Tammy Tomczyk, FSA, MAAA

Oliver Wyman
411 East Wisconsin Avenue, Suite 1600
Milwaukee, WI 53202-4419
414 223 7988 Fax 414 223 3244
tammy.tomczyk@oliverwyman.com
www.oliverwyman.com

OLIVER WYMAN

April 9, 2012

Department of Administration
Purchasing Division
Building 15
2019 Washington Street, East
Charleston, WV 25305-0130

Subject:
Proposal for West Virginia Offices of the Insurance Commissioner, RFP #INS 12001

Dear Ms. Murray:

Enclosed please find separately labeled packages containing Oliver Wyman Actuarial Consulting, Inc.'s response to the West Virginia RFP #INS 12001.

We have registered with the Purchasing Division and paid the $125 fee to become registered with the State of West Virginia. Our Vendor ID is ***709003154**.

If you have any questions regarding our proposal response, or any other matter, please feel free to give me a call. My direct line is 414 223 7988.

Sincerely,

Tammy Tomczyk, FSA, MAAA
Principal and Consulting Actuary

State of West Virginia
Department of Administration
Purchasing Division
2019 Washington Street East
Post Office Box 50130
Charleston, WV 25305-0130

Request for Quotation

RFQ NUMBER	PAGE
INS12001	1

ADDRESS CORRESPONDENCE TO ATTENTION OF:
SHELLY MURRAY
304-558-8801

VENDOR
RFQ COPY
TYPE NAME/ADDRESS HERE

SHIP TO
INSURANCE COMMISSION

1124 SMITH STREET
CHARLESTON, WV
25305-0540 304-558-3707

DATE PRINTED	TERMS OF SALE	SHIP VIA	F.O.B.	FREIGHT TERMS
03/20/2012				

BID OPENING DATE: 04/10/2012 BID OPENING TIME 01:30PM

LINE	QUANTITY	UOP	CAT. NO.	ITEM NUMBER	UNIT PRICE	AMOUNT
				---------- ADDENDUM NO. 1 ----------		
				THIS ADDENDUM IS ISSUED TO ADDRESS QUESTIONS RECEIVED PRIOR TO THE QUESTION SUBMISSION DEADLINE OF 02/28/2012		
				BID OPENING DATE EXTENDED:		
				FROM: 03/21/2012		
				TO : 04/10/2012		
				---------- END OF ADDENDUM NO. 1 ----------		
0001	1	LS	946-12	ACTUARIAL AND ECONOMIC MODELING SERVICES		

SEE REVERSE SIDE FOR TERMS AND CONDITIONS

SIGNATURE [signature] TELEPHONE 414-223-7988 DATE April 9, 2012

TITLE Principal FEIN 13-4147522 ADDRESS CHANGES TO BE NOTED ABOVE

WHEN RESPONDING TO RFQ, INSERT NAME AND ADDRESS IN SPACE ABOVE LABELED 'VENDOR'

RFP # INS12001
Addendum #1
Questions & Answers

1. Does successfully bidding on this project preclude us from bidding on follow-up work?

   Answer: No, the State operates an open bidding process.

2. Please verify that the state is anticipating making only one award under this RFQ.

   Answer: Yes, the State will be making one award.

3. RFQ Form – Should this form be included in the Cost Proposal?

   Answer: This is explained in the bid document.

4. RFP Section 2.5. Mandatory Requirements.

   "The firm shall have no conflict of interest with regard to any carrier that is actively writing individual or group health products in the West Virginia market."

   As one of the nation's largest independent actuarial consulting firms, we have contractual relationships with many health care providers and health insurers. As such, we routinely encounter situations where potential conflict of interests (or the appearance of conflicts) exist, and hence, have formal policies in place to mitigate and manage those situations.

   Utilizing our existing policies and our experience dealing with similar situations as a routine component of our business, we believe that any conflicts of interest relevant to the award of this contract can be mitigated to the satisfaction of the state.

   Let us know if this would be acceptable to the state.

   Answer: The State requests this as part of all bid packages.

5. RFP Section 3.3 Proposal Format, Attachment A, Deliverables
   The final sentence reads "The final report is due." Please provide the due date.

   Answer: This is based on the award of the contract.

6. RFP section 3.3 Proposal Format, Attachment A, Key Personnel
   How does the state define "Key Personnel"?

   Answer: Key Personnel – Persons assigned to the project.

7. RFP Section 3.3 Proposal Format, Attachment E

   Attachment E: Specific deliverables as outlined.

   Attachment E was not provided with the RFQ.

Answer: This is a typographical error. There is no Attachment E Please refer to Attachment A.

8. Attachment C: Cost Sheet

   The cost proposal includes a line for "Section 2.4.5 Vendor Experience". Please explain what tasks this cost estimate would include.

   Answer: A revised cost sheet is attached.

9. Please provide the expected budget for the project.

   Answer: That information is not available.

10. Please provide the states expected timeline for the project.

    Answer: The timeline will be established after the award of the contract.

11. Please provide an estimate of the amount of on-site assistance being requested (i.e., meetings, presentation of deliverables, etc.).

    Answer: The Vendor will provide this information based on the bid.

12. Does the state have any prior reports/studies/papers that it will make available to the bidders?

    Answer: The WVOIC website (www.wvinsurance.gov) has reports, studies and papers and a link to the Health Benefit Exchange.

13. Does the state have information on residents working out-of-state as well as the number of non-residents

    Answer: WVOIC does not have this information.

14. Has the state conducted an internal review of the data it has available? If so, will the state provide the bidders with a description of these data sources?

    Answer: WVOIC has conducted no review.

15. Will all bidder questions be released?

    Answer: Yes.

16. What is the amount of funding available for this contract?

    Answer: That information is not available.

17. What data will the State make available to the vendor for this contract?

    Answer: WVOIC will work closely with the successful vendor.

18. Many of the subtasks could be addressed in more or less detail. What tasks constitute the State's highest priorities for this work?

    Answer: All tasks are a priority.

19. Task 2.4.1.e (p. 12) requires carrier and producer information. Will the Insurance Commission conduct a data call to obtain this information? Should the bid assume that the vendor would prepare the data call and follow up with carriers as necessary?

    Answer: WVOIC will work closely with the successful vendor.

20. Task 2.4.1.f (p. 13) refers to "various reforms," "specified market changes and policy decisions," and "various legislative and policy decisions." Could the State provide an estimate of the number of options that would be modeled?

    Answer: No.

21. Task 2.4.3.b.iii (p. 16) refers to "an incremental phase-in of the market reforms." Could the state clarify the years over which this phase-in might occur?

    Answer: The Exchange is expected to be operational January 1, 2014

22. With respect to Task 2.4.1.e.ii, subpart b) (p. 13), could the State clarify what types of estimates of commission structure and compensation ranges it is looking for? For example, commission structures and ranges in other states, or other commissions in West Virginia?

    Answer: The successful Vendor will research and provide this information to the State.

23. With respect to Task 2.4.1.e.ii, subpart c) (p. 13), could the State clarify the question(s) it wants addressed or the measures it is asking to see in the 20-year analysis?

    Answer: The successful Vendor will research and provide this information to the State.

24. How should the vendor anticipate the level of effort required for *ad hoc* work?

    Answer: The responding Vendor should determine the effort required and provide this information to the State.

25. Has the State hired any vendors previously for similar kinds of work, and if so, please specify whom and when?

    Answer: No, WVOIC has not hired any vendors previously for the type of work that is requested in this RFP.

26. Page 20 of the RFQ mentions "Specific deliverables are listed in Attachment E." We are unable to locate Attachment E in the RFQ.

    Answer: This is a typographical error. There is no Attachment E. Please refer to Attachment A.

27. Does Attachment E contain a timeline for the deliverables, and if not, do you have one?

    Answer: This is a typographical error. There is no Attachment E. Please refer to Attachment A.

28. In the cost proposal, do we need to break out the flat fee for Section 2.4.1, 2.4.2 and 2.4.3?

    Answer: Yes, it is WVOIC's desire that this information be provided.

29. Should travel expenses be included in our flat fee bid?

    Answer: Yes.

30. How many days of on-site meetings should the vender assume for this project?

    Answer: Unknown.

31. Are surveying services included in this actuarial and economic RFP. If surveying is outside this RFP, are you expecting a separate bid to be developed for these services?

    Answer: Survey is described at Item 2.4.1 (e) (i) (p. 12-13). It is desired that the successful vendor provide the qualitative and quantitative analysis of the current health insurance marketplace in West Virginia. Include an analysis of the impact and or a recommendation as to whether state law shall require that all comprehensive health insurers participate in the Exchange. It will be at the successful vendor's discretionary expertise as to how to best create this information for the State.

32. When does the WVOIC expect to conclude its review of proposals and selection of the winning bidder? Does the WVOIC have an estimated date for when work would start?

    Answer: This is a priority project and the process will be completed in a timely manner. There is no estimated start date.

33. Item 2.4.1 (a) Study of the Uninsured and Underinsured in West Virginia requests a quantitative analysis of the underinsured. Can the WVOIC provide guidance on how it will define "underinsured" so that bidders may assess the information needs to perform such an analysis?

    Answer: The successful vendor will research and provide this information to the State.

34. Item 2.4.1 (b)(ii) requests a study of coverage trends, past and projected, by market, geography and income. Can more information around this requested analysis be provided and the metric(s) you are seeking information for? For example, are you seeking enrollment trends, premium trends, etc.? Would you consider a shorter historical period than 10 years as depending upon the metrics requested it may require a carrier data call and we suspect many carriers will have archived data that old from their systems?

    Answer: No, this is a firm bid specification.

