB valuation system. We will review the data for reasonableness and compare it with expectations regarding numbers of employees and key demographic characteristics. This includes employee data on all current retirees, beneficiaries, and active employees who may eventually become eligible for OPEB benefits. We will ask questions, as appropriate, regarding data that appears to be missing, inconsistent, unexpected, or questionable. NYS will provide corrections, confirmations, or clarifications, as appropriate, and Aon will incorporate any indicated changes.

Phase 3 – Claims Data Collection, Review, and Analysis

Aon will use the historical medical and prescription drug claim experience for the retirees and disabled individuals (when available) as the basis for developing expected future claim costs for these groups. We expect to receive this data in a format which is readily adaptable to the valuation process.

Aon will adjust the historical data for any benefit changes and/or demographic shifts that occurred during the experience period. After reviewing the data and making any necessary adjustments for anomalies, Aon will trend the experience data forward to the projection period based on the trend rates from Aon's national trend survey and the historical trends of the plans. Missing, unavailable or non-credible data cells will be addressed by using appropriately adjusted national data.

As a result of the claim cost development process, Aon will obtain age/gender/benefit plan claim costs. We will review these costs for internal consistency and against external benchmarks for reasonableness. Aon will review existing work papers regarding Medicare Part D and the determination that the prescription drug benefit plans are determined to be "actuarially equivalent" to the Medicare Part D Standard Plan. We understand some of the retirees have enrolled in Medicare Advantage plans which contain an official Part D prescription drug product. These will be isolated and segmented from the creditable coverage plans.

At this point the initial assumption review report will be prepared and submitted to the Department for discussion and agreement.

Phase 4 – Valuation Processing

Aon will determine the OPEB obligation by projecting the expected claim costs that will be incurred in future years for current retirees, beneficiaries, and active employees who are expected to eventually become eligible for OPEB benefits. This determination will be completed on our actuarial valuation system, ProVal®. It will reflect the specific plan provisions, employee data, claims experience, and the actuarial assumptions that are agreed to during Phase 1 of the project.

After the OPEB obligations are determined as of the current valuation date, Aon will determine annual accounting expense amounts, and net OPEB liability for each plan and other amounts required in accordance with GASB 75.

After valuation results are finalized for the initial year of the study, we will project plan liabilities and costs into future years. This will allow NYS/SUNY to see the implications of maintaining the plan in the future on a status-quo basis. First, we will project funding requirements on a pay-as-you-go basis, and project the associated expense and liability amounts. Then, we will analyze the effect of prefunding the plans, and project expense amounts, based on an assumed level of prefunding.

We will calculate the expense for the projected plan liabilities. In our expense projection, we will separately identify the funding stream due to the payment by CMS for the retiree drug subsidy due to creditable coverage.

Phase 5 – Report Preparation

We will prepare a report for NYS/SUNY that will include OPEB obligations by plan:

- Expense, total OPEB liability, Plan Bet Position, net OPEB liability and deferred inflows/outflows by plan
- Projection of plan costs on a pay-as-you-go basis
- Projection of annual expense amounts on a prefunding basis
- Narrative description of issues that should be considered in the prefunding decision
- Suggested plan design or other changes that could reduce the State's OPEB obligations
- Key observations from the valuations
- Actuarial certification as to the accuracy of the results
- Summary of current plan provisions

- Summary of the actuarial assumptions and methods used to develop plan obligation and annual required contribution amounts
- Certain other information required by GASB 75

Phase 6 – Presentation of Results

Aon will meet onsite with NYS/SUNY officials to present and discuss the valuation results. This meeting will include a discussion of prefunding options, plan design opportunities, trends in the public sector, and opportunities created by other legislation, such as recent health care reform legislation.

The required staff resources are described in #2 below.

(b) The number of individuals per title and total number of hours per title using the Position Titles set forth in RFP Section V – Assumption #6 in your work plan. Please note that the projected total number of hours per Position Title per year as set forth in the Offeror's work plan must match the total number of hours per Position Title per year as set forth in the Offeror's Exhibit V.A, Form 3 submission.

Personnel and Hours for Task #3		
Position/Title	**Anticipated Number of Personnel**	**# Hours Per Year**
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]

The team proposed for this work is largely the same as the current Aon team doing this work now. The team will be led by Tom Vicente, FSA. Tom is the actuary overseeing the GASB work for NYS currently.

(c) Any added assumptions, including justification of those assumptions.

The above plan is based on the current understanding of the plan, New York's data process, and the accounting standard requirements. Any material change to any of these requirements could impact the scope and timing of the project. We will notify you of any material changes as they arise.

(d) A timeline with specified start dates based on number of Business Days, of the major milestones and interim activities for completion of the Task and related activities.

Period	Business Days Needed	Key Activities	Deliverables
March 15-28	1	Initial Planning Meeting[1]	Project Plan Methods & Assumptions
April 6-May 15	25	NYS Department of Civil Service (the Department) sends employee and historical claims data, and other required information Aon loads and edits employee data Aon reviews plan provisions Aon analyzes claims data Aon programs the plan provisions into its valuation system The Department clarifies all questions regarding plan provisions, retiree contribution levels, etc.[2]	Data files and reports Initial questions about employee data Initial questions about claims data
May 15-June 15	20	Aon finalizes employee data Aon finalizes claims data analysis Aon sends data questions Aon programs the plan provisions into its valuation system	Final questions about employee data Final questions about claims data
June 15-June 30	10	The Department sends answers to all employee and claims data questions Aon tests valuation system	
June 30-July 15	10	Aon reviews new employee data and makes appropriate adjustments Aon finalizes calculation of baseline per capita claims Aon finishes preliminary testing of valuation system	Summary of baseline per capita claims[3]
July 1-July 31	20	Aon loads new employee data and creates first full valuation runs Initial draft of Assumption report	Summary of employee counts[4]

Period	Business Days Needed	Key Activities	Deliverables
July 15	10	Initial draft of Assumption report	Draft assumption report
July 15-August 15	20	Finalize draft NYS/SUNY actuarial assumptions report (exclusive of March 31 GASB 75 discount rate)	NYS/SUNY Actuarial Assumptions report
August 15-August 31	10	Aon reviews initial results and makes adjustments as appropriate Aon begins drafting preliminary report Aon determines appropriate costing method	
September 1-September 30	25	Aon calculates initial results The Department provides any final guidance Meeting to discuss report, results, options, key observations etc.	Summary of estimated results OPEB report
September 1-September 30	25	Draft of PE and PA preliminary actuarial assumptions reports	Draft of PE and PA preliminary actuarial assumptions reports
April 1-April 15	10	Discount rate set for GASB 75 Finalize assumption report and PA/PE assumption reports	Rate determination Assumption reports
May 1-May 31	20	The Department provides cash payments for period 4/1 to 3/31 for all entities	
May 1-May 31	20	Draft final GASB 75 report	Draft report
June 1 – June 30	25	Discussion and review of report. Finalization of report for all entities	Final report

Key issues and decision points (numbers below correspond to footnote marks above):

1. Decide actuarial assumptions. This meeting is a key time for NYS/SUNY to provide initial guidance for the entire study.
2. Key time for the Department to clarify any plan provisions to be reflected in the valuation.
3. Key time for the Department to review baseline claim calculations for reasonableness.
4. Key time for the Department to review employee counts, by plan, for reasonableness.

(e) A description of the steps the Offeror will take to ensure that due dates and deadlines for Task #3 are met; and

Aon's focus on client and project management (along with developing a detailed work plan with steps and milestones) ensures that due dates and deadlines are met.

Aon will meet the timeframes, deadlines, and due dates for all steps and processes involved in Task #3. Aon has worked with large governmental clients in the past and was successful in meeting similar timeframes. In addition, Jim Christ, as Aon Account Executive, will be intimately involved in the work and will provide updates to the Department on the status of the work to ensure deadlines are met.

(f) A description of the quality assurance process to be used to ensure Task #3 reports, documents and services are complete, accurate and of the quality required by the Department.

All work produced by Aon checked and peer reviewed. The peer review procedure is completed by a consultant responsible for reviewing the final product as well as the process and assumptions utilized in producing the final product. The peer review procedure checks:

- Clarity of presentation
- Reasonability of final results
- Appropriateness and reasonableness of assumptions
- Sufficiency of scope and detail in the analysis and presentation

Aon senior management requires that all colleagues abide by our formal peer review process. Failure to comply may be addressed with disciplinary action, up to and including termination of employment.

(3) NYS/SUNY Deliverables:

The Offeror should provide a comprehensive outline of the information to be provided in the "New York State/State University of New York GASB 75 Postemployment Healthcare Benefits Actuarial Valuation" report, including an explanation of each of the subject areas to be included in the document.

For a valuation of this size and scope, we expect that we would validate the necessary exhibits and content with you prior to the delivery of the report, and have complete buy-in of important assumptions and methodologies including confirmation of the substantive plan of benefits. Our report will follow the outline set forth below, with content as discussed. Content will be for each entity as well as a consolidated display of the sum of the different groups.

Executive Summary – Highlights of the valuations including summary results, key drivers of movements in the costs and liabilities, including plan amendments and adaptations to legislative changes.

Actuarial Certification – Certification of the valuation by the signing actuaries. All OPEB valuations from Aon have two signing actuaries, one for valuation processes and one for substantive plan processes.

Valuation Results – Detailed valuation results of Total OPEB Liability, Fiduciary Net Position, Net OPEB Liability, Fiduciary Net Position as a percentage of Total OPEB Liability, and development of the OPEB Expense pursuant to the actuarial cost method required for the valuation.

Accounting Information – Detailed calculation of the accounting displays for the CAFR – interest rate sensitivity and healthcare trend sensitivity for the Net OPEB Liability, changes in the Total OPEB Liability, Fiduciary Net Position and Net OPEB Liability and related ratios. Required supplementary information is also developed in this section.

Projected Pay-As-You-Go Costs – Projected benefit payments from the valuation process, which form the total OPEB Liability.

Summary of Plan Provisions Section – All relevant plan provisions required for disclosure, which feed into the actuarial assumptions section, are displayed in this section. This includes eligibility and the benefit delivery descriptions. The financial commitment to the benefit delivery – that is the apportionment methodology of total costs to plan sponsor and plan participant – is also described here.

Actuarial Assumptions – All relevant actuarial assumptions including demographic assumptions, economic assumptions, and substantive plan assumptions

Census Data and Demographics – Synopsis of census data utilized in the valuation, with relevant statistics.

(4) PE/PA Deliverables:

The Offeror should confirm its ability to produce a modified version of the NYS/SUNY actuarial assumptions report as required for distribution to NYSHIP PEs and PAs.

Aon confirms we will produce the required PE/PA deliverables set forth as requirements in this request for proposal. We have significant familiarity with these deliverables, as we have utilized them to perform valuations for other enterprises in the State of NY as well as our current valuation work performed for NYSHIP.