35. Item 2.4.1 (b)(iii) indicates that in modeling the impact that the ACA will have on enrollment in public programs such as Medicaid the selected contractor should take into account studies that have already been conducted by other West Virginia State agencies such as DHHR. Can you provide more information about the content and timing of these studies and, if publicly available provide copies of related reports or a link to a website where they are located?

    Answer: WVOIC does not have this information.

36. Item 2.4.1 (c)(i) requests a quantitative analysis of the number of small groups in West Virginia and indicates the information should be "stratified by the following criteria" however no criteria are listed. Can you please provide the criteria you seeking be used?

    Answer: This item is defined in the section specified in this question.

37. Item 2.4.1 (c)(ii) requests estimates for 2014-2016 for the small group market.

    - Can you clarify the metric for which you are requesting estimates by group size (e.g. members, employees, premium, etc.)?

      Answer: All metrics need to be applied.

    - Can you clarify what is meant by "single risk pool and separate risk pool," particularly in light of the fact that beginning in 2014 the ACA requires all small groups up to 100 (unless the state elects to implement its current definition until 2016) must be pooled for rate setting purposes?

      Answer: The successful Vendor will research and provide this information to the State. This item is defined in the section specified in this question.

    - Based on the layout it appears that the sub-bullet items number 1 through 6 (household income, household size, etc.) apply only to 101+ employee markets. Please confirm that whether this is correct or not.

      Answer: Yes, item 2.4.1 (c)(ii) Sub-bullet items number 1 through 6 refer to the other employee markets: a) 1-25 b) 26 -50 c) 51-100 and d) 101 +.

38. Item 2.4.1 (c)(iii) requests an analysis of West Virginia residents who work out of state and out of state residents that work in West Virginia. While we have access to information that will allow us to size these populations by income, age, gender state of residence, state of employment, and type of insurance coverage (i.e.. Individual, employer, uninsured, Medicaid) we are not aware of readily available information that will allow us to analyze the type of health plans offered with participation rates by provider without significant efforts required to attempt to gather this information both in West Virginia and in other states for those covered by employer plans in other states. Does the WVOIC have any information in this regard that will be made available to the winning bidder? Would you consider limiting this analysis to the

    Answer: WVOIC does not have in-state and out-of-state workforce information. "Would you consider limiting this analysis to the" - Vendor question was incomplete. WVOIC is unable to respond.

39. Item 2.4.1 (c)(iii)(a) requests an analysis related to pooling risk with surrounding states. Can you provide more information on this item what is meant by pooling risk. Are you referring to pooling the experience of West Virginia policyholders with the experience of policy holders in other states for purposes of developing rates? If so, are you referring to such pooling occurring even if a carrier's West Virginia experience is fully credible?

    Answer: The successful Vendor will research and provide this information to the State.

40. Please clarify item 2.4.1 (c)(iv) which asks for a projection of the number of employers that may not participate in the SHOP and the impact it will have on the individual market. We are confused by this item because it is our understanding that a group's decision to participate in the SHOP or the small group market outside the exchange will not impact the individual market given rates in the small group are developed independently of rates in the individual market, and even if the individual and small group markets are merged for rating purposes the rates inside and outside the exchange must be the same so employers decision as to whether to purchase coverage in the SHOP or outside market will not impact individual rates.

    Answer: The successful Vendor will research and provide this information to the State.

41. With regard to item 2.4.1 (c)(vi), does the WVOIC have information related to efforts the State has taken to provide assistance to small employers that will be shared with the winning bidder?

    Answer: WVOIC does not have this information.

42. For item 2.4.1 (d)(iv) please provide more information as to what is meant by "transition of current and future consumers of the Exchange."

    Answer: This item is defined in the section specified in this question.

43. For item 2.4.1 (e) will the WVOIC be able to mandate that carrier's respond to a survey conducted by the winning bidder? Likewise, for item 2.4.1(f) we would like to propose a data call to WV carriers in order to assist in calibrating our microsimilation model to the West Virginia premiums, claims, current rating practices, etc. as in our opinion this will lead to better modeling results that more accurately reflect the WV market. Will the WVOIC be able to require that carriers to respond to such a request?

    Answer: WVOIC will work closely with the successful bidder.

44. For item 2.4.1 (f)(ix), please clarify what is meant by "analyze risk adjustment methodologies" . For example, given a detailed comparison of various risk adjustors which includes modeling impacts of various risk adjustment methods on various populations, assessing various implementation methods and the impact it may have on premiums, etc. is a very large project in itself, please confirm that for this sub-item you are simply seeking a comparison of different risk adjustment options available to the state with discussion around how they would function, impact carriers, etc in order for the WVOIC to make decisions around further analysis required to select and implement a risk adjustment option.

    Answer: The successful Vendor will research and provide this information to the State.

45. For item 2.4.1 (f)(xi) please provide further detail as to what is meant by "various reforms." Can you provide examples of the types of reforms that must be analyzed and how analyzing the impact of these reforms on premiums differs from the items requested in item 2.4.2.

    Answer: The successful Vendor will research and provide this information to the State.

46. For item 2.4.1 (f)(xii) please clarify whether the winning bidder must simply develop the methodologies that could be used to measure the cost of mandated benefits or whether the winning bidder will also have to perform the analysis to assess the cost. Also, it appears this question may have been included to assess costs the State may be required to cover for mandated benefits that were not included in the essential health benefit (EHB) package for individuals covered through the exchange. However, with recent guidance from HHS indicating that it is likely that final regulations will allow states to select their own benchmark plans for the essential health benefit package such that the State would no longer be required to cover the cost of mandated benefits provided through the Exchange, would the WVOIC consider removing this item from the scope of work?

    Answer: The item referenced in this question is not the actual bid item 2.4.1(f) (xii) (p.14) which states – Model the impact of merging small and non-group markets.

47. For item 2.4.1 (xvii) please provide more detail as to what is meant by "analyze" the various rating factors listed which will be allowed after 2014. Will the winning bidder be asked to gather pricing and claims information from carriers and perform analysis to determine how rating regions defined by the states will impact their rates which is a significant project in itself?

    Answer: For item 2.4.1 (f) (xvii) (p.14)–Yes, that will be some of the analysis. The successful vendor will research this and related items in the section and provide this information to the State.

48. For item 2.4.3 (4) please clarify whether the statement "impact on existing state programs" requires a qualitative response or whether a comprehensive financial analysis is being requested.

    Answer: For item 2.4.3 (4) (p.15) - Impact on Existing State Programs: Assess the cost impact of an Exchange on other State programs, and

    This is number 4 of 4 general tasks associated with broad organizational issues related to the Exchange within the context of item 2.4.3. It is desired that the successful vendor provide the research associated with assessing the cost impact of the Exchange on other State programs, and

49. Please confirm that for item 2.4.3 (b) when it states "quantitative impact" you are not requesting actuarial and economic modeling of the various items listed but rather consultative advice as to how each of the items listed may impact the Exchange.

    Answer: Item 2.4.3 (b) (p. 16) WVOIC is asking the successful vendor to advise the State on the qualitative and quantitative impact of various options around the major policy decisions, providing the best and worst case scenarios and with phasing

recommendations. At a minimum, this would include: items (i-xiii). It will be at the successful vendors' discretionary expertise as to how to best illustrate this advice for the State.

50. Related to items 2.4.3 (d)(i) and 2.4.3(d)(ii), there is a wide range of analysis that can be performed related to a basic health plan. This could range from assessing the number of individuals that could be eligible for the BHP and potential subsidies from the federal government to very comprehensive feasibility studies that some states are conducting as stand alone projects which have significant costs involving actuarial modeling which examines, morbidity costs of the BHP eligible population, relative cost differentials between commercial rates upon which the federal subsidies are based and Medicaid reimbursement levels at which claims will be paid, the impact on rates in the individual exchange of including/excluding BHP eligibles, etc., in order to assess whether it is feasible for the State. Please clarify the level of analysis the WVOIC is seeking for this item.

    Answer: Items 2.4.3 (d) (i) and 2.4.3(d) (ii) (p. 16) – Yes, WVOIC is asking for a wide range of analysis. It will be at the successful vendors' discretionary expertise as to how to best create this advice for the State.

51. For item 2.4.3 (d)(iii) please clarify that you are seeking a qualitative response and not financial modeling

    Answer: The successful Vendor will research and provide this information to the State.

52. For item 2.4.3 (d)(iv) please clarify that you are not requesting detailed financial modeling

    Answer: The successful Vendor will research and provide this information to the State.

53. For item 2.4.3 (d)(vii) please provide further information as to what is meant by "moving Medicare into the Exchange." Are you referring to traditional FFS Medicare or Medicare Advantage? Given a navigator type system is already in place (Medicare.gov) that allows Medicare eligible individuals to compare Medicare Advantage plans (benefits, premiums, out-of-pocket calculator, quality rankings, etc.) and enroll in the program of their choice, please explain the functions the Exchange would perform and the impact analysis being requested in this item.

    Answer: The successful Vendor will research and provide this information to the State.

54. Please confirm that the ad hoc services in item 2.4.4 are not being requested at this time, however the WVOIC would like to assess the bidder's ability to provide these services in the future and the cost associated with these services, assuming 1,500 hours of work were requested. Please clarify whether the bidder is committing to all of the services listed in item 2.4.4 for 1,500 hours or whether this amount is being used for proposal evaluation purposes and the winning bidder would be requested to provide specific cost estimates for ad hoc services as they arise until the 1,500 hours are used.

    Answer: The 1500 hours are for proposal evaluation purposes.

55. Our economic and actuarial microsimulation healthcare reform model is proprietary. Please confirm that although the WVOIC is requesting output/results from the modeling as well as copies of all data collected through primary research, you are not requesting a model.

    Answer: This is explained in Section 5 - Contract Terms and Conditions in the bid document, starting on page 23.

56. Section three of the RFP which describes the required response format refers to Attachment A and states "within the attached response sheet.." Are you requesting that bidders follow the format of Attachment A or list each of the questions/items and provide a response below each. If the later, can you provide an electronic version Attachment A in Word format to facilitate our response? Further, under the description of Attachment A there is a subsection related to deliverables. The last sentence reads "The final report is due." Is there an intended due date that is omitted from this sentence?

    Answer: It is WVOIC's desire that the vendor adhere to the order of the bid format. No, a word format is not available. The final report is based on the award of the contract.

57. There are several items being requested that relate to items in other sections of the RFP. As one example, item 2.4.3 (a)(ii) requests analysis of the impact of the federal mandate being deemed unconstitutional and this question would be answered using our microsimulation model and fit better with the economic modeling in item 2.4.1 (e). In addition, there are some items that are duplicated in later sections of the RFP. Please clarify whether bidders can organize the items in their response differently than in the order presented in the RFP as long as all items are covered. Or, would you prefer the response follow the same order and refer back to other sections of the response when certain tasks will be performed as part of a work process previously described?

    Answer: It is WVOIC's desire that the vendor adhere to the order of the bid format.

58. The RFP references Appendix E: Specific deliverables as outlined however there is no Appendix E attached to the RFP. Could you provide a copy of this Appendix?

    Answer: This is a typographical error. There is no Appendix E. Please refer to Attachment A.

59. For the cost sheet in Attachment C:
    - Please confirm that you are requesting a flat fee bid and that the cost should be listed separately for each of the projects listed with a total (indicated as Subtotal 1). While it is clear what is requested in terms of a cost for Sections 2.4.1, 2.4.2 and 2.4.3, please clarify what type of cost estimate you are seeking for Section 2.4.5 "Vendor Experience".

      Answer: A revised cost sheet is attached.

    - Please confirm that the row labeled "composite hourly rate" is to be the hourly rate applicable to the Ad Hoc services under 2.4.4 and not the blended hourly rate associated with the services under Sections 2.4.1, 2.4.2 and 2.4.3, which may be different

Answer: Yes.

- Please confirm that Subtotal 2 is to represent the product of the hourly rate times an estimate of 1,500 hours

  Answer: Yes.

60. The RFP is very comprehensive and the studies and items included are by far more than we have seen from any other state in terms of the volume and the detailed level of questions to be answered. Further, several of the sub-items listed could involve a wide range as to the level of analysis that could be performed and several could be interpreted to be significant projects themselves. Please clarify whether for RFP items which contain a long list of items to be analyzed or modeled (e.g. item 2.4.1 (f) or item 2.4.3 (b)) required prospective bidders are to assume that every item in the list is to be covered in the scope of work when developing their cost bids. Please provide this guidance to bidders so that they do not over-scope or under-scope the level of analysis desired by the WVOIC when preparing their cost proposals.

    Answer: The successful Vendor will research and provide this information to the State.

61. The words "analyze" and "assess" show up frequently throughout the RFP. Please clarify that any economic/actuarial microsimulation modeling is contained to item 2.4.3 (f) and that when these terms appear in other sections the level of quantitative analysis is anticipated to be at a higher level.

    Answer: The successful Vendor will research and provide this information to the State.

62. Please indicate whether the budget for the projects that are the subject of this RFP has changed from that included in the State's Level I grant application to HHS

    Answer: This information is not available.

63. Has the State performed any modeling to date that would be available to the winning bidder? If so, can you describe the analysis performed that will be made available?

    Answer: WVOIC has not performed any modeling or analysis.

64. Will bidders be allowed to suggest changes or alterations to the Terms and Conditions included in the RFP? Will including suggested changes in a bidder's response adversely impact how a bidder's proposal is scored?

    Answer: A bidder's failure to comply with a mandatory requirement will result in bid disqualification and changes or alterations of terms and conditions may impact proposal scoring. Proposed changes or alterations to the terms and conditions may necessitate the signing of a WV-96 or WV-96a form by the bidder. Copies of the WV-96 and WV-96a forms are attached to this addendum for your reference.

65. Does submission of a proposal obligate a bidder to execute a contract if awarded the work?

Answer: A bidder's submission of a proposal obligates the bidder to provide the services/goods contained in the proposal if awarded a contract. The submission of a proposal is considered a binding offer that will be accepted or rejected by the State with the issuance of a Purchase Order through the Purchasing Division. The issuance of a Purchase Order is the point at which a contract is consummated

66. Will a list of potential bidders submitting questions be available?

Answer: No.

67. If the proposer wishes to take exception to certain terms and conditions in the RFP, may those exceptions be included in the proposal? If so, where within the proposal should the exceptions be included? Will the State accept a Limitation of Liability clause?

Answer: A bidder's failure to comply with a mandatory requirement will result in bid disqualification and exceptions to terms and conditions may impact proposal scoring. Proposed exceptions to the terms and conditions may necessitate the signing of a WV-96 or WV-96a form by the bidder. Copies of the WV-96 and WV-96a forms are attached to this addendum for your reference. Any exception to the terms and conditions should be aggregated and included in a separate section of the RFP entitled exceptions. Each exception should expressly reference the term or conditions in the RFP that is affected.

68. Will the Contractor have access to Medicaid demographic and enrollment data? Are there other sources of information within various State agencies that the contractor may have access to?

Answer: WVOIC will work closely with the successful bidder.

69. What state insurance department data exists regarding premiums and coverages in the existing non-group and small group insurance markets? Does this information include satisfaction surveys?

Answer: WVOIC will work closely with the successful bidder.

70. Does the State have its own recent population/demographic and economic projections? If so, which demographic/economic characteristics are included in these studies?

Answer: WVOIC does not have this information.

71. Does the State anticipate the contractor will answer all the detailed questions in section 2.4.1? Alternatively, is the objective of 2.4.1 to identify the level of analysis necessary to satisfy the evaluation of design options (2.4.2) and Exchange –related organization and administration (2.4.3)?

Answer: Yes.

72. What preparation or other identifying of information technology expected Exchange business requirements has been performed by the State and will be available to the selected vendor to assist in its review?

Answer: WVOIC Website (www.wvinsurance.gov) has reports, studies and papers.

73. Who/what office will be liaison for the financial data, ownership of the proposed budgets, and assisting with the assumptions for the projected program financials? Has a high-level analysis of potential funding sources been completed? Does this office include the authority over taxes?

    Answer: Unknown.

74. The date and time of the submission is by 1:00pm Eastern Standard. The instructions further stipulate copies be mailed. Will electronic copies be allowed? If so, is PDF an acceptable format?

    Answer: No. Submissions must be mailed.

75. The RFP pricing spreadsheet separates the scope of work into fixed fee and ad hoc components. Is there a budget associated with the fixed-fee component of the project? If so, can the State indicate the budget amount associated with the fixed-fee component of the project? Further, can the State indicate what the expected budget for the ad hoc services may be, in addition to the hour budget already provided in the RFP?

    Answer: WVOIC Website (www.wvinsurance.gov) has reports, studies and papers.

76. Part of the scope extends beyond evaluation/feasibility. Is the project being funded by an evaluation grant or a level 1 grant? Is the State looking to tie the deliverable due dates of this project to successful receipt of the grant monies? Does the State anticipate needing assistance with grant applications?

    Answer: The WVOIC website (www.wvinsurance.gov) has reports, studies and papers and a link to Health Benefit Exchange information.

77. Is there a task force or work group established that the contractor will be in contact with? Who are the members of the Task Force and what Offices from the State do they represent?

    Answer: Please refer to the WVOIC website (www.wvinsurance.gov) linking to Health Benefit Exchange information.

78. On page 19, the RFP states that the firm shall have no conflict of interest with any carrier that is actively writing individual or group health products in West Virginia. Can the state clarify if an audit relationship would constitute a conflict if the engagement team had no relationship with such carriers?

    Answer: This could potentially create a conflict of interest. More information would be required about the nature of the relationship, such as the name of the carrier, whether the unit or division of the vendor in the business relationship with the WV carrier is the same units as would be performing the work under the subject RFP, and all other details which could be germane to determining whether a conflict of interest could potentially arise.

79. Can the state elaborate on the level of involvement that state personnel would provide? For example, in identifying state available data elements?

Answer: WVOIC will work closely with the successful bidder.

80. What minimal number of subsets has the State targeted based upon their review of the available and credible data?

Answer: All tasks are a priority.

81. Will the state accept evidence of qualification certifications of individual personnel to be provided at a later date by the successful vendor?

Answer: It is WVOIC's desire that all necessary documentation be provided by the bidder at the time of the submission of their bid.

82. In section 3.3, there is reference to "key personnel." Does the state have a definition of key personnel? Are these personnel expected to be onsite?

Answer: Key Personnel – Persons assigned to the project. On-site information is not available.

83. The time table for the scope of work is very broad. Does the state have an expected start and finish date for the fixed fee component of work (understanding that the ad hoc work is by definition is random)?

Answer: No.

84. Who are the current actuarial vendors being used by the Insurance Commission or any other agency of the State?

Answer: *We can only respond to the actuarial services utilized by the WVOIC. Currently, we have contracts with Merlinos & Associates Inc., Pinnacle Actuarial Resources, and United Health Actuarial Services.*

85. Who is on the Agency evaluation committee?

Answer: This information is not available.

86. Will the state make available or provide access to their data on health, health insurance, insured, uninsured, health care costs, insurance company financials, insurance company rate filings and rate reviews?

Answer: WVOIC will work closely with the successful vendor.

87. Will the state be using funding from the federal government?

Answer: This information is not available.