4.B 4. Task #4 – Ad Hoc Consulting Services

b. Required Submission

In regard to Task #4, please provide the information requested below as part of your technical proposal:

(1) A description of the proposed process by which the Offeror will plan, complete and report back to the Department on Ad Hoc projects;

As ad-hoc projects emerge, Aon will scope out the project plan, outlining required data, as well as timing and projected fees and report back to the Department. To the extent the project will last more than approximately two weeks, we will provide the Department with periodic progress reports.

(2) A description of the steps the Offeror will take to ensure that due dates and deadlines for the required ad hoc deliverables are met, including how the Offeror will ensure that this process meets the time constraints and specialized needs of the Department, and

Aon's focus on client and project management (along with developing a detailed work plan with steps and milestones) ensures that due dates and deadlines are met.

Aon will meet the timeframes, deadlines, and due dates for all steps and processes involved in all ad hoc projects. Aon has worked with large governmental clients in the past and was successful in meeting similar timeframes. In addition, Jim Christ, as Aon Account Executive, will be intimately involved in the work and will provide updates to the Department on the status of the work to ensure deadlines are met.

During the term of this current contract, Aon has not missed one deadline.

(3) A description of the quality assurance process to be used to ensure requested Ad Hoc reports, documents and services are complete, accurate and of the quality required by the Department.

All work produced by Aon checked and peer reviewed. The peer review procedure is completed by a consultant responsible for reviewing the final product as well as the process and assumptions utilized in producing the final product. The peer review procedure checks:

- Clarity of presentation
- Reasonability of final results
- Appropriateness and reasonableness of assumptions
- Sufficiency of scope and detail in the analysis and presentation

Aon senior management requires that all colleagues abide by our formal peer review process. Failure to comply may be addressed with disciplinary action, up to and including termination of employment.

As an additional step to assure the quality of our final reports, we plan to send the Department a preliminary report about a week before the final report is due. We will ask the Department to review the preliminary report to make sure that it meets their expectations.

(4) Provide a description of two (2) prior ad hoc projects undertaken by the Offeror for a client(s). (The ad hoc projects provided cannot be for ad hoc projects undertaken for the benefit of the Department, DOB and/or GOER.) Each of the projects should have, in the opinion of the Offeror, required a comprehensive analysis of a highly complex issue that was of urgent nature to the client.

Please see Exhibit III.B entitled Project Abstract Sample #1 Project Title: Medicare Advantage Expansion for the State of New Jersey and Project Abstract Sample #2 Project Title: Kentucky Strategy and Re-Design for a comprehensive description and analysis of highly complex issues that Aon resolved for similar clients.

(5) The Offeror should complete and submit RFP Exhibit III.B, entitled “Project Abstract” for each of the two (2) examples discussed above using the instructions provided in the Exhibit.

Please see the following pages.

Exhibit III.B -- Project Abstract

Sample # _1_____

Project Title:	Medicare Advantage Expansion for the State of New Jersey
Name of the Client for whom services were performed:	Division of Pensions and Benefits, State of New Jersey
Client Contact Information:	
Contact's Name:	[redacted]
Contact's Title:	Deputy Director NJ Division of Pensions and Benefits
Phone Number:	[redacted]
Email Address:	[redacted]

Project Description: ***The Offeror should submit specific details concerning the project identified in satisfaction of the requirements in RFP Section IV.B.4. The required information should be provided as an attachment to this Abstract Form. Include the Sample # and Project Title on the attachment and entitle the document or that section of the document containing the required information as "Project Description – Project Title _____".***

Included below is a complete description of the project.

The State of New Jersey has approximately 200,000 Medicare-eligible members covered under their state health plans that include both State and Local retirees and dependents. Beginning in 2009, New Jersey introduced a Medicare Advantage plan as an option for their retirees alongside other Medicare supplement plans. Since most retirees do not contribute towards the cost of coverage, enrollment was fairly low and peaked at approximately 15% of the overall enrollment in 2015.

Beginning in 2014, Aon recommended the State consider a full replacement Medicare Advantage PPO Program. From 2014 to 2016, Aon worked in a more focused fashion with a Blue Ribbon panel established by the Governor of New Jersey. The panel included both labor and management representatives. Aon assisted with analyzing the cost and member impacts related to establishing a national Medicare Advantage PPO program. This program was projected to result in significant savings and would have minimal impact on retirees since the program includes all providers who accept Medicare reimbursement. The program had no benefit cutbacks as the in-network and out-of-network benefits were the same.

At the conclusion of the Blue Ribbon panel work, Aon worked closely with both labor and management committees for more than a year to explain this change and provide information supporting the fact that there were virtually no benefits cutbacks, or access/provider disruption issues.

Project Title:	Medicare Advantage Expansion for the State of New Jersey

Aon recommended the State conduct a full procurement process to select the Medicare Advantage provider with the best combination of access, quality, cost, and member satisfaction. Due to procurement issues and timing constraints, the current in-force medical plan providers were selected to be the Medicare Advantage PPO vendors. Even though no full-scale marketing process was conducted, Aon was able to secure favorable terms with these vendors that included performance guarantees (initial and ongoing), rate guarantees, minimum loss ratio requirements, and transparency requirements for the vendors related to sources of revenue.

As a result of this collaborative process, labor and management agreed to implement a broad-based full-replacement Medicare Advantage PPO program in 2017 for the State and Local Government Medicare component of the program.

Beginning in January of 2017, the vast majority of State and Local Government Medicare retirees were enrolled in a Medicare Advantage program that reduced Medicare retiree projected overall cost by approximately 12%, or $20 million.

Complexity of Issue: ***In the space provided below or as an attachment to this Abstract Form, describe the complexities of the sample project. (If provided as an attachment, include the Sample # and Project Title on the attachment and entitle the document or that section of the document containing the required information as "Complexity of Issue")***

In addition to having to work with State requirements related to procurement processes, Aon, working closely with the Division of Pensions and Benefits, had to overcome labor's reluctance to make the change. Since this change had to be approved by a joint labor/management committee (the Plan Design Committee) with equal labor/management representation, Aon had to clearly document in detail the lack of any real member access, plan designs or cost-share changes. Several open meetings with both the Plan Design Committee as well as closed door meetings with labor and management were needed to gain the consensus to adopt this change, which will ultimately benefit both the member and the employer (State and Local Government payers).

Urgency: ***In the space provided below or as an attachment to this Abstract Form, provide an explanation of what caused the undertaking to be urgent in nature. (If provided as an attachment, include the Sample # and Project Title on the attachment and entitle the document or that section of the document containing the required information as "Exigency")***

Like many other employers in the public sector, the State of New Jersey is grappling with significant costs related to employee benefit plans. The Blue Ribbon panel noted that at the current rate of increase, costs for these programs could consume more than 25% of the State budget in the near future. Additionally, there was an urgency to ensure that any change made during the year would be finalized with enough lead time to ensure a smooth and successful implementation of the plans, including a robust retiree communication campaign. Unlike many other changes reviewed and considered by labor and management groups, Medicare Advantage PPO programs can produce significant savings and potentially improve retiree health, without negatively impacting member access or plan design cost sharing. After a thorough discussion and analysis of all of the issues, both labor and management saw the significant upside in appointing this change.

Project Title:	Medicare Advantage Expansion for the State of New Jersey

Resources: ***In the space provided below or as an attachment to this Abstract Form, detail the resources used to undertake the project (number and titles of analysts and man-hours expended per title) - (Note: the titles to be used should be the Positions Titles set forth in RFP Section V Assumption 6.) (If provided as an attachment, Include the Sample # and Project Title on the attachment and entitle the document or that section of the document containing the required information as "Resources")***

The Aon team, including health and benefit consultant and actuaries, spent more than 500 hours over more than a year period on this project, with an approximate split of as hours as follows:

Team Role	Percent of Time
Principals	20%
Lead Consultants	40%
Consultants	25%
Analysts	15%

Timeline: ***In the space provided below or as an attachment to this Abstract Form, detail the timeline (at a minimum provide start and end dates) to undertake and complete the project. (If provided as an attachment, include the Sample # and Project Title on the attachment and entitle the document or that section of the document containing the required information as "Timeline")***

At Aon's recommendation, the State of New Jersey implemented a Medicare Advantage program in 2009. Beginning in August 2014 and culminating in the spring of 2016, Aon developed reports and PowerPoints outlining the issues related to implementing a Medicare Advantage plan for the State on a broader basis. This included meetings over several months and the development and review of Medicare Advantage proposals from the two incumbent vendors. The Plan Design Committee ultimately approved implementing a Medicare Advantage program, covering the vast majority of all State and Local government Medicare retirees, for a January 1, 2017, implementation.

Change Orders: ***In the space provided below or as an attachment to this Abstract Form, provide a description of any change orders issued in regard to the project. (If provided as an attachment, include the Sample # and Project Title on the attachment and entitle the document or that section of the document containing the required information as "Change Orders")***

While Aon developed a project plan for this work at the start of the assignment, there were many changes required over the course of the work to manage the questions and the detailed deliverables as they emerged.

Project Title:	Medicare Advantage Expansion for the State of New Jersey

Modifications/Corrections: ***In the space provided below or as an attachment to this Abstract Form, provide an explanation of any modifications/corrections required to secure the client's approval of the final deliverable(s). (If provided as an attachment, include the Sample # and Project Title on the attachment and entitle the document or that section of the document containing the required information as "Modifications/Corrections")***

Over time it became clear that a segment of the covered population would not agree to this change under any circumstances and conditions; therefore, modifications were required to address the population covered.

Cost: ***In the space provided below or as an attachment to this Abstract Form, indicate the initial projected cost of the project and the final cost of the project. Provide an explanation as to any variance in the two amounts. (If provided as an attachment, include the Sample # and Project Title on the attachment and entitle the document or that section of the document containing the required information as "Cost")***

Fees paid by our clients for specific services are confidential in nature. Aon does not provide client-specific cost data related to Aon fees. The "Resources" noted above should provide some indication of overall resources and costs.

Initial Projected Cost: N/A

Final Cost: N/A

Explanation of Variance: N/A

Sample Deliverable: ***As a separate attachment to this Abstract Form, provide a copy of the final deliverable(s) (e.g., report or documentation) resultant from the project, if permissible. If it is not permissible to release, indicate why and provide a general description of the final deliverable(s).Include the Sample # and Project Title on the attachment and entitle the document as "Sample Deliverable".***

Please see **Appendix A** the "Member Experience Overview" PowerPoint presented to the State Plan Design Committee in May 2016. Please note there were several other deliverables including others specifically on cost-savings, which were provided to our client and other individuals and departments in the State Government of New Jersey that are not public information.