88. We do not have a copy of Attachment E. Please furnish.

Answer: This is a typographical error. There is no Attachment E. Please refer to Attachment A.

89. Are there start dates and target completion dates? We could not find in the RFQ. If they are in the RFQ, please direct us to the section.

Answer: The timeline will be established after the award of the contract.

State of West Virginia
Department of Administration
Purchasing Division
2019 Washington Street East
Post Office Box 50130
Charleston, WV 25305-0130

Request for Quotation

RFQ NUMBER	PAGE
INS12001	1

ADDRESS CORRESPONDENCE TO ATTENTION OF:
SHELLY MURRAY
304-558-8801

VENDOR
RFQ COPY
TYPE NAME/ADDRESS HERE

SHIP TO
INSURANCE COMMISSION

1124 SMITH STREET
CHARLESTON, WV
25305-0540 304-558-3707

DATE PRINTED	TERMS OF SALE	SHIP VIA	F.O.B.	FREIGHT TERMS
02/09/2012				

BID OPENING DATE: 03/21/2012 BID OPENING TIME 01:30PM

LINE	QUANTITY	UOP	CAT. NO.	ITEM NUMBER	UNIT PRICE	AMOUNT
				REQUEST FOR PROPOSAL THE WEST VIRGINIA PURCHASING DIVISION, FOR THE AGENCY, THE WEST VIRGINIA INSURANCE COMMISSION, IS SOLICITING PROPOSALS FOR PROFESSIONAL ACTUARIAL AND ECONOMIC MODELING SERVICES IN SUPPORT OF ALL ASPECTS OF PLANNING, IMPLEMENTATION AND DEVELOPMENT OF THE WEST VIRGINIA HEALTH BENEFIT EXCHANGES PER THE ATTACHED SPECIFICATIONS. TECHNICAL QUESTIONS MUST BE SUBMITTED IN WRITING TO SHELLY MURRAY IN THE WEST VIRGINIA PURCHASING DIVISION VIA MAIL AT THE ADDRESS SHOWN IN THE BODY OF THIS RFP, VIA FAX AT 304-558-4115, OR VIA E-MAIL AT SHELLY.L.MURRAY@WV.GOV. DEADLINE FOR ALL TECHNICAL QUESTIONS IS 02/28/2012 AT THE CLOSE OF BUSINESS. ALL TECHNICAL QUESTIONS RECEIVED, IF ANY, WILL BE ADDRESSED BY ADDENDUM AFTER THE DEADLINE.		
0001	1	LS		946-12 ACTUARIAL AND ECONOMIC MODELING SERVICES EXHIBIT 3 LIFE OF CONTRACT: THIS CONTRACT BECOMES EFFECTIVE UPON AWARD AND EXTENDS FOR A PERIOD OF ONE (1) YEAR OR UNTIL SUCH "REASONABLE TIME" THEREAFTER AS IS NECESSARY TO OBTAIN A NEW CONTRACT OR RENEW THE		

SEE REVERSE SIDE FOR TERMS AND CONDITIONS

SIGNATURE [signature] TELEPHONE 414.223.7988 DATE April 9, 2012

TITLE Principal FEIN 13-4147522 ADDRESS CHANGES TO BE NOTED ABOVE

WHEN RESPONDING TO RFQ, INSERT NAME AND ADDRESS IN SPACE ABOVE LABELED 'VENDOR'

State of West Virginia
Department of Administration
Purchasing Division
2019 Washington Street East
Post Office Box 50130
Charleston, WV 25305-0130

Request for Quotation

RFQ NUMBER	PAGE
INS12001	2

ADDRESS CORRESPONDENCE TO ATTENTION OF:
SHELLY MURRAY
304-558-8801

VENDOR
RFQ COPY
TYPE NAME/ADDRESS HERE

SHIP TO
INSURANCE COMMISSION

1124 SMITH STREET
CHARLESTON, WV
25305-0540 304-558-3707

DATE PRINTED	TERMS OF SALE	SHIP VIA	F.O.B.	FREIGHT TERMS
02/09/2012				

BID OPENING DATE: 03/21/2012 BID OPENING TIME 01:30PM

LINE	QUANTITY	UOP	CAT NO	ITEM NUMBER	UNIT PRICE	AMOUNT

ORIGINAL CONTRACT. THE "REASONABLE TIME" PERIOD SHALL NOT EXCEED TWELVE (12) MONTHS. DURING THIS "REASONABLE TIME" THE VENDOR MAY TERMINATE THIS CONTRACT FOR ANY REASON UPON GIVING THE DIRECTOR OF PURCHASING 30 DAYS WRITTEN NOTICE.

UNLESS SPECIFIC PROVISIONS ARE STIPULATED ELSEWHERE IN THIS CONTRACT DOCUMENT BY THE STATE OF WEST VIRGINIA, ITS AGENCIES, OR POLITICAL SUBDIVISIONS, THE TERMS, CONDITIONS, AND PRICING SET FORTH HEREIN ARE FIRM FOR THE LIFE OF THE CONTRACT.

RENEWAL: THIS CONTRACT MAY BE RENEWED UPON THE MUTUAL WRITTEN CONSENT OF THE SPENDING UNIT AND VENDOR, SUBMITTED TO THE DIRECTOR OF PURCHASING THIRTY (30) DAYS PRIOR TO THE EXPIRATION DATE. SUCH RENEWAL SHALL BE IN ACCORDANCE WITH THE TERMS AND CONDITIONS OF THE ORIGINAL CONTRACT AND SHALL BE LIMITED TO TWO (2) ONE (1) YEAR PERIODS.

CANCELLATION: THE DIRECTOR OF PURCHASING RESERVES THE RIGHT TO CANCEL THIS CONTRACT IMMEDIATELY UPON WRITTEN NOTICE TO THE VENDOR IF THE COMMODITIES AND/OR SERVICES SUPPLIED ARE OF AN INFERIOR QUALITY OR DO NOT CONFORM TO THE SPECIFICATIONS OF THE BID AND CONTRACT HEREIN.

OPEN MARKET CLAUSE: THE DIRECTOR OF PURCHASING MAY AUTHORIZE A SPENDING UNIT TO PURCHASE ON THE OPEN MARKET, WITHOUT THE FILING OF A REQUISITION OR COST ESTIMATE, ITEMS SPECIFIED ON THIS CONTRACT FOR IMMEDIATE DELIVERY IN EMERGENCIES DUE TO UNFORESEEN CAUSES (INCLUDING BUT NOT LIMITED TO DELAYS IN TRANSPORTATION OR AN UNANTICIPATED INCREASE IN THE VOLUME OF WORK.)

QUANTITIES: QUANTITIES LISTED IN THE REQUISITION ARE

SEE REVERSE SIDE FOR TERMS AND CONDITIONS

SIGNATURE [signature] TELEPHONE 414 223 7988 DATE April 9, 2012

TITLE Principal FEIN 13-4147522 ADDRESS CHANGES TO BE NOTED ABOVE

WHEN RESPONDING TO RFQ, INSERT NAME AND ADDRESS IN SPACE ABOVE LABELED 'VENDOR'

State of West Virginia
Department of Administration
Purchasing Division
2019 Washington Street East
Post Office Box 50130
Charleston, WV 25305-0130

Request for Quotation

RFQ NUMBER	PAGE
INS12001	3

ADDRESS CORRESPONDENCE TO ATTENTION OF:
SHELLY MURRAY
304-558-8801

VENDOR
RFQ COPY
TYPE NAME/ADDRESS HERE

SHIP TO
INSURANCE COMMISSION

1124 SMITH STREET
CHARLESTON, WV
25305-0540 304-558-3707

DATE PRINTED	TERMS OF SALE	SHIP VIA	F.O.B.	FREIGHT TERMS
02/09/2012				

BID OPENING DATE: 03/21/2012 BID OPENING TIME 01:30PM

LINE	QUANTITY	UOP	CAT. NO	ITEM NUMBER	UNIT PRICE	AMOUNT

APPROXIMATIONS ONLY, BASED ON ESTIMATES SUPPLIED BY THE STATE SPENDING UNIT. IT IS UNDERSTOOD AND AGREED THAT THE CONTRACT SHALL COVER THE QUANTITIES ACTUALLY ORDERED FOR DELIVERY DURING THE TERM OF THE CONTRACT, WHETHER MORE OR LESS THAN THE QUANTITIES SHOWN.

ORDERING PROCEDURE: SPENDING UNIT(S) SHALL ISSUE A WRITTEN STATE CONTRACT ORDER (FORM NUMBER WV-39) TO THE VENDOR FOR COMMODITIES COVERED BY THIS CONTRACT. THE ORIGINAL COPY OF THE WV-39 SHALL BE MAILED TO THE VENDOR AS AUTHORIZATION FOR SHIPMENT, A SECOND COPY MAILED TO THE PURCHASING DIVISION, AND A THIRD COPY RETAINED BY THE SPENDING UNIT.

BANKRUPTCY: IN THE EVENT THE VENDOR/CONTRACTOR FILES FOR BANKRUPTCY PROTECTION, THE STATE MAY DEEM THE CONTRACT NULL AND VOID, AND TERMINATE SUCH CONTRACT WITHOUT FURTHER ORDER.

THE TERMS AND CONDITIONS CONTAINED IN THIS CONTRACT SHALL SUPERSEDE ANY AND ALL SUBSEQUENT TERMS AND CONDITIONS WHICH MAY APPEAR ON ANY ATTACHED PRINTED DOCUMENTS SUCH AS PRICE LISTS, ORDER FORMS, SALES AGREEMENTS OR MAINTENANCE AGREEMENTS, INCLUDING ANY ELECTRONIC MEDIUM SUCH AS CD-ROM.