Exhibit III.B -- Project Abstract

Sample # 2

Project Title:	Kentucky Strategy and Redesign
Name of the Client for whom services were performed:	Commonwealth of Kentucky
Client Contact Information:	
Contact's Name:	[redacted]
Contact's Title:	Commissioner
Phone Number:	[redacted]
Email Address:	[redacted]

Project Description: ***The Offeror should submit specific details concerning the project identified in satisfaction of the requirements in RFP Section IV.B.4. The required information should be provided as an attachment to this Abstract Form. Include the Sample # and Project Title on the attachment and entitle the document or that section of the document containing the required information as "Project Description – Project Title _____".***

The Commonwealth of Kentucky has 170,000 plan subscribers with 270,000 members made up of state, local education, and local government agencies, including active employees and pre-65 retirees and several bargaining units.

Below is an overview of the project and results:

Prior to 2014	2014 Plan Year	2015 Plan Year	2016 Plan Year
• Grandfathered plan • Received $95M in ERRP funds • Four PPO plans offered • Lowest actuarial value plan had $0 contribution for single tier • 1 HDHP with low participation (~8% of subscribers) • Majority (~65% of subscribers) were in the richest plan • Low engagement in wellness programs **Preparation for 2014:** • Consistently modelled different plan offerings • Client hosted focus group studies across the state • Open communication and buy-in with different agencies- state, education, unions, retirees	**Effective 2014:** • KEHP offered four new plan options (2) PPOs options and (2) CDHPs • Two plans were wellness plans and two were non-wellness plans • Approximately **43%** members enrolled in the two CDHPs. • Over **80%** employees enrolled in LivingWell plans and are required to complete LivingWell Promise • In 2014 KEHP's paid claims cost for medical and pharmacy benefits was nearly **8.7% lower** than the plan cost in 2013.	• KEHP Personal Cabinet staff has marketed the health plans effective 1/1/2015 • Current medical and pharmacy vendors in place since 2006 • Comparing against the 2014 plan cost, **savings from the RFPs are 8%** of total expenses o Medical—7.5% o Prescription drug (Rx)—9% • The following slide is a graph that illustrates incurred claims through 6/30/15 (note 2015 claims are lower than 2011)	• Two percent overall budgeted employer contribution increase for 2016 • Due to favorable claims experience and savings from the RFPs • **No employee contribution increase to plans** • **Benefit enhancement:** Value-Based Benefit Design (VBBD) to encourage members with diabetes to adhere to treatment regimens • Continue to promote wellness and consumer driven plans to see continual savings and favorable claims experience

Project Title:	Kentucky Strategy and Redesign

Complexity of Issue: ***In the space provided below or as an attachment to this Abstract Form, describe the complexities of the sample project. (If provided as an attachment, include the Sample # and Project Title on the attachment and entitle the document or that section of the document containing the required information as "Complexity of Issue")***

Below is an overview of the Kentucky benefit plan landscape prior to 2014:

- Grandfathered plans
- Received $95M in ERRP funds that was used to offset plan years shortfalls
- Four PPO plans offered
- Lowest actuarial value plan had $0 contribution for single tier
- 1 HDHP with low participation (~8% of subscribers)
- Majority (~65% of subscribers) were in the richest plan
- Low engagement in wellness programs

The issue was how to redesign the healthcare plans for plan years 2014 and 2015 in order to offset budget shortfalls without disrupting the members and purchasing agencies. At the same time, Kentucky wanted to better communicate consumerism and engage members in the available care management and wellness programs. The state budget was set by the governor so there was no additional funds available; at the same time, the employees and pre-65 retirees were used to rich benefits with little cost sharing and low contributions.

Urgency: ***In the space provided below or as an attachment to this Abstract Form, provide an explanation of what caused the undertaking to be urgent in nature. (If provided as an attachment, include the Sample # and Project Title on the attachment and entitle the document or that section of the document containing the required information as "Exigency")***

The state budget was set by the governor so there was no additional funds available; at the same time, the employees and pre-65 retirees were used to rich benefits with little cost sharing and low contributions. The plans had to be redesigned to meet budgets that were already set. If no changes were made, the health fund would have been over budget with no source to make up the deficit. Since ERRP funds were utilized to offset prior year shortfalls, the plan had to make up the ERRP funds as well as claims trend increases.

Also, if the changes were deemed too great, unions would strike. The unions, employees, and retirees were already concerned with the pension deficit and didn't want the health plan to be underfunded.

Project Title:	Kentucky Strategy and Redesign

Resources: ***In the space provided below or as an attachment to this Abstract Form, detail the resources used to undertake the project (number and titles of analysts and man-hours expended per title) - (Note: the titles to be used should be the Positions Titles set forth in RFP Section V Assumption 6.) (If provided as an attachment, Include the Sample # and Project Title on the attachment and entitle the document or that section of the document containing the required information as "Resources")***

The Aon team was compromised of actuaries, wellness consultants, RFP specialists, and clinicians. The level of the actuaries ranged from actuarial student to senior vice president. The course of this work began in 2012 until 2015. In 2012 - 2013, the actuarial team consistently modelled different plan offerings. The client hosted focus group studies on these plan offerings across the state to gauge open communication and buy-in with different agencies- state, education, unions, and retirees. The new plans were rolled out effective 1/1/2014.

To prepare for plan year 2015, the Aon team and Kentucky started to work on the procurement of a medical TPA, prescription drug TPA, wellness vendor, HRA/FSA vendor, and transparency vendor.

The Aon team, including health and benefit consultant and actuaries, spent hundreds of hours of time over a two year period on this project, with an approximate split of as hours as follow:

Team Role	Percent of Time
Principals	10%
Lead Consultants	30%
Consultants	30%
Analysts	30%

Timeline: ***In the space provided below or as an attachment to this Abstract Form, detail the timeline (at a minimum provide start and end dates) to undertake and complete the project. (If provided as an attachment, include the Sample # and Project Title on the attachment and entitle the document or that section of the document containing the required information as "Timeline")***

2012 - 2013:

- Consistently modelled different plan offerings
- Client hosted focus group studies across the state
  - Open communication and buy-in with different agencies- state, education, unions, retirees

2014: New plans and contributions were rolled out

- 3Q13 - 1Q14: KEHP Personal Cabinet staff and Aon prepared RFPs for all vendor partners effective 1/1/2015
- 1Q14: KEHP released the marketings effective 1/1/2015
- 2Q14: Vendors were selected; prior medical and pharmacy vendors in place since 2006
- 2Q14 - 2Q14: New vendors worked on implementation
- 4Q14 - 1Q15: Aon conducted pre-implementation and post-implementation audits to ensure seamless transition to new vendors

Project Title:	Kentucky Strategy and Redesign

Change Orders: ***In the space provided below or as an attachment to this Abstract Form, provide a description of any change orders issued in regard to the project. (If provided as an attachment, include the Sample # and Project Title on the attachment and entitle the document or that section of the document containing the required information as "Change Orders")***

None were required for this project.

Modifications/Corrections: ***In the space provided below or as an attachment to this Abstract Form, provide an explanation of any modifications/corrections required to secure the client's approval of the final deliverable(s). (If provided as an attachment, include the Sample # and Project Title on the attachment and entitle the document or that section of the document containing the required information as "Modifications/Corrections")***

None were required for this project.

Cost: ***In the space provided below or as an attachment to this Abstract Form, indicate the initial projected cost of the project and the final cost of the project. Provide an explanation as to any variance in the two amounts. (If provided as an attachment, include the Sample # and Project Title on the attachment and entitle the document or that section of the document containing the required information as "Cost")***

Fees paid for specific services confidential. Aon does not provide client specific cost data related to Aon fees. The "Resources" noted above should allow some indication of overall resources and costs.

Initial Projected Cost: N/A

Final Cost: N/A

Explanation of Variance: N/A

Sample Deliverable: ***As a separate attachment to this Abstract Form, provide a copy of the final deliverable(s) (e.g., report or documentation) resultant from the project, if permissible. If it is not permissible to release, indicate why and provide a general description of the final deliverable(s).Include the Sample # and Project Title on the attachment and entitle the document as "Sample Deliverable".***

Please see **Appendix B** "Briefing for the Kentucky Group Health Insurance Board" PowerPoint presented to the board in May 2014. Please note there were several other deliverables which were provided to our client and other individuals and departments in the state government that are not public information.

4.C. Performance Guarantees

The Contractor must agree to Performance Guarantees in areas critical to the quality and delivery of the required services. The Contractor must agree to, at a minimum, the following guarantees and propose, in its Technical Proposal, amounts expressed as either a fixed dollar per day or fixed percent per day **amount to be put at risk for failure to meet a guarantee(s).**

b. Required Submission

Offerors' proposed performance guarantee responses including penalty fee amounts to be put at risk for non-performance are not considered to be cost information and therefore should be stated in the Offeror's Technical Proposal. At this part of its Technical Proposal, the Offeror must state its agreement to the following minimum guarantees and propose amounts, expressed as either a fixed per day dollar amount or a fixed percent per day amount to be put at risk for failure to meet the guarantee. Failure to agree to one or more of the following minimum guarantees and/or failure to propose an associated penalty fee amount(s), expressed as either a fixed per day dollar or a fixed percent per day amount, to be put at risk for failure to meet the guarantee(s), may result in the Offeror deemed non-responsive and eliminated from further consideration.

1. Turnaround Time Guarantees

Task #1 - Premium Rate Renewals: State your willingness to guarantee that the Contractor will support the Department during the Premium Renewal Process and that the two required reports and other Task #1 deliverables will be provided in accordance with the requirements set forth in RFP Section IV.B.1 provided that the required electronic data is received by the Contactor from all vendors by July 15th of each renewal cycle and the vendor renewals are received by no later than the first week in September. If the Contractor does not receive the data and/or renewals by the specified dates, different due dates shall be agreed upon in writing by the Parties and guaranteed by the Contractor. The Offeror must propose a penalty for failure to meet the above guarantee and the guarantee must be proposed in the following format:

> "For each twenty-four (24) hour period, or part thereof, that a Task #1 report or final deliverable is not provided to the Department by the report(s)/deliverable(s)' due date, the Contractor shall pay the Department $_____ per day, until such time that the report(s)/ deliverable(s) is provided to the Department. The aggregate total penalty amount shall not exceed the actual cost incurred by the Contractor in its performance of the associated Task #1 activity."

The Standard Credit Amount for each twenty-four (24) hour period, or part thereof, that a Task #1 report or final deliverable is not provided to the Department by the report(s)/deliverable(s)' due date, is $3,000.00. However, Offerors may propose higher or lesser amounts.

For each twenty-four (24) hour period, or part thereof, that a Task #1 report or final deliverable is not provided to the Department by the report(s)/deliverable(s)' due date, the Contractor shall pay the Department $4,000 per day, until such time that the report(s)/ deliverable(s) is provided to the Department. The aggregate total penalty amount shall not exceed the actual cost incurred by the Contractor in its performance of the associated Task #1 activity.