ANY INDIVIDUAL SIGNING THIS BID IS CERTIFYING THAT: (1) HE OR SHE IS AUTHORIZED BY THE BIDDER TO EXECUTE THE BID OR ANY DOCUMENTS RELATED THERETO ON BEHALF OF THE BIDDER, (2) THAT HE OR SHE IS AUTHORIZED TO BIND THE BIDDER IN A CONTRACTUAL RELATIONSHIP, AND (3) THAT THE BIDDER HAS PROPERLY REGISTERED WITH ANY STATE AGENCIES THAT MAY REQUIRE REGISTRATION.

EXHIBIT 10

SEE REVERSE SIDE FOR TERMS AND CONDITIONS

SIGNATURE [signature] TELEPHONE 414-223-7988 DATE April 9, 2012

TITLE Principal FEIN 13-4147522 ADDRESS CHANGES TO BE NOTED ABOVE

WHEN RESPONDING TO RFQ, INSERT NAME AND ADDRESS IN SPACE ABOVE LABELED 'VENDOR'

State of West Virginia
Department of Administration
Purchasing Division
2019 Washington Street East
Post Office Box 50130
Charleston, WV 25305-0130

Request for Quotation

RFQ NUMBER	PAGE
INS12001	4

ADDRESS CORRESPONDENCE TO ATTENTION OF:
SHELLY MURRAY
304-558-8801

VENDOR
RFQ COPY
TYPE NAME/ADDRESS HERE

SHIP TO
INSURANCE COMMISSION

1124 SMITH STREET
CHARLESTON, WV
25305-0540 304-558-3707

DATE PRINTED	TERMS OF SALE	SHIP VIA	F.O.B.	FREIGHT TERMS
02/09/2012				

BID OPENING DATE: 03/21/2012 BID OPENING TIME 01:30PM

LINE	QUANTITY	UOP	CAT NO	ITEM NUMBER	UNIT PRICE	AMOUNT

REQUISITION NO.: .....

ADDENDUM ACKNOWLEDGEMENT

I HEREBY ACKNOWLEDGE RECEIPT OF THE FOLLOWING CHECKED ADDENDUM(S) AND HAVE MADE THE NECESSARY REVISIONS TO MY PROPOSAL, PLANS AND/OR SPECIFICATION, ETC.

ADDENDUM NO.'S:

NO. 1 ✓.....

NO. 2 .....

NO. 3 .....

NO. 4 .....

NO. 5 .....

I UNDERSTAND THAT FAILURE TO CONFIRM THE RECEIPT OF THE ADDENDUM(S) MAY BE CAUSE FOR REJECTION OF BIDS.

VENDOR MUST CLEARLY UNDERSTAND THAT ANY VERBAL REPRESENTATION MADE OR ASSUMED TO BE MADE DURING ANY ORAL DISCUSSION HELD BETWEEN VENDOR'S REPRESENTATIVES AND ANY STATE PERSONNEL IS NOT BINDING. ONLY THE INFORMATION ISSUED IN WRITING AND ADDED TO THE SPECIFICATIONS BY AN OFFICIAL ADDENDUM IS BINDING.

.....
SIGNATURE

Oliver Wyman Actuarial
.....
COMPANY

SEE REVERSE SIDE FOR TERMS AND CONDITIONS

SIGNATURE [signature] TELEPHONE 414 223 7988 DATE April 9, 2012

TITLE Principal FEIN 13-4147522 ADDRESS CHANGES TO BE NOTED ABOVE

WHEN RESPONDING TO RFQ, INSERT NAME AND ADDRESS IN SPACE ABOVE LABELED 'VENDOR'

State of West Virginia
Department of Administration
Purchasing Division
2019 Washington Street East
Post Office Box 50130
Charleston, WV 25305-0130

Request for Quotation

RFQ NUMBER	PAGE
INS12001	5

ADDRESS CORRESPONDENCE TO ATTENTION OF:
SHELLY MURRAY
304-558-8801

VENDOR
RFQ COPY
TYPE NAME/ADDRESS HERE

SHIP TO
INSURANCE COMMISSION

1124 SMITH STREET
CHARLESTON, WV
25305-0540 304-558-3707

DATE PRINTED	TERMS OF SALE	SHIP VIA	F.O.B.	FREIGHT TERMS
02/09/2012				

BID OPENING DATE: 03/21/2012 BID OPENING TIME 01:30PM

LINE	QUANTITY	UOP	CAT. NO.	ITEM NUMBER	UNIT PRICE	AMOUNT

4/9/12
DATE

NOTE: THIS ADDENDUM ACKNOWLEDGEMENT SHOULD BE SUBMITTE WITH THE BID.

PURCHASING CARD ACCEPTANCE: THE STATE OF WEST VIRGINIA CURRENTLY UTILIZES A VISA PURCHASING CARD PROGRAM WHICH IS ISSUED THROUGH A BANK. THE SUCCESSFUL VENDOR MUST ACCEPT THE STATE OF WEST VIRGINIA VISA PURCHASING CARD FOR PAYMENT OF ALL ORDERS PLACED BY ANY STATE AGENCY AS A CONDITION OF AWARD.

NOTICE

A SIGNED BID MUST BE SUBMITTED TO:

DEPARTMENT OF ADMINISTRATION
PURCHASING DIVISION
BUILDING 15
2019 WASHINGTON STREET, EAST
CHARLESTON, WV 25305-0130

THE BID SHOULD CONTAIN THIS INFORMATION ON THE FACE OF THE ENVELOPE OR THE BID MAY NOT BE CONSIDERED:

SEALED BID

BUYER: SHELLY MURRAY

SEE REVERSE SIDE FOR TERMS AND CONDITIONS

SIGNATURE [signature] TELEPHONE 414 223 7988 DATE April 9, 2012

TITLE Principal FEIN 13-4147522 ADDRESS CHANGES TO BE NOTED ABOVE

WHEN RESPONDING TO RFQ, INSERT NAME AND ADDRESS IN SPACE ABOVE LABELED 'VENDOR'

State of West Virginia
Department of Administration
Purchasing Division
2019 Washington Street East
Post Office Box 50130
Charleston, WV 25305-0130

Request for Quotation

RFQ NUMBER	PAGE
INS12001	6

ADDRESS CORRESPONDENCE TO ATTENTION OF:
SHELLY MURRAY
304-558-8801

VENDOR
RFQ COPY
TYPE NAME/ADDRESS HERE

SHIP TO
INSURANCE COMMISSION

1124 SMITH STREET
CHARLESTON, WV
25305-0540 304-558-3707

DATE PRINTED	TERMS OF SALE	SHIP VIA	F.O.B.	FREIGHT TERMS
02/09/2012				

BID OPENING DATE: 03/21/2012 BID OPENING TIME 01:30PM

LINE	QUANTITY	UOP	CAT NO	ITEM NUMBER	UNIT PRICE	AMOUNT
	RFQ. NO.:			INS12001		
	BID OPENING DATE:			03/21/2012		
	BID OPENING TIME:			1:30 PM		
	PLEASE PROVIDE A FAX NUMBER IN CASE IT IS NECESSARY TO CONTACT YOU REGARDING YOUR BID:					

	CONTACT PERSON (PLEASE PRINT CLEARLY):					

	****** THIS IS THE END OF RFQ INS12001 ****** TOTAL:					

SEE REVERSE SIDE FOR TERMS AND CONDITIONS

SIGNATURE [signature] TELEPHONE 414 223-7988 DATE April 9, 2012

TITLE Principal FEIN ID 13-4147522 ADDRESS CHANGES TO BE NOTED ABOVE

WHEN RESPONDING TO RFQ, INSERT NAME AND ADDRESS IN SPACE ABOVE LABELED 'VENDOR'