Task #2 – Quarterly Analysis: State your willingness to guarantee that Quarterly Contractor Commentary Reports will be provided in accordance with the requirements set forth in RFP Section IV.B.2, not later than forty-five (45) calendar days from the end of the quarter under review, provided that the required electronic data is received by the Contactor from all vendors within fifteen (15) days of the close of the quarter, and the vendor reports within twenty-three (23) days of the close of the quarter. If the Contractor does not receive the data and/or vendor reports by the specified dates, the due date shall be extended by one day for each day the data and/or vendor reports are late. The Offeror must propose a penalty for failure to meet the above guarantee and the guaranteed must be proposed in the following format:

> "For each twenty-four (24) hour period, or part thereof, beyond a given Quarterly Contractor Commentary Reports' due date that the final Quarterly Contractor Commentary Reports is not provided to the Department by the Contractor, the Contractor shall pay the Department $_____ per day, until such time as the required final Quarterly Contractor Commentary Reports are provided to the Department. The aggregate total penalty amount shall not exceed the actual cost incurred by the Contractor in its performance of the associated Task #2 activity."

The Standard Credit Amount for each twenty-four (24) hour period, or part thereof, beyond the given Quarterly Contract Commentary Reports' due date, is $3,000.00. However, Offerors may propose higher or lesser amounts.

For each twenty-four (24) hour period, or part thereof, beyond a given Quarterly Contractor Commentary Reports' due date that the final Quarterly Contractor Commentary Reports is not provided to the Department by the Contractor, the Contractor shall pay the Department $4,000 per day, until such time as the required final Quarterly Contractor Commentary Reports are provided to the Department. The aggregate total penalty amount shall not exceed the actual cost incurred by the Contractor in its performance of the associated Task #2 activity.

Task #3 – GASB 75 Valuation: State your willingness to guarantee that GASB 75 valuation services and the five (5) required reports will be provided in accordance with the requirement set forth in RFP Section IV.B.3 and that other specified deliverables as requested by the Department in fulfillment of GASB obligations will be provided in accordance with due dates specified in the annual Task #4 task order negotiated by the Parties, as may be amended by a Department approved Change Order Request(s). The Offeror must propose a penalty for failure to meet the above guarantee and the guarantee must be proposed in the following format:

> "For each twenty-four (24) hour period, or part thereof, beyond the due date for a given Task #3 report, as specified in the annual Task #4 task order negotiated by the Parties, as may be amended by a Department approved Change Order Request, is not provided to the Department by the Contractor, the Contractor shall pay the Department _____ percent of the negotiated Task #3 task order Total Project Cost amount, until such time as the report(s) is/are provided to the Department. The aggregate total penalty amount shall not exceed the actual cost incurred by the Contractor in its performance of the associated Task #3 activity."

The Standard Credit Amount for each twenty-four (24) hour period, or part thereof, beyond the given due date for a given Task #3 report, is three percent (3%) of the negotiated Task #3 task order Total Project Cost amount. However, Offerors may propose higher or lesser amounts.

For each twenty-four (24) hour period, or part thereof, beyond the due date for a given Task #3 report, as specified in the annual Task #4 task order negotiated by the Parties, as may be amended by a Department approved Change Order Request, is not provided to the Department by the Contractor, the Contractor shall pay the Department four (4) percent of the negotiated Task #3 task order Total Project Cost amount, until such time as the report(s) is/are provided to the Department. The aggregate total penalty amount shall not exceed the actual cost incurred by the Contractor in its performance of the associated Task #3 activity.

Task #4 – Ad Hoc Consulting Services: State your willingness to guarantee that, in accordance with the requirements of RFP Section IV.B.4, analysis provided for a given Ad Hoc Project will be 1) based on the most current information available, 2) comprehensive, and 3) actuarially sound and reasonable, and that an Ad Hoc Project's final deliverables will be provided to the Department not later than the due date agreed upon by the Department and the Contractor for a given Ad Hoc final deliverable. The Offeror must propose a penalty for failure to meet the above guarantee when the Not-To-Exceed Total Cost of a given Ad Hoc project is equal to or greater than fifty thousand dollars ($50,000) and the guaranteed must be proposed in the following format:

> "As regards Ad Hoc projects whose Not-To-Exceed Total Cost is equal to or greater than fifty thousand dollars ($50,000), for each twenty-four (24) hour period, or part thereof, beyond the due date for the Ad Hoc Project's report or final deliverable, as negotiated by the Parties on a case-by-case basis, that the report/deliverable is not provided to the Department by the Contractor, the Contractor shall pay the Department _____ percent of the Task #4 Ad Hoc Not-To-Exceed Total Cost amount, until such time as the report(s)/deliverable(s) is provided to the Department. The aggregate total penalty amount shall not exceed the actual cost incurred by the Contractor in its performance of the associated Task #4 Ad Hoc project."

The Standard Credit Amount for each twenty-four (24) hour period, or part thereof, beyond the given due date for an Ad Hoc project whose Not-To-Exceed Total Cost is equal to or greater than fifty thousand dollars ($50,000), is three percent (3%) of the Task #4 Ad Hoc Not-To-Exceed Total Cost amount, until such time as the report(s)/deliverable(s) is provided to the Department. However, Offerors may propose higher or lesser amounts.

As regards Ad Hoc projects whose Not-To-Exceed Total Cost is equal to or greater than fifty thousand dollars ($50,000), for each twenty-four (24) hour period, or part thereof, beyond the due date for the Ad Hoc Project's report or final deliverable, as negotiated by the Parties on a case-by-case basis, that the report/deliverable is not provided to the Department by the Contractor, the Contractor shall pay the Department four (4) percent of the Task #4 Ad Hoc Not-To-Exceed Total Cost amount, until such time as the report(s)/deliverable(s) is provided to the Department. The aggregate total penalty amount shall not exceed the actual cost incurred by the Contractor in its performance of the associated Task #4 Ad Hoc project.

4.D. Diversity Practices Questionnaire

Diversity practices are the efforts of contractors to include New York State-certified Minority and Women-owned Business Enterprises ("MWBEs") in their business practices. Diversity practices may include past, present, or future actions and policies, and include activities of contractors on contracts with private entities and governmental units other than the State of New York. Assessing the diversity practices of contractors enables contractors to engage in meaningful, capacity-building collaborations with MWBEs.

The Department has determined, pursuant to New York State Executive Law Article 15-A, that the assessment of the diversity practices of respondents to this procurement is practical, feasible, and appropriate. Accordingly, respondents to this procurement shall be required to include as part of their response to this procurement, as described in this section and in Section VI, herein, Exhibit IV.A entitled "Diversity Practices Questionnaire."

a. Required Submission

The Offeror must submit the Diversity Practices Questionnaire (Exhibit IV.A) signed by both the Offeror's authorized representative and public notary. The Offeror's completion of the questionnaire is voluntary and blank submissions will not disqualify an Offeror from the procurement.

Please see Exhibit IV.A below.

Exhibit IV.A – Diversity Practices Questionnaire

Exhibit IV.A – Diversity Practices Questionnaire

Diversity Practices Questionnaire

I, **James Christ**, as **Vice President** (title) of **Aon Consulting, Inc.** firm or company (hereafter referred to as the company), swear and/or affirm under penalty of perjury that the answers submitted to the following questions are complete and accurate to the best of my knowledge:

1. Does your company have a Chief Diversity Officer or other individual who is tasked with supplier diversity initiatives? (Yes) or No

   If Yes, provide the name, title, description of duties, and evidence of initiatives performed by this individual or individuals.

   Aon's supplier diversity program is led by Shelly Brown (Aon Diversity Solutions Lead) and Leatha King (Diverse Sourcing & Compliance Manager).

   Program duties and initiatives include the following:

   - **Diverse Spend Best Practices: ongoing review of supplier diversity data and activities to support ongoing improvements to broadening / impacting engagement with diverse certified firms. Initiatives include monthly meetings with procurement buyers; embedding (mandatory) diverse supplier evaluation within buying decision processes; strategic discussions with marketplace thought leader organizations (e.g. NMSDC, BDR, WBENC) and participation on benchmarking surveys to identify program improvements within peer groups.**
   - **Internal Program Education: conduct supplier diversity education with internal procurement buyers. Initiatives include on-boarding orientation, procurement (buyer) participation within tradeshow fairs, procurement leadership appointments to local / regional (diverse) councils and periodic thought leadership (e.g. NMSDC, FSRSD) training sessions.**
   - **Reporting & Compliance: conduct data integrity checks / audits across diverse spend data and certification validation. Initiatives include: ongoing partnership with leading supplier diversity technology vendor to capture accurate certifications locally, regionally and nationally. Also engaged to support / identify spend trend activity is a dedicated in-house Analytics team.**
   - **Market Engagement & Outreach: build meaningful relationships with the diverse business community and advocacy groups to foster expanded project opportunities for diverse businesses. Initiatives include: membership and tradeshow sponsorships at key national / local advocacy organizations (e.g. NMSDC, WBENC, WBDC, CMSDC) and match-making events to meet with diverse businesses across geographies. Supplier sourcing leverages (paid) membership / certification databases a (paid) on-line supplier registration portal and tradeshow attendance.**

2. What percentage of your company's gross revenues (from your prior fiscal year) was paid to New York State certified minority and/or women-owned business enterprises as subcontractors, suppliers,

Exhibit IV.A – Diversity Practices Questionnaire

joint-venturers, partners or other similar arrangement for the provision of goods or services to your company's clients or customers?

Aon has a global presence with operations in over 120 countries. Based on the US revenue figure, we estimate that our spend with New York State certified minority and/or women-owned business enterprises to be less than 1%.

3. What percentage of your company's overhead (i.e. those expenditures that are not directly related to the provision of goods or services to your company's clients or customers) or non-contract-related expenses (from your prior fiscal year) was paid to New York State certified minority- and women-owned business enterprises as suppliers/contractors?[1]

   Aon reports diverse spend as a percentage of addressable expenses. During the 2016 reporting year, spend activity with New York State certified minority and / or women-owned business enterprises as subcontractors, totaled $3.9 MM.

4. Does your company provide technical training[2] to minority- and women-owned business enterprises? Yes or (No)

   If Yes, provide a description of such training which should include, but not be limited to, the date the program was initiated, the names and the number of minority- and women-owned business enterprises participating in such training, the number of years such training has been offered and the number of hours per year for which such training occurs.

   Not applicable.

5. Is your company participating in a government approved minority- and women-owned business enterprise mentor-protégé program?

   If Yes, identify the governmental mentoring program in which your company participates and provide evidence demonstrating the extent of your company's commitment to the governmental mentoring program.

   Aon does not participate in a government approved mentor-protege program.

6. Does your company include specific quantitative goals for the utilization of minority- and women-owned business enterprises in its non-government procurements? Yes or (No)

   If Yes, provide a description of such non-government procurements (including time period, goal, scope and dollar amount) and indicate the percentage of the goals that were attained.

   Not applicable.

7. Does your company have a formal minority- and women-owned business enterprise supplier diversity program? (Yes) or No

[1] Do not include onsite project overhead.
[2] Technical training is the process of teaching employees how to more accurately and thoroughly perform the technical components of their jobs. Training can include technology applications, products, sales and service tactics, and more. Technical skills are job-specific as opposed to soft skills, which are transferable.