OLIVER WYMAN

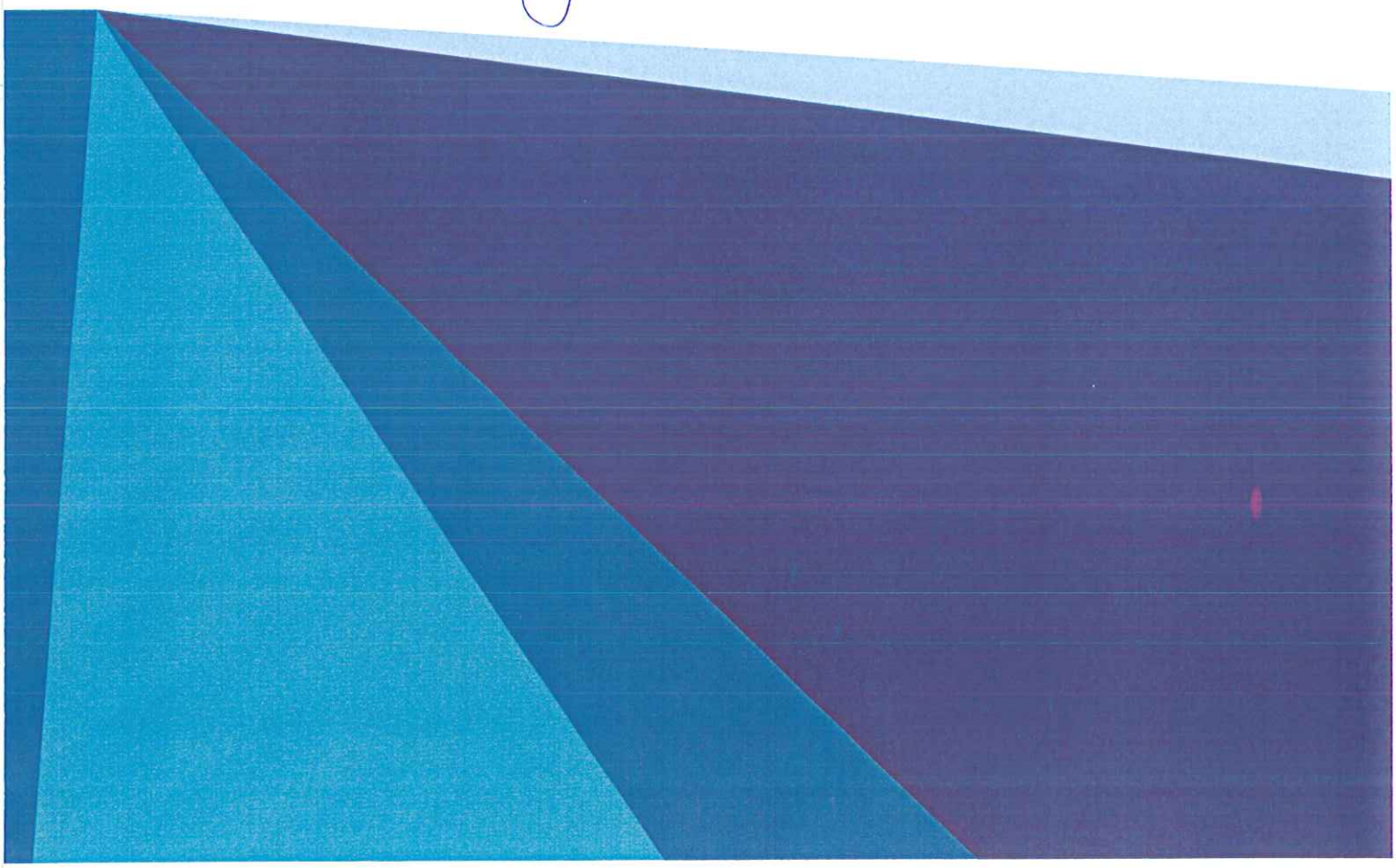
RESPONSE TO

REQUEST FOR PROPOSAL # INS12001 – TECHNICAL PROPOSAL

WEST VIRGINIA OFFICES OF THE INSURANCE COMMISSIONER

Oliver Wyman Actuarial Consulting, Inc.
411 East Wisconsin Avenue, Suite 1600,
Milwaukee, WI 53202-4419
Phone: 414 223 7988 Fax 414 223 3244
Tammy P. Tomczyk, FSA, MAAA
tammy.tomczyk@oliverwyman.com

Signature _____ Date 4/9/12



Executive Summary

Oliver Wyman is a wholly-owned subsidiary of the Marsh & McLennan Companies, a global professional services firm providing advice and solutions in the areas of risk, strategy, and human capital. Marsh & McLennan Companies is a publicly-held company with over $11 billion in annual revenue. The Marsh & McLennan Companies are active in the following sectors: risk and insurance services through Marsh, Inc. and Guy Carpenter, and consulting through Mercer and the Oliver Wyman Group.

The Oliver Wyman Group includes consultants with expertise in actuarial science, strategy, financial services (including insurance), brand management and economics. Oliver Wyman's 3,300 professionals operate in more than 40 cities globally. The firm works with clients across a range of industries to deliver sustained shareholder value growth. The Life and Health Actuarial Practice of Oliver Wyman has provided extensive support to several insurance departments regarding legislative matters for over 20 years.

We are familiar with the actuarial needs of insurance regulators, and have demonstrated the expertise and capacity to meet those needs in a timely fashion with a quality work product. Among this work we have assisted several States (North Carolina, Connecticut, Vermont, Maryland, and The District of Columbia) prepare and plan for health care reform, specifically related to their health care Exchanges. We also have many commercial clients for which we develop and certify rates in various States and have significant expertise in the individual and small group markets. We are currently assisting our commercial insurance clients in understanding the potential impacts of reform so that they may best position themselves in a post-reform market.

We are considered by our peers and clients to be on the leading edge of health care reform. We have a solid understanding of the potential impacts that recently passed Federal health care reforms may have on both the individual and group insurance markets. Clients turn to Oliver Wyman for our high-level strategic advice and our ability to model proposed health care reforms and respond to changes in regulations at both the State and Federal levels.

Oliver Wyman has built a market-leading actuarial and economic micro-simulation model to evaluate the impact that Federal insurance reforms will have at the State level.

Oliver Wyman has built a market-leading actuarial and economic micro-simulation model to evaluate the impact that Federal insurance reforms will have at the State level.

Our model is a leading edge tool for analyzing the impact of various health care reform provisions, as well as proposed legislation. Economic modeling that captures the flow of individuals across various markets based on their economic purchasing decisions is integrated with actuarial modeling designed to assess the impact that the various aspects of the ACA have on insurance markets and premiums. It is this rare integration of economic and

actuarial modeling that allows us to capture the complex migration likely to occur as a result of the ACA.

In 2009 Oliver Wyman published a study based on analyses that Oliver Wyman performed to estimate the impact of the Senate Finance Committee's health reform bill. The resulting report was widely cited as a credible estimate of the impact of reform. Oliver Wyman believes the reinsurance program that was included in the final legislation was a direct result of the modeling, which showed there was a high likelihood the individual market would collapse absent a strong mandate or other means to stabilize that market. As a result of Oliver Wyman's work, our consultants have participated in press conferences, met with key policy makers including White House staff and provided testimony to the United States Senate regarding these reforms.

Oliver Wyman intends to partner with an extraordinary subcontractor in Health Management Associates, Inc. to help address the complex issues and opportunities in health care reform.

The broad scope of this Request for Proposal (RFP) as it relates to health care reform necessitates bringing together a broad range of expertise. Fortunately, much of that expertise is available within Oliver Wyman. However, even the impressive experience and broad expertise of internal resources cannot address all of the issues for which the State of West Virginia may need assistance. Oliver Wyman is partnering with an exceptional independent subcontractor to provide additional resources and depth of experience to meet any need that might arise under this RFP. For this additional expertise we will draw on the health care policy expertise of Health Management Associates, Inc. (HMA).

HMA is a research and consulting firm headquartered in Lansing Michigan and specializing in the fields of health system restructuring, government program development and evaluation, health economics and finance, program evaluation and data analysis. The firm is widely regarded as a leader in providing policy analysis and technical and analytical services to States, purchasers, payers and providers, with a special concentration on policy initiatives that address the needs of the medically indigent and underserved. The firm regularly provides expertise on quality measurement, payment reform, coverage expansions and financing issues in Medicaid to State governments, foundations, associations, hospital systems, managed care organizations and other providers and health care organizations.

HMA offers staff with hands-on experience in designing, developing and operating a Health Insurance Exchange (in Massachusetts), former state officials responsible for initial Health Insurance Exchange planning (in Texas), and experience working with other States to plan for an Exchange (including Michigan, Illinois, Nebraska, Tennessee, Puerto Rico and Connecticut).

HMA staff includes former State Medicaid and CHIP directors, former State budget directors, State insurance department officials and other seasoned State, Federal and private sector health care officials. More specifically, HMA staff includes individuals with hands-on experience in designing, developing and operating a Health Insurance Exchange (in Massachusetts), former State officials responsible for

initial Health Insurance Exchange planning (in Texas and Colorado), and experience working with other States to plan for an Exchange (including Michigan, Illinois, Nebraska, Tennessee, Puerto Rico and Connecticut).

Oliver Wyman's sister company, Mercer Government Human Services Consulting, is a specialized government health care consulting practice with over 130 dedicated professionals with backgrounds in Medicaid/Child Health Insurance Program (CHIP) administration and operations, actuarial rate work, Federal health care policy and reform, large data/information management, pharmacy reimbursement, clinical quality, mental/behavioral health needs, actuarial/financial analyses and project management. Oliver Wyman will draw on the additional expertise of Mercer for this project.

As our proposal will show, we are able to provide all of the services requested in the RFP, and have the experience and expertise to provide additional services beyond those requested in the RFP should the State find the need for them. We believe our project approach and work plan provided in response to the West Virginia Office of the Commissioner's RFP demonstrates our understanding of the services being requested. We believe that West Virginia will benefit by choosing a highly qualified team that:

- Has extensive knowledge of the private health insurance and Medicaid markets
- Possesses a solid understanding of health care reform
- Has developed a leading edge micro-simulation model that can be calibrated at a very granular level to provide State-specific results
- Has performed projects of similar size and scope for other States
- Has the technical expertise needed to help ensure the State has the information it needs to consider policy options
- Can bring the dedicated resources to deliver high quality work products timely and effectively
- Has the ability to clearly communicate and document complex issues

We believe that we are that team. We welcome and look forward to the opportunity to assist the State of West Virginia in the planning and development of its health insurance Exchange.

CONTENTS

1

Work Plan

Oliver Wyman provides our proposed work plan beginning on the following page. The detailed, task-oriented breakdown for each task and accompanying deliverables is provided. We recognize that the work products associated with this engagement may evolve throughout the short duration of the initial engagement, and more so if the engagement is extended. Based on that and the broad nature of the types of services described in the RFP, we believe our partnership of highly specialized firms will best meet the State's needs over the long-term. Our approach to meeting the need for the broad and specialized support that health care reform demands is to provide the West Virginia Offices of the Insurance Commissioner (WVOIC) with a team of nationally-recognized firms and individuals that has been already working on health care reform and Exchanges, tracking new developments, and prepared to address all of the components that reform requires. While Oliver Wyman will serve as the prime contractor and will provide overall project management, we will always choose the best resource for the task regardless of the firm where that person works, as evidenced in our proposed work plan.