Exhibit IV.A – Diversity Practices Questionnaire

If Yes, provide documentation of program activities and a copy of policy or program materials.

The documentation of program activities and an overview of Aon's policy are below.

Aon's supplier diversity program is a unique platform that fosters opportunities for diverse businesses through both internal (procurement) projects, as well, across external (client) engagements. Aon Diversity Solutions, a dedicated business unit within the firm, is committed to fostering opportunity and growth of diverse firms.

Supplier diversity program activities include:

- **Internal Procurement Engagement: Aon's supplier diversity program provides diverse suppliers with equal access to the awarding of business for purchased and sourced goods and services. Aon works to inform internal buyers on the value of diverse supplier capabilities to support program engagement.**
- **Industry Affiliates & Market Awareness: Aon actively seeks suppliers through membership in diverse supplier business advocacy organizations and participation in various tradeshow activities. Additionally, diverse suppliers have an opportunity to register as a potential supplier through Aon's online registration tool.**
- **External Client Solution: Aon pioneered a unique client solution that supports Tier 1 & Tier 2 project opportunities. Established in 2009, this platform fosters the opportunity for diverse firms to work directly with Aon colleagues to deliver a seamless client solution. To date, ADS maintains a privately established, leading network of diverse professional services firms. Through this unique model, the collaboration leverages the strengths of a local, small-mid-size firm with that of a global firm.**

To participate in Aon's supplier diversity program, diverse business must be certified by a third party organization. Aon accepts the following certifications: MBE, WBE, VBE, Hub zone, 8(a), GLBT, SBE, SDB, DBE. As part of the registration process, diverse suppliers are required to provide proof of active (diverse) certifications.

Aon is partnered with Minority-/Woman-Owned/Small Business Enterprise organizations to create appropriate alignment to supplier diversity program sourcing goals and certification processes. Memberships include, National Minority Supplier Development Council (NMSDC), Women's Business Enterprise National Council (WBENC) / local affiliates and the Small Business Administration (SBA).

To ensure meaningful program activities, Aon leverages an information management system that maintains a comprehensive database of diverse suppliers, reporting capabilities and periodic validation of diverse supplier classifications. We encourage suppliers to set up a profile in our registration site to be considered for potential sourcing opportunities at: http://aon.cvmsolutions.com/.

Aon's supplier diversity program is led by Shelly Brown, Senior Director and supported by Leatha King, Diverse Sourcing & Compliance Manger. For specific program inquiries, please contact Leatha King at leatha.king@aon.com.

Exhibit IV.A – Diversity Practices Questionnaire

8. Does your company plan to enter into partnering or subcontracting agreements with New York State certified minority- and women-owned business enterprises if selected as the successful respondent?
(Yes) or No

If Yes, attach Utilization Plan Exhibit I.O

Please refer to the attached Utilization Plan Exhibit I.O.

All information provided in connection with the questionnaire is subject to audit and any fraudulent statements are subject to criminal prosecution and debarment.

Signature of Owner/Official [redacted]

Printed Name of Signatory James Christ

Title Vice President

Name of Business Aon Consulting Inc.

Address 400 Atrium Drive, 5th Floor South

City, State, Zip Somerset, NJ 08873

STATE OF N.J.
COUNTY OF Somerset) ss:

On the 17 day of May, 2017, before me, the undersigned, a Notary Public in and for the State of N.J., personally appeared James Christ, personally known to me or proved to me on the basis of satisfactory evidence to be the individual whose name is subscribed to this certification and said person executed this instrument.

[redacted]

Notary Public

DARLENE MICHELLE M TAYLOR
ID # 2196315
NOTARY PUBLIC
STATE OF NEW JERSEY
My Commission Expires Nov. 25, 2018

State of New York
Department of Civil Service
Albany, NY 12239

MWBE UTILIZATION PLAN

OFFICE OF FINANCIAL ADMINISTRATION **MWBE-100 (9/2011)**

INSTRUCTIONS: All Offerors must complete this MWBE Utilization Plan and submit it as part of their Proposal. The Plan must contain a detailed description of the services to be provided by each Minority and/or Woman-Owned Business Enterprise (M/WBE) identified by the Offeror.

Offeror Name: Aon Consulting Inc.	**Federal Identification No.:** 22-2232264
Address: 400 Atrium Drive	**Solicitation No.:** ABMC-2017-1
City, State, Zip Code: Somerset, NJ 08873	**M/WBE Goals for the Solicitation: MBE:** 2 **% WBE:** 2 **%**

1. M/WBE Subcontractors/Suppliers Name, Address, Email Address, Telephone No.	2. Classification	3. Federal ID No.	4. Detailed Description of Work (Attach additional sheets, if necessary.)	5. Dollar Value of Subcontracts/Supplies
A. AIRAM - 13430 E. Del Timbre Dr Scottsdale, AZ 85259 Phone: 480-619-0427; Email - mdominiak@airamactuary.com	NYS ESD Certified ☐ MBE ☑ WBE	45-4549912	Consulting input/peer review of actuarial assumptions across Quarterly/ Renewal /GASB 75 reports. Input on trend assumptions. Ad-hoc support as needed.	Fees for core work approx. $7,000 per year or min. 2% of overall fees. If ad-hoc services required, est. vendor fees amount to at least 2% of fees as well.
B. FIRM - One Penn Plaza, 36th Floor New York, NY 10119 Phone: 212-786-7588; Email - phil@firmadvisor.com	NYS ESD Certified ☑ MBE ☐ WBE	43-1973664	Involved in Data scrubbing process of enrollment/ claims data. Assist developing initial completion factors for Quarterly/Renewal reports. Ad-hoc support as needed.	Fees for core work approx. $7,000 per year or min. 2% of overall fees. If ad-hoc services required, est. vendor fees amount to at least 2% of fees as well.

6. WAIVER REQUESTED: MBE: ☐ **YES** ☑ **NO If YES, submit form MWBE101** / **WBE:** ☐ **YES** ☑ **NO If YES, submit form MWBE101**

PREPARED BY (Signature) [redacted]	**TELEPHONE NO.:** 732-271-2672	**EMAIL ADDRESS:** james.christ@aonhewitt.com
NAME AND TITLE OF PREPARER (Print or Type): James A. Christ, VP, Aon		
DATE: Offeror's Certification Status: **MBE** **WBE** Not Applicable ☑		

SUBMISSION OF THIS FORM CONSTITUTES THE OFFEROR'S ACKNOWLEDGEMENT AND AGREEMENT TO COMPLY WITH THE M/WBE REQUIREMENTS SET FORTH UNDER NYS EXECUTIVE LAW, ARTICLE 15-A. FAILURE TO SUBMIT COMPLETE AND ACCURATE INFORMATION MAY RESULT IN A FIUNDING OF NONCOMPLIANCE AND/OR PROPOSAL DISQUALIFICATION.

*******************FOR DEPARTMENT USE ONLY*******************

REVIEWED BY: **DATE:**

UTILIZATION PLAN APPROVED: ☐ **YES** ☐ **NO Date:____**

MBE CERTIFIED: ☐ **YES** ☐ **NO**

WBE CERTIFIED: ☐ **YES** ☐ **NO**

WAIVER GRANTED: ☐ **YES** ☐ **NO**

☐ **Total Waiver** ☐ **Partial Waiver**

NOTICE OF DEFICIENCY ISSUED: ☐ **YES** ☐ **NO**

Date: _____

Appendix

Appendix A – Sample Deliverable: State of New Jersey, Member Experience Overview

Project Abstract Sample Deliverable #1:
Medicare Advantage Expansion for the State of New Jersey

Member Experience Overview
State of New Jersey
SHBP PDC Meeting
Medicare Advantage Proposal for Plan Year 2017

May 20, 2016

Prepared by Consulting
Health & Benefits

AON
Empower Results®

Agenda

- What is Medicare Advantage?
- Member Considerations
- Open Discussion and Next Steps
- Appendix – Sample Communications

What is Medicare Advantage?

What is Medicare Advantage?

- Medicare Advantage plans are offered to individuals and employers to provide Medicare-eligible retiree medical coverage

- Traditional Medicare Supplement plans pay the cost of care after Medicare pays the first approximately 80% of the cost of care
  - Traditional Medicare plans are not “managed” and have a high degree of inefficiency (high emergency room usage, high hospital admission and re-admission rates, and poor care coordination)
  - It is inefficient for an employer-sponsored plan to coordinate behind an inefficient primary plan (Medicare)
  - This leads to higher costs for the employer’s Medicare Supplement plan

- Medicare Advantage plans instead receive payments from Medicare to take on the full risk of the cost of care
  - The Medicare program essentially removes itself from the member’s care and pays the insurer to administer and insure the coverage

What is the Value of Medicare Advantage?

- Many health plans are able to manage care more efficiently and effectively than traditional Medicare
- Employers can achieve cost savings due to low premiums paid to Medicare Advantage insurers who keep costs low with effective, high-quality care management
- Insurers are held to strict minimum loss ratio standards to prevent excessive profits (both at the Federal level as well as through contractual agreements with large employers)
- Medicare Advantage PPO plans offer a national network basis with no restrictions – members can access any provider who accepts traditional Medicare

Example of How Medicare Reimbursements Work

	Current SHBP/SEHBP Medicare Supplement Plans with Horizon	Medicare Advantage Plans
Premium Paid by SHBP/SEHBP	SHBP/SEHBP sets aside funds to pay future claims at estimated premium equivalent amounts. SHBP/SEHBP also pays an administrative charge to Horizon to administer coverage.	Premium paid to Medicare Advantage vendor to insure coverage for SHBP/SEHBP members (currently in place with Aetna)

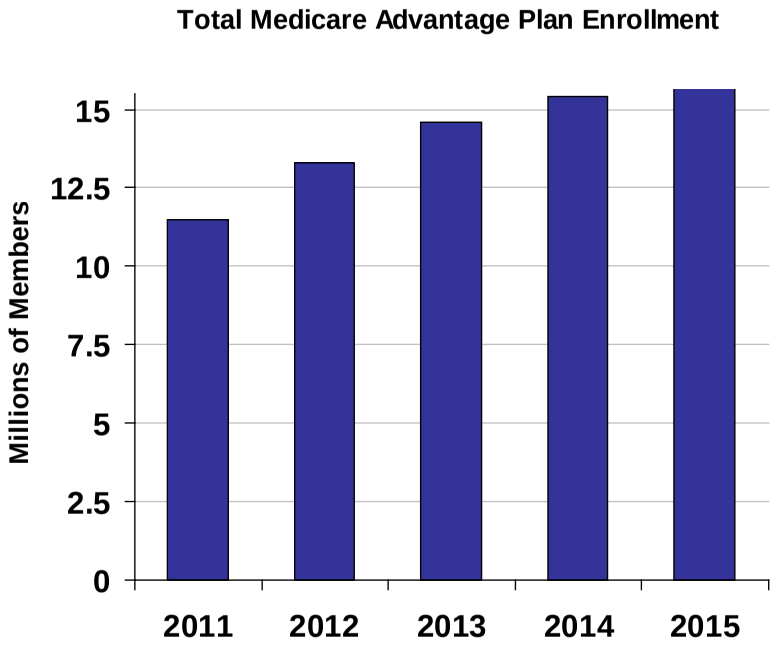
Claim Example – A Medicare-eligible member in a $10 copay PPO plan goes to an out-of-network provider for an in office procedure. The cost of the procedure is $300.

Note: Payments are estimated and shown for illustrative purposes only.

	Current SHBP/SEHBP Medicare Supplement Plans with Horizon	Medicare Advantage Plans
Medicare Pays	$240	Nothing – Medicare has already paid the insurer to take on the full risk of the cost of care.
SHBP/SEHBP pays	$48	The SHBP/SEHBP pays a premium to the insurer to cover the cost of the care (as noted above).
Member Pays	$12	$10

Prevalence of Medicare Advantage Plans

- Over 20,000 SHBP/SEHBP members are already enrolled in a Medicare Advantage plan through Aetna today
- According to Aon's 2015 Retiree Health Care Survey, approximately 1/3 of employers offer group-based Medicare Advantage Plans
  - This numbers is growing as employers continue to seek ways to save on health plan costs without reducing member coverage
- Over 16 million Americans are enrolled in Medicare Advantage plans



Source: Centers for Medicare and Medicaid Services January 2015 enrollment files

Medicare Advantage in the Public Sector – Example

- **Kentucky Teachers' Retirement System – 31,000 Medicare-eligible members**
  - Full replacement Medicare Advantage plan implemented in 2007
    - Savings of $10 million/year and benefit design improvements for members
  - Minimal member disruption in regards to plan design and network since 2007
    - No material change in deductibles, copays, coinsurance, or out-of-pocket maximums from 2006 through 2015
  - Medicare Advantage RFP in 2015 saved additional $13 million per year, with benefit design improvements for members
  - In 10th year of Medicare Advantage program, still saving almost $10 million/year compared to Medicare Supplement estimated costs
  - Union/teachers highly satisfied with MA plan
- **State of Georgia** has a full-replacement Medicare Advantage plan for Medicare-eligibles
- **State of Texas** implemented Medicare Advantage in 2011 and saved approximately $18 million in the first year (Note: Retirees are able to opt-out of the Medicare Advantage plans)
- Many other states (including but not limited to **North Carolina, Ohio,** and **New York**) offer Medicare Advantage plans for portions of their retiree population

Member Considerations

MA Vendor Experience

- **New Jersey Network**
  - Aetna: 140 participating hospitals, 15,000 primary care doctors, 29,000 specialists
  - Horizon: 34,400 health care providers

- **Total 2015 Group Medicare Advantage Membership**
  - Aetna: 580,000 total group members, 770,000 individual members
  - Horizon: 3,400 group members and 25,000 individual market members

Plan Design Considerations for MA Plans

Overall, benefits will be the same or better for members under Medicare Advantage plans than in their current plans.

- Out-of-network benefits will match in-network benefits, so retirees will be able to seek care from any provider at the same out-of-pocket cost
  - Current NJ DIRECT PPO Medicare retiree enrollees pay a coinsurance of 20%-30% for all out-of-network services

Care Coordination

- Aetna or Horizon will actively coordinate care for SHBP/SEHBP members
  - Because they are taking on the full risk for the cost of the member's care, the insurers have an incentive to help the member seek cost-effective providers and appropriate care
  - Members will have more access to nurse lines and care coordination programs
  - Members can have in-home visits (on a voluntary basis)

Enhanced Access

- There will be no disruption for currently utilized providers by Medicare-eligible enrollees
  - Medicare Advantage plans will allow members to continue to see any provider which currently accepts traditional Medicare
- Currently, approximately 170,000 combined SHBP/SEHBP Medicare members are enrolled with Horizon on a Medicare Supplement basis and approximately 20,000 combined SHBP/SEHBP Medicare members are enrolled in Aetna's current MA program

Since members are free to see both in-network and out-of-network providers with no difference in plan design, members will be able to see their current providers with no change in access or cost-sharing provisions.

Member Satisfaction

- In general, member satisfaction for Medicare Advantage plans is very high and membership in the product continues to grow each year

- Aetna's 2015 Survey of current SHBP/SEHBP Medicare Advantage members

Aetna Survey Data

We listen to your retirees which we feel is the most important part of a health partnership:

- **Does our network have hospitals your members want to use –** 98% of your members agree
- **Does our network have PCP's your members want to use –** 99% of your members agree
- **Does our network have specialists your members want to use –** 98% of your members agree

Member Services

- Aetna and/or Horizon will be held to performance guarantees to ensure the best possible services for members, with percentages of their premium at risk for adherence to these high standards
  - Overall Member Satisfaction guarantees
  - Claim turnaround time
  - Timeliness and accuracy of customer service centers

Implementation

- Each vendor has provided a detailed implementation plan to ensure a high-quality, accurate, and timely implementation process
- Vendor will contact members with chronic medical conditions to ensure their ease with any transition
- An implementation credit has been offered to assist with costs related to communications and implementation
- A strong, clear communication plan is **CRITICAL**
  - Make it clear to members that their benefits will remain the same or even improve
  - Ensure easy access to provider directories, plan summaries, and customer service numbers for retirees to call with any questions
  - Vendor websites have senior-focused communication tools and links
- A decision and start date of not later than July 1, 2016, is critical to ensure a smooth and effective implementation

Open Discussion and Next Steps

Appendix – Sample Communications

Aetna Sample Communications

How the Aetna Medicare Advantage plan option compares to your current plan

Below are coverage and cost examples of key benefits that are important to many people. See Medicare Advantage plan complete coverage information in the packet coming soon from Aetna.

Comparison examples	Your current New Jersey SHBP and SEHBP medical plan	The New Jersey SHBP and SEHBP Aetna Medicare Advantage plan option in 2017	
Medical deductible (the amount you pay before plan medical coverage begins)	You pay $200	You pay $0	**No deductible — plan starts paying on day one!**
Annual limit you pay for medical costs	There's no limit on what you would pay annually for medical cost	$3,000 is the most you'd possibly pay in 2017 (the plan would pay 100% after that)	**Protects you financially if you need substantial medical care**
Lifetime maximum medical coverage by the plan	$100,000 maximum	No cap on how much the plan will pay throughout your lifetime as a member	
Preventive services	You pay 20% after deductible	You pay $0	**You'll get all these services at no additional cost**
Annual eye exam	You pay 20% after deductible	You pay $0	
Annual hearing exam	You pay 20% after deductible	You pay $0	
Primary care doctor visit	You pay 20% after deductible	You pay $5	**Predictable, lower costs for medical services**
Inpatient hospital care	You pay 20% per stay after deductible	You pay $25/day for days 1–50/ $50/day for days 51+	
Programs to support health, happiness and peace of mind	Not included	You pay $0	**New with this plan — Important extra benefits**
Eyewear reimbursement	Not included	$180 reimbursement every 24 months	
Hearing aid reimbursement	Not included	$240 reimbursement every 36 months	

FPO

We're here to help! Call us at **1-888-267-2637 (TTY: 711)**, Monday through Friday, 8 a.m. to 6 p.m., all times zones.

How doctors accept the new Aetna Medicare Advantage plan

The Aetna Medicare Advantage plan is a Preferred Provider Organization (PPO) plan. It lets you use doctors and hospitals in or out of the Aetna Medicare network, without paying more out of network. **Chances are your doctors are in the network, or will accept the plan if they aren't in the network.**

To see if your doctors accept the new plan, call the number at the top of this page – it's that easy

It's usually not a problem if you use an out-of-network doctor or hospital. However, they must:

- Be eligible to receive Medicare payment
- Agree to accept your PPO plan before treating you

How to learn more

Attend a New Jersey SHBP and SEHBP retiree meeting. To RSVP, call the number at the top of this page.

Thursday, October 27	**Thursday, October 27**
10 a.m. – 12 p.m. Thompson Conference Center 2405 Robert Dedman Drive Austin, TX 78712	2 p.m. – 4 p.m. Thompson Conference Center 2405 Robert Dedman Drive Austin, TX 78712
Friday, October 28	**Friday, October 28**
10 a.m. – 12 p.m. Kiest Park Recreational Center 3080 S. Hampton Road Dallas, TX 75224	2 p.m. – 4 p.m. Kiest Park Recreational Center 3080 S. Hampton Road Dallas, TX 75224
Monday, October 31	**Tuesday, November 1**
2 p.m. – 4 p.m. Arlington Convention Center 1200 Ballpark Way Arlington, TX 76011	2 p.m. – 4 p.m. Region 17 Service Center 1111 West Loop 289 Lubbock, TX 79416

FPO

At meetings, an Aetna salesperson will be present with information. For accommodation of persons with special needs at sales meetings, call **1-800-307-4830 (TTY: 711)**.

Aetna Sample Communications (cont.)

Check out your health care benefits — tools and extras available to you

Health and wellness benefits

You may be retired from one job but you're still on the go. So your health plan includes extras to help you feel your best, day after day. These extras are available to you if and when you need them. You're in charge.

Disease management programs

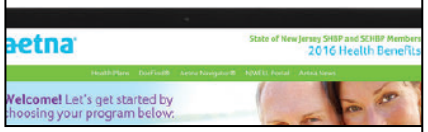
Personal attention for your health conditions so you can:

1. Manage your conditions and lower risk for new conditions
2. Work better with your doctor
3. Take your medicine safely

Informed Health

Sometimes, a phor
the difference. You
registered nurse 2-

1. Learn about
2. Find out mor
test or proce
3. Get help prep
doctor's visit



Aetna Navigator® site

Aetna Navigator is our secure member website for convenient access to tools and resources:

- Check the status of a claim
- Print Explanation of Benefits (EOB) statements
- Request ID cards and print temporary ID cards
- Check benefits and coverage
- Get special discounts, like eyewear and hearing
- Request a provider directory

It's easy. **Visit aetnastatenj.com.** Scroll down to Health and wellness benefits, open the Aetna Navigator website section and then click on the Aetna Navigator website link. Select "Login" and "Register Now."

Other

- Acupu
for sur
covere
- Compr
covere
- Private
covere

How do you reduce the risk of stroke, heart attack and kidney failure in Medicare beneficiaries? Make some phone calls.

Hypertension Disease Management Program

Using automated technology to combat hypertension in older adults.

Approximately 59% of the Medicare population has hypertension, which is a significant but manageable risk factor for catastrophic cardiovascular events.[1] So, Aetna set out to do something about it.