RFP Reference	Deliverable/Task	Team Lead(s)	Duration	Target start date*	Target end date*	Key deliverable/Milestone
* All timelines assume a May 15, 2012 contract start date. If the contract start date is delayed, timelines will be adjusted accordingly.						
	General Project Management Tasks	**Tammy Tomczyk**				
	Contract begins: Contract signed and provided to authorize start of work		1 day	05/15/12	05/15/12	
	Initial planning meeting Conference calls to initiate project and plan initial kick-off meeting		1 day	05/17/12	05/17/12	Meeting with State of West Virginia (State)
	Initial kick-off meeting		1 day	05/23/12	05/23/12	Meeting with State
	Update work plan (if necessary)		2 days	05/24/12	05/25/12	Updated work plan
	Hold regular project status calls		ongoing	05/30/12	12/31/12	Conference calls bi-weekly
	Monthly progress reports		ongoing	05/31/12	12/31/12	Monthly reports
	Carrier data call for actuarial and economic modeling	**Tammy Tomczyk**				
	Draft carrier data call		5 days	05/17/12	05/21/12	
	Discuss draft data call with State		1 day	05/23/12	05/23/12	Meeting with State
	Revise data call and issue to carriers		2 days	05/24/12	05/25/12	
	Receive data call back from carriers		21 days	05/25/12	06/15/12	
	Issue any questions on data call to carriers and receive revised data		7 days	06/16/12	06/22/12	
2.4.1(a)	**Project Deliverable #1: Study of the uninsured and underinsured population in West Virginia**	**Dianna Welch**				
1.1	Establish practicable definitions of uninsured and underinsured		3 days	05/21/12	05/23/12	Meeting with State
1.2	Acquire data sources		20 days	05/24/12	06/12/12	
1.2.1	Acquire publicly available studies and research sources		20 days	05/24/12	06/12/12	
1.2.2	Meet with State staff to define available State data sources		1 day	05/29/12	05/29/12	Meeting with State
1.2.3	Acquire State data sources		14 days	05/30/12	06/12/12	
1.3	Analyze available data sources		30 days	05/29/12	06/28/12	
1.4	**Summarize results and draft preliminary section of report** on uninsured population		30 days	06/29/12	07/29/12	**Section of final report on the uninsured**
1.5	integrate results of actuarial and economic modeling with analysis completed to date to perform analysis of underinsured population		14 days	09/01/12	09/15/12	
1.6	Summarize results and draft final section of report on uninsured and underinsured		14 days	09/16/12	09/30/12	**Section of final report on the uninsured and underinsured**

RFP Reference	Deliverable/Task	Team Lead(s)	Duration	Target start date*	Target end date*	Key deliverable/Milestone
* All timelines assume a May 15, 2012 contract start date. If the contract start date is delayed, timelines will be adjusted accordingly.						
2.4.1(b), 2.4.1(d)	**Project Deliverable #2: Study of the insured population in West Virginia**	**Tammy Tomczyk**				
2.1	Discuss desired summaries with State		1 day	05/23/12	05/23/12	Meeting with State
2.2	Acquire data sources		14 days	05/24/12	06/07/12	
2.2.1	Acquire information from DHHR		10 days	05/24/12	06/02/12	
2.2.2	Acquire information on Medicare population from CMS		7 days	05/24/12	05/30/12	
2.2.3	Gather financial statement information for West Virginia carriers		7 days	05/24/12	05/30/12	
2.2.4	Extract information from American Community Survey for West Virginia residents and employees and integrate with other sources		14 days	05/24/12	06/07/12	
2.3	Analyze available data sources		20 days	06/08/12	06/28/12	
2.4	Summarize results and draft section of report on uninsured and underinsured		30 days	06/29/12	07/29/12	**Section of final report on the insured population in West Virginia**
2.4.1(c)	**Project Deliverable #3: Study of the small group population in West Virginia**	**Josh Sober**				
3.1	Discuss desired summaries with State		1 day	05/23/12	05/23/12	Meeting with State
3.2	Acquire data sources		14 days	05/24/12	06/07/12	
3.2.1	Gather financial statement information for West Virginia carriers		14 days	05/24/12	06/07/12	
3.2.2	Acquire information on West Virginia employers from Dun and Bradstreet		14 days	05/24/12	06/07/12	
3.2.3	Extract information from American Community Survey for West Virginia employees		14 days	05/24/12	06/07/12	
3.3	Analyze available data sources		21 days	06/08/12	06/29/12	
3.3.1	Analyze and estimate number of groups eligible for tax credits		3 days	06/29/12	07/02/12	
3.3.2	Analyze small group information from carrier data call		21 days	06/08/12	06/29/12	
3.4	Summarize results and draft section of report on current small group population		30 days	06/29/12	07/29/12	**Section of final report on the insured population in West Virginia**

RFP Reference	Deliverable/Task	Team Lead(s)	Duration	Target start date*	Target end date*	Key deliverable/Milestone
* All timelines assume a May 15, 2012 contract start date. If the contract start date is delayed, timelines will be adjusted accordingly.						
2.4.1(e)	**Project Deliverable #4: Survey and analysis of the current insurance market (products and premiums)**	Dianna Welch				
5.1	Review existing survey information and gather background information		14 days	05/17/12	05/30/12	
5.2	Discuss goals of the surveys with the State		1 day	05/23/12	05/23/12	Meeting with State
5.3	Develop proposed survey questionnaire for health insurers		15 days	05/24/12	06/07/12	
5.3.1	Identify the targeted survey participants from the target group of health insurance carriers		5 days	05/24/12	05/29/12	
5.3.2	Identify specific information to include in the survey		5 days	05/24/12	05/29/12	
5.3.3	Build survey		14 days	05/30/12	06/13/12	
5.3.4	Review survey with the State		1 day	06/14/12	06/14/12	Meeting with State
5.4	Make any necessary revisions to survey and issue to carriers		4 days	06/15/12	06/18/12	
5.5	answer questions from carriers completing surveys		21 days	06/19/12	07/09/12	
5.6	surveys due back		1 day	07/09/12	07/09/12	
5.7	Validate and aggregate survey results		15 days	07/10/12	07/25/12	
5.8	Summarize results and draft section of report on current insurance market (products and premiums)		20 days	07/25/12	08/14/12	**Section of final report on current insurance market (products and premiums) in West Virginia**
2.4.1(e)	**Project Deliverable #5: Survey and analysis of the current insurance market (producers)**	HMA				
5.1	Review existing survey information and gather background information	David Fosdick	14 days	05/17/12	05/30/12	
	Literature review	David Fosdick	2 days	05/17/12	05/21/12	
	Market Study	David Fosdick	2 days	05/22/12	05/24/12	
	Document findings	David Fosdick	2 days	05/25/12	05/29/12	**Memo detailing producer market in West Virginia**
	Discuss goals of the surveys with the State		1 day	05/23/12	05/23/12	**Meeting with State**
	Identify the targeted survey participants from licensed brokers/agent listings					
	External stakeholder interviews (40 total)	Larry Zbanek	34 days	06/11/12	07/30/12	
	Document results of interviews	Larry Zbanek	34 days	06/11/12	07/30/12	**Consolidated summary of interview responses**
	Summarize results and draft section of report on current insurance market (products and premiums)	Larry Zbanek	11 days	07/31/12	08/14/12	**Section of final report on current insurance market (producers) in West Virginia**

RFP Reference	Deliverable/Task	Team Lead(s)	Duration	Target start date*	Target end date*	Key deliverable/Milestone
* All timelines assume a May 15, 2012 contract start date. If the contract start date is delayed, timelines will be adjusted accordingly.						
2.4.1(d) 2.4.1(f) 2.4.2	Project Deliverable #6: Economic and actuarial modeling and Exchange design options	Tammy Tomczyk				
6.1	Meet with State to discuss and explain Oliver Wyman's existing models and identify any additional needs; discuss data needs		1 day	05/23/12	05/23/12	Meeting with State
6.2	Collect and update data inputs, as needed, for the models such as claims database, premium and underwriting information, carrier data call		45 days	05/24/12		
6.2.1	Obtain rate flings from the State		10 days	05/24/12	06/03/12	
6.2.2	Acquire information from DHHR		10 days	05/24/12	06/03/12	
6.2.3	Issue carrier data call		1 day	05/25/12	05/25/12	
6.2.4	Extract information from Secondary data sources (ACS, MEPS, Dun & Bradstreet, etc.)		21 days	05/25/12	06/15/12	
	Answer questions from carriers on data call		21 days	05/25/12	06/15/12	
6.3	Receive data call back from carriers		21 days	05/25/12	06/15/12	
6.4	Review carrier data submitted, send questions and requests for clarification and revisions		14 days	06/10/12	06/24/12	
6.5	Build synthetic rate manuals		21 days	06/25/12	07/16/12	
6.6	Calibrate model to be West Virginia specific		14 days	07/17/12	07/31/12	
6.7	Run modeling scenarios		30 days	08/01/12	08/31/12	
6.7.1	Model Enrollment in various markets under baseline scenario (separate individual and small group markets; small group defined as 50 until 2016; no BHP)		30 days	08/01/12	08/31/12	
6.7.2	Model premium and enrollment if individual and small group markets are merged		30 days	08/01/12	08/31/12	
6.7.3	Model premium and enrollment if small group definition is increased to 50 in 2014		30 days	08/01/12	08/31/12	
6.7.4	Model Exchange premium and enrollment if a BHP is established		30 days	08/01/12	08/31/12	
6.7.5	Model premium and enrollment if no individual mandate is in place		30 days	08/01/12	08/31/12	
6.8	Summarize results and draft section of report on results of actuarial and economic modeling			09/01/12	09/30/12	**Section of final report containing results of the economic and actuarial modeling and analyses and implications to various policies**