The result? A Hypertension Management Program so innovative and successful, it was cited by *Time* Magazine[2] and is now available to all Aetna Medicare Advantage members with high blood pressure.

Horizon Sample Communications

Let's take the confusion out of Medicare.

Horizon.
Horizon Blue Cross Blue Shield of New Jersey

JOIN US.

Attend a meeting near you.

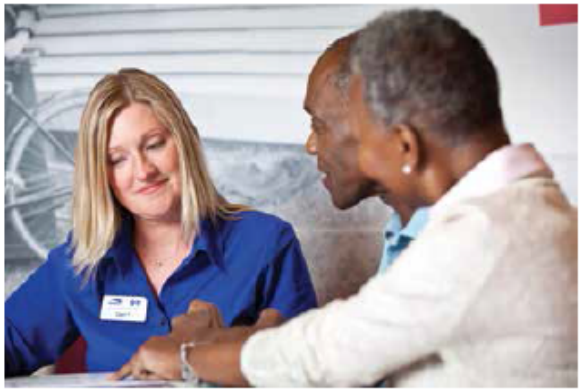
Medicare can sometimes come with more questions than answers. That's why we're here to help.
The information covered will include:

- How Medicare works.
- Understanding when you can enroll.
- Available plan options.
- And more.

This is a great opportunity to get your questions answered and find out more about all the different Medicare health plan options available to you.

Sign up for a meeting today!

MONTH 20, 2015
Location, 123 Anystreet, Town, NJ 12345
X:00 p.m. to X:00 p.m.



WE'RE HERE TO HELP.

To secure your spot or arrange accommodations for persons with special needs, call:

1-888-328-4423
(TTY/TDD #: **711**)
Monday through Sunday, 8 a.m. to 8 p.m., Eastern Time.
A sales person will be present with information and applications.

To register for a meeting online, visit:
MeetHorizon.com

Horizon Sample Communications (cont.)

Horizon

Horizon Blue Cross Blue Shield of New Jersey

FIND A HEALTH CARE PROFESSIONAL WHO PARTICIPATES IN THE BLUE MA PPO NETWORK

Horizon Blue Cross Blue Shield of New Jersey makes it easy to find a Medicare Advantage PPO participating doctor, hospital, ancillary facility or other health care professional located outside of New Jersey. You can search for a doctor by his or her last name, ZIP code or specialty.

Visit the National Doctor and Hospital Finder at **Provider.**

- Enter the first 3 letters of your member ID number from your member ID card. These letters are: **YKK**.
- Choose your network from the list: **Medicare Advantage PPO**.
- Select your plan from the list: **New Jersey, Horizon Blue Cross and Blue Shield**.
- Enter any additional search criteria

MP

Horizon

Horizon Blue Cross Blue Shield of New Jersey

DON'T LET THE FLU CATCH YOU.

Protect yourself during the cold and flu season!

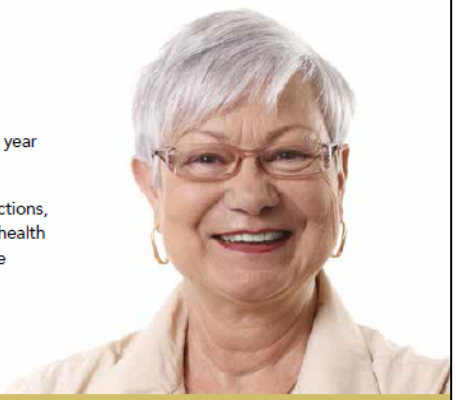
The flu shot is your best defense against getting the flu.
Don't Delay...Call your doctor for a flu shot today.

Now is a good time to schedule your annual flu shots. Flu season can start as early as October and most often peaks in January/February. You should get a flu shot each year to protect yourself from getting the flu.

The flu usually lasts about a week to 10 days. It can lead to more dangerous lung infections, such as pneumonia, mainly among people 65 years and older, and those with certain health issues. Symptoms of the flu usually come on faster and harder than a cold, and include fever, body aches and a great need for rest.

People age 50 or older have a higher risk of getting the seasonal flu and should get the flu shot.

(over, please)



SHBP/SEHBP

Appendix B – Sample Deliverable: Briefing for the Kentucky Group Health Insurance Board

Project Abstract Sample Deliverable #2:
KY Strategy and Redesign

Commonwealth of Kentucky

Kentucky Employees' Health Plan

Briefing

Kentucky Group Health Insurance Board

May 2014

Prepared by Consulting
Health and Benefits

AON Hewitt

Today's Discussion

- Health Care Reform Update
  - KEHP Plan Impacts for 2015 and beyond
- An Early Look at 2014 KEHP Plan Performance
  - Wellness Update
  - 2014 Plan Migration
  - Q1 2014 Medical Plan Performance
  - Q1 2014 Drug Plan Performance
- What Other States are Doing

Health Care Reform Update

AON Hewitt

KEHP Plan Impact for 2015 and Beyond

Reform Requirement	Year	Explanation	Impact/Compliance Status
1. Employer Responsibility to Provide Affordable Minimum Essential Health Coverage	2015 and beyond	Employers that employ an average of at least 50 full-time employees during the prior calendar year: 1) Offer minimum essential coverage(MEC) 2) Offer at least 1 plan with minimum 60% actuarial value 3) Offer Affordable Coverage - the lowest contribution for single coverage cannot exceed 9.5% of the household income 4) Offer to all full-time employees (FTE) - by HHS definition, FTEs are those who regularly work 30 hours or more per week, measured monthly **Penalty** 1) $2,000 per FTE for failing to offer MEC to FTEs ▪ Penalty applies if MEC is offered to less than 70% of FTEs in 2015, and less 95% of FTEs after 2015. ▪ Penalty applied if at least one FTE receives a premium credit through public exchanges. ▪ Subject to an exemption for the first 30 FTEs. ▪ Not tax deductible. 2) $3,000 per FTE if MEC is unaffordable or does not provide a 60% Actuarial Value ▪ Penalty applies to each FTE who enrolls in an Exchange and receive a federal subsidy. ▪ Not tax deductible.	No material impact on KEHP as all plans meet the requirement ▪ KEHP plans already offers MEC ▪ All four plans have actuarial values higher than 60% ▪ 2014 Standard CDHP Single Tier Contribution is only $12.98 per month ▪ Employers need to ensure that MEC is offered to all FTEs

KEHP Plan Impact for 2015 and Beyond

Reform Requirement	Year	Explanation	Impact/Compliance Status
2. Patient Centered Outcomes Research Institute (PCORI)fee	2012 – 2019	PCORI fee helps fund research that evaluates and compares health outcomes, clinical effectiveness, and the risks and benefits of medical treatments and services. The fee is $1 PMPY for 2012, $2 for 2013 and indexed for medical inflation after 2013. Payment must be submitted by July 31 of the calendar year immediately following the last day of the plan year.	2013 fee paid in July 2014 is expected to be around $500,000 using the snapshot factor methods.
3. Transitional Reinsurance Fee	2014 - 2016	The transitional reinsurance fee is a per capita fee used to stabilize individual market premiums. The fees are set at $63 per covered life for 2014, and $44 for 2015. The fee is likely to be lower for 2016. HHS will collect the reinsurance payment for each year in two installments. The first payment is due by January of the following year, and the second payment will be payable in the fourth quarter of the following year. The 2014 and 2015 payments are as follows: ▪ $52.50 PMPY due in January 2015 ▪ $10.50 PMPY due in the 4th quarter of 2015 ▪ $33.00 PMPY due in January 2016 ▪ $11.00 PMPY due in the 4th quarter of 2016	Estimated payment are $16M for PY 2014 (paid in CY2015), and $11M for PY 2015 (paid in CY2016).

KEHP Plan Impact for 2015 and Beyond

Reform Requirement	Year	Explanation	Impact/Compliance Status
4. Individual Mandate to Purchase Insurance or Pay Penalty	2014 and beyond	All individuals and their eligible dependents are required to maintain minimum essential coverage or pay tax penalties as follows: ▪ 2014: $95 or 1 percent of household income whichever is greater. ▪ 2015: $325 of 2 percent of household income whichever is greater. ▪ 2016: $695 or 2.5 percent of household income whichever is greater. The penalty is payable on tax return for the year in which the penalty was incurred.	As the amount of tax penalties increase over time, the KEHP plans could attract more uninsured employees.
5. Annual OOP Limits Capped	2014 and beyond	Annual limitation on out-of-pocket maximum applies to all non-grandfathered group health plans. ▪ Includes all in-network costs shares: deductibles, coinsurance, copays, referenced-based differentials. ▪ Allows separate pharmacy and medical out-of-pocket maximum, as long as the cumulative total does not exceed the annual OOP limits 2014 ACA limit: $6,350 Single and $12,700 Family 2015 ACA limit: $6,600 Single and $13,200 Family 2014 ACA matches 2014 HSA. For 2015 (and beyond), the ACA maximum annual limit will no longer be tagged the HSA maximum OOP limit. Each will be indexed based on separate calculations in future years.	The current 2014 design is already in compliance

KEHP Plan Impact for 2015 and Beyond

Reform Requirement	Year	Explanation	Impact/Compliance Status
6. Increased Cap on Rewards for Participation in Wellness Program	2014 and beyond	The maximum permissible employer wellness program incentive to participants based on an individual's satisfying a standard related to a heath status factor is increased to 30% of the cost of coverage. For wellness program designed to prevent or reduce tobacco use, the maximum reward is increased to 50% of the cost of coverage.	Current KEHP incentive is not tied to a health status; therefore, the cap doesn't apply.
7. Employer Reporting of Health Insurance Information to Government and Participants	2015 and beyond	Employers and group health plans must provide certain disclosures to IRS and participants under the Internal Revenue Code to establish compliance with the employer mandate and the individual mandate. ▪ Reporting an Individual's Enrollment in Minimum Essential Coverage (MEC). ▪ Reporting an offer of affordable MEC to FTEs.	The regulations apply to calendar years beginning after December 31, 2014. Employers will not be subject to any penalties for failing to comply for 2015 if employers timely file report by the applicable due dates in 2016.
8. Auto-Enrollment	TBD	Requires that newly hired employees be automatically enrolled in coverage.	Delayed; pending guidance.

KEHP Plan Impact for 2015 and Beyond

Reform Requirement	Year	Explanation	Impact/Compliance Status
9. Excise Tax on High-Cost Coverage	2018 and beyond	Beginning in 2018, insurers (including TPAs for self-insured plans) pay a 40% excise tax on the aggregate value of the portion of employer-sponsored insurance in excess of thresholds. Thresholds for actives and post-Medicare retirees are: ▪ $10,200 for single coverage in 2018 ▪ $27,500 for family coverage in 2018 ▪ Thresholds indexed at CPI-U (plus 1% in 2019 only) ▪ Higher thresholds for high-risk occupations, telecom workers and pre-65 retirees 2018 thresholds will be adjusted upward if the cost of the standard benefit option for federal employees increases more than 55% between 2010 and 2018 (i.e., annual effective trend of 5.6%). Coverage subject to tax includes medical, health FSA or HRA and employer (or employee salary reduction) HSA contributions ▪ Fully-insured vision and dental coverage is not subject to the tax ▪ Currently, self-insured dental and vision are included by legislative text, but that is expected to change by 2018 Excise Tax is not tax deductible.	Will be highly impacted by actual claims cost trend and plan design changes in the next few years.

An Early Look at 2014 KEHP Plan Performance

AON Hewitt

Wellness Update

What is the LivingWell Promise?

- If the member chooses one of the KEHP LivingWell plans, they are making a LivingWell Promise and agree to:
  - Complete online HumanaVitality® Health Assessment between January 1, 2014- May 1, 2014 and
  - Keep contact information (i.e. mailing address, phone number, and email) current in KHRIS or, if a retiree, keep contact information current with your retirement system.

Year to Date Result

- More than 131,000 members have completed Health Assessment by May 1 (over 97% fulfillment).
- Twice as many members as last year have completed the Vitality Check® (biometric screening), which is not required of LivingWell plan holders.
- Over 32,000 members participated in Humana Vitality HealthyFood Program

2014 Plan Migration

- Close to 60% employees stayed in the PPO plans
- Over 40% employees enrolled in CDHP plans
- Over 80% employees enrolled in LivingWell plans and are required to complete LivingWell Promise

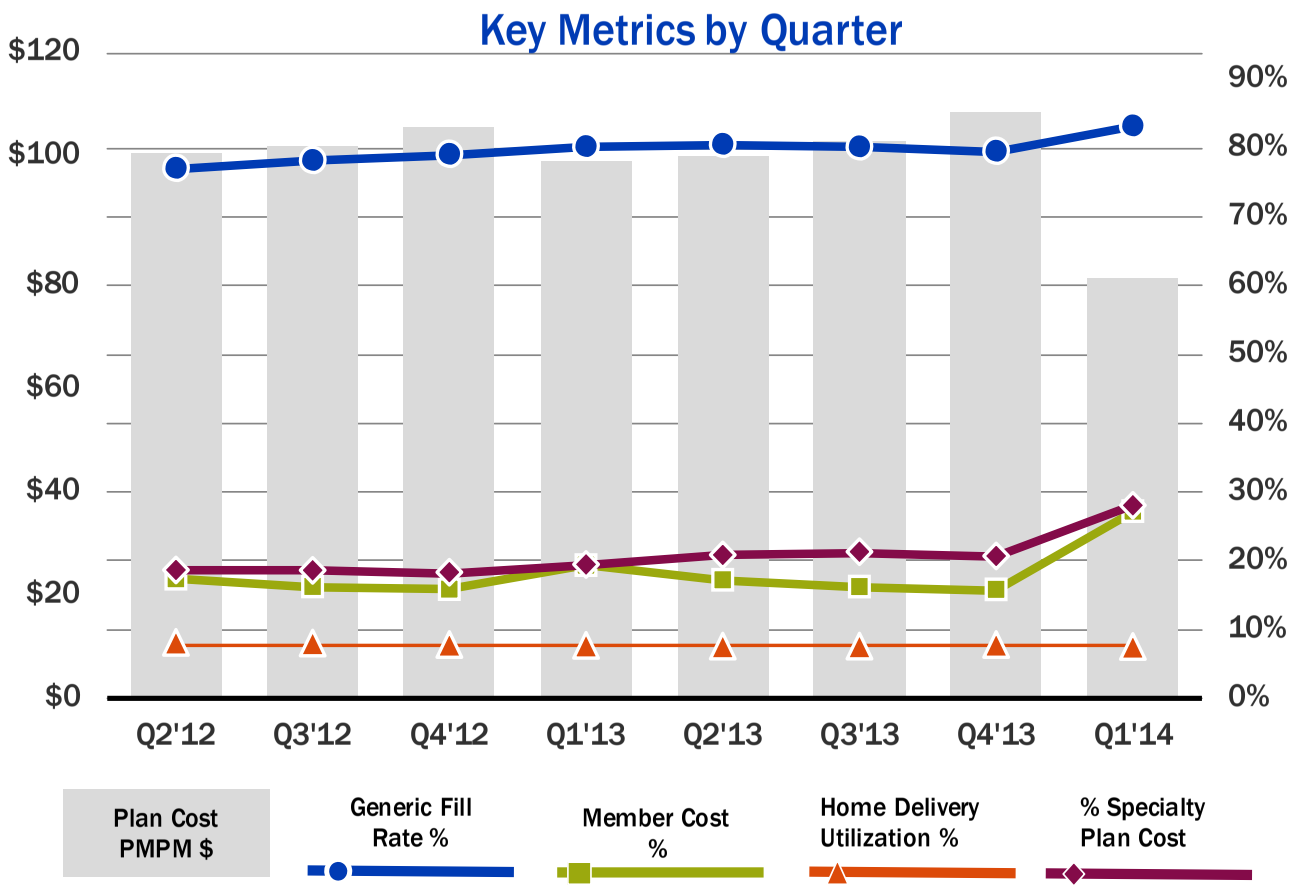
	Standard CDHP	Standard PPO	LivingWell PPO	LivingWell CDHP
Standard PPO	35%	19%	11%	35%
Maximum Choice	15%	2%	7%	76%
Capitol Choice	11%	8%	45%	36%
Optimum PPO	4%	5%	65%	26%
Total	9%	7%	51%	33%

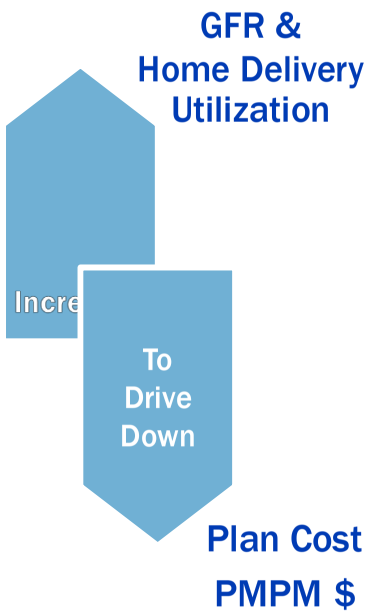
Q1 2014 Medical Plan Performance

- Allowed claims cost per admit and per visit both increased from last year
- This was offset by the number of admits and visits decreasing from last year
- Net impact on plan paid cost is a -20% change from last year; however, the new plan designs will have more seasonality given the HRA components as well as members understanding their new benefits

Key Metrics	Current - Incurred Jan 2014 Paid Mar 2014	Prior - Incurred Jan 2013 Paid Mar 2013	Difference	Variance
Allowed Amt	$ 94.2M	$ 102.7M	$ (8,425,836.05)	-8%
Net Paid	$ 68.1M	$ 85.0M	$ (16,928,787.93)	-20%
Allowed Amt Per Admit	$ 71.3K	$ 70.2K	$ 1,165.14	2%
Net Paid Per Admit	$ 51.5K	$ 58.1K	$ (6,569.64)	-11%
Allowed Amt Per Visit	$ 348.07	$ 318.76	$ 29.30	9%
Net Paid per Visit	$ 251.42	$ 263.91	$ (12.50)	-5%
Allowed Amt PMPM	$ 353.46	$ 382.25	$ (28.79)	-8%
Net Paid PMPM	$ 255.31	$ 316.48	$ (61.16)	-19%
Admits	1,321	1,463	(142)	-10%
Visits	270,756	322,079	(51,323)	-16%
Days	6,003	6,075	(72)	-1%
ALOS	4.54	4.15	0.39	9%
Admits per 1000	59.45	65.36	(5.91)	-9%
Visits per 1000	12185.97	14389.93	(2,203.96)	-15%
Days per 1000	270.18	271.42	(1.24)	0%

Q1 2014 Drug Plan Performance





Drug Plan Top Line Performance Metrics (Q1 2014 vs. Q1 2013)

- Plan Cost PMPM is $81.76, a -21.5% change over the previous period which takes into account member cost share (the change is -12.9% of allowed costs PMPM)
- Generic Fill Rate (GFR) increased 3.0 percentage points to 83.3% which saved almost $5.6 million
- Retail 90 utilization increased from 18.4% to 20.3%
- Plan Cost PMPM trend on specialty drugs is 13.5%, compared to a - 29.8% Plan Cost PMPM trend on non-specialty drugs
  - There are 2,252 unique specialty patients, a decrease of 159 specialty patients over the previous period
  - 10 of the top 25 are specialty drugs
  - Top 25 specialty drugs represent 21.3% of total Plan Cost and comprise 13 indications
- Top 25 drugs represent 39.6% of total Plan Cost and comprise 16 indications

Q1 2014 Compass SmartShopper Program Update

- Q1 2014 8.7% of members shopped for medical services and 2.1% of those members selected a cost effective option
- Q1 2014 net plan saving is approximately $0.5M
- Potential Savings is close to $20M for Q1 2014 if 100% redirection rate achieved

Cost Avoidance Summary							
	Gross Savings	Incentives	Medical Savings	Incentive ROI	Admin Fee	Net Savings	Cases
March MTD	$265,749	$27,550	$238,199	865%	$80,323	$157,876	299
2014 YTD	$769,741	$83,980	$685,761	817%	$234,017	$451,743	915

Conversion Rate Summary		Conversion Rate Definitions
Shopping Rate	8.7%	The rate at which members search online or via call center compared to claims volume
Conversion Rate	23.8%	The percentage of members who opt to take the incentive after shopping with Compass
Redirection Rate	2.1%	The total percent of all claims that were redirected to a lower-cost location
Net Savings Per Search	$178	The actual average savings each time someone shops with Compass
Net Savings Per Incentive	$749	The actual average savings for each incentive earned

What Other States Are Doing?

Tennessee's "Partnership Promise" Benefit Design:

- Tennessee offers two plans— Standard PPO and Partnership PPO. The Partnership PPO had the same level of benefits as the Standard PPO, but lower premiums and more generous cost sharing.
- "Partnership Promise" required an online health assessment in 2011.
- 2011 enrollment/engagement in program:
  - 79% made the "Partnership Promise"
    - 90% of those achieved the "Partnership Promise" (took the health assessment)
- In 2013, "Partnership Promise" required both the online health assessment *and* identified wellness activities. All new employees hired after January 1, 2013 are required to take the online health assessment and biometric screening within 120 days.

Georgia's "Wellness Promise" Benefit Design:

- Georgia offers six plans— three Standard plans and three Wellness plans. Wellness plans provide better benefits and lower premiums.
- The "Wellness Promise" required an online health assessment *and* a biometric screening in 2012.
- 2012 enrollment/engagement in program:
  - 60% made the "Wellness Promise"
    - 70% of those achieved the "Wellness Promise" (took the health assessment and completed the biometric screening)
- In 2013, the "Wellness Promise" again required both the health assessment *and* a biometric screening.

Questions and Comments