RFP Reference	Deliverable/Task	Team Lead(s)	Duration	Target start date*	Target end date*	Key deliverable/Milestone
* All timelines assume a May 15, 2012 contract start date. If the contract start date is delayed, timelines will be adjusted accordingly.						
2.4.3 (a) 2.4.3 (c)	**Project Deliverable #7: Develop financial model for sustainable Exchange, including start-up and ongoing operating costs**	**Rosemarie Day**				
	Memo detailing financial projection options available to State	Rosemarie Day	4 days	05/15/12	5/21/2012	Summary of options for state review
7.1	Initial meeting with State. Gather information on publicly available cost information	Rosemarie Day	2 days	05/22/12	05/23/12	Meeting with State
7.2	Initial paper outlining strengths/weaknesses of revenue options available to State	Rosemarie Day	12 days	05/15/12	06/01/12	Revenue draft paper
7.3	Gather data on budget model inputs	Rosemarie Day	10 days	06/04/12	06/15/12	
7.4	Construct budget model	Rosemarie Day	10 days	06/18/12	06/29/12	
	Discussion of State revenue preferences	Rosemarie Day	1 day	07/02/12	07/02/12	
	Creation of initial budget estimates	Rosemarie Day	9 days	09/04/12	09/14/12	Tables outlining initial estimates
	Discussion of State revenue preferences	Rosemarie Day	3 days	09/17/12	09/19/12	
	Generation of final budget estimates	Rosemarie Day	7 days	9/201/2012	09/30/12	
7.5	Summarize results and draft section of report on financial model options	Rosemarie Day	20 days	09/03/12	09/30/12	**Section of the final report containing results of the financial model options**
2.4.3 (b)	**Project Deliverable #8: Assess Potential Impacts of Substantive Options on the Insurance Market**	**Karen Bender**				
8.1	Meet with State to discuss proposed analysis		1 day	05/23/12	05/23/12	Meeting with State
8.2	Perform background research and analysis		10 days	05/24/12	06/03/12	
8.3	Draft report		55 days	06/04/12	07/29/12	
8.3.1	Discussion of impact of Exchange functioning as an active/passive purchaser		7 days	06/04/12	06/10/12	
8.3.2	Discussion of impact of reforms on purchasing habits		7 days	06/11/12	06/17/12	
8.3.3	Discussion of impact of reforms on large employer offerings		7 days	06/18/12	06/24/12	
8.3.4	Discuss the likely impact of pooling with surrounding states		7 days	06/25/12	07/01/12	
8.3.5	Discuss potential for adverse selection and methods for mitigating		7 days	07/02/12	07/08/12	
8.3.6	Discuss various open enrollment strategies that could be used for the outside market		7 days	07/09/12	07/15/12	
8.3.7	Discuss various options for risk adjustment		7 days	07/16/12	07/22/12	
8.3.8	Discuss potential regional rating factors and anticipated age rating bands that will be used by carriers		7 days	07/23/12	07/29/12	
8.4	Summarize, integrate and edit various pieces of section of report		15 days	07/30/12	08/14/12	**Section of the final report containing analysis of substantive options on the insurance market**

RFP Reference	Deliverable/Task	Team Lead(s)	Duration	Target start date*	Target end date*	Key deliverable/Milestone
* All timelines assume a May 15, 2012 contract start date. If the contract start date is delayed, timelines will be adjusted accordingly.						
2.4.3 (d)	**Project Deliverable #9: Impact of Other State Programs**	**Tom Dehner/Tammy Tomczyk**				
9.1	Meet with State to discuss proposed analysis		1 day	05/23/12	05/23/12	Meeting with State
9.2	Early implementation or phase in of consumer protections	Tom Dehner		05/24/12	06/24/12	Paper outlining
	Meeting with State regarding Medicaid data	Tom Dehner		06/01/12	07/01/12	
	Analysis of Medicaid data	Tom Dehner		07/01/12		
	Presentation of initial findings to State	Tom Dehner		08/01/12		
	Discussion of initial findings with relevant State staff	Tom Dehner		09/15/12		
9.3	Presentation of final estimates regarding impact of Medicaid expansion	Tom Dehner		09/30/12		
9.4	Basic Health Program Analysis			09/01/12	09/15/12	
9.4.1	Estimate average Federal payments based on Silver premium and cost sharing subsidies from economic and actuarial modeling		14 days	09/01/12	09/11/12	
9.4.2	Estimate potential BHP enrollment for various current statuses (e.g. uninsured, individual, group)		14 days	09/01/12	09/11/12	
9.4.3	integrate results		4 days	09/11/12	09/15/12	
	Summarize results and draft section of report			09/01/12	09/30/12	**Section of final report containing the results of the impact study of the Medicaid program on the Exchange**
	Project Deliverable #10: Final Report	**Tammy Tomczyk**				
10.1	Draft and compile final comprehensive report		35 days	10/01/12	11/05/12	Draft report
10.2	Feedback from State staff on draft report		7 days	11/06/12	11/13/12	
10.3	Finalize report incorporating feedback from State		10 days	11/14/12	11/24/12	
10.4	Present draft final report to the State		1 day	11/26/12	11/26/12	Meeting with State to discuss report
10.5	Incorporate any changes that arise from presentation and discussion		5 days	11/27/12	12/01/12	
10.6	Submit final report		1 day	12/01/12	12/01/12	**Comprehensive report containing results from all project deliverables**
10.7	Project wrap-up / next steps		1 day	12/15/12	12/15/12	Meeting with State

2

Attachment A: Vendor Response

Organizational Profile

Oliver Wyman Actuarial Consulting, Inc. (Oliver Wyman) has assembled an exceptional team to assist WVOIC with the planning, research, data analytics, and actuarial and economic modeling that are key to establishing the policy direction and implementation strategy for its health insurance Exchange. Reforming West Virginia's health care system will impact the lives of every West Virginia resident. It will be virtually impossible to please every stakeholder, person or politician in this endeavor; however, this problem can be effectively solved (or at least mitigated) through a combination of strong State leadership, transparency in the decision-making process, professionalism throughout the entire process, actively seeking input from stakeholders, and thoughtful, detailed analytics. WVOIC requires a strong partner to assist in establishing the foundational understanding that will become the building blocks for the design, development and implementation of the Exchange.

Oliver Wyman has created a team that is diverse and wide-ranging in skill and experience. Our team has deep expertise in health care reforms at both the State and Federal levels. The Oliver Wyman team includes multiple divisions within the Marsh & McLennan family of companies (Oliver Wyman Actuarial Consulting, and Mercer Government Human Services Consulting) as well as an exceptional subcontractor in Health Management Associates (HMA) to provide the WVOIC with the qualifications, skills, resources and experience critical to ensuring ongoing success as the State plans and then implements its Exchange. Collectively, our team has recently assisted the States of Connecticut, Maryland, Michigan, North Carolina, Vermont, and The District of Columbia in developing their health exchanges.

We believe that West Virginia will benefit by choosing a highly qualified team that:

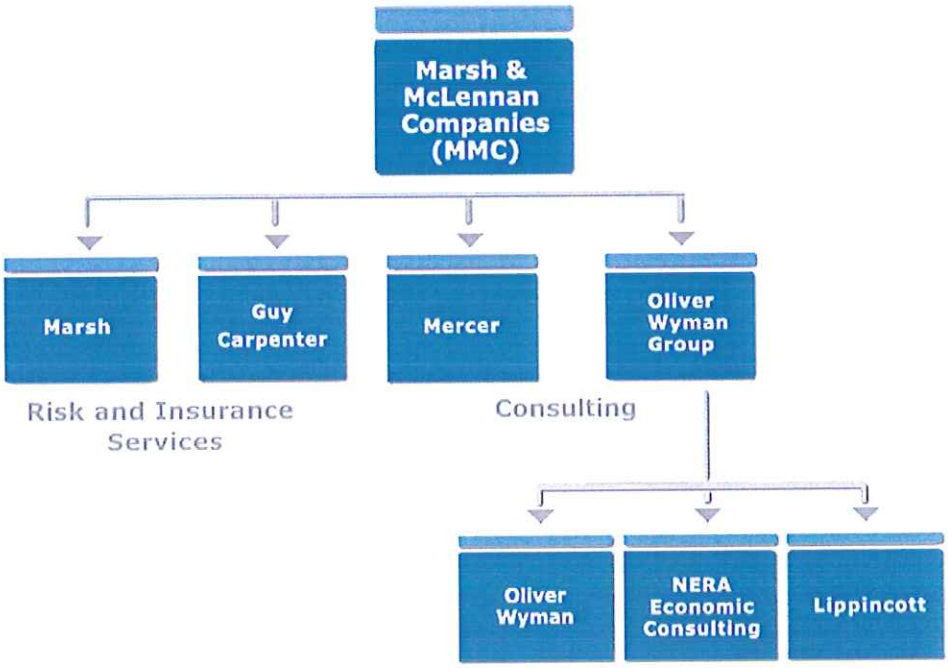
- Has extensive knowledge of the private health insurance and Medicaid markets
- Possesses a solid understanding of health care reform
- Has developed a leading edge micro-simulation model that can be calibrated at a very granular level to provide State-specific results
- Has performed projects of similar size and scope for other States
- Has the technical expertise needed to help ensure the State has the information it needs to consider policy options
- Can bring the dedicated resources to deliver high quality work products timely and effectively
- Has the ability to clearly communicate and document complex issues

We believe that we are that team. We welcome and look forward to the opportunity to assist the State of West Virginia in the planning and development of its health insurance Exchange. This proposal is submitted by Oliver Wyman Actuarial Consulting, Inc. as the prime vendor. Qualifications of Oliver Wyman and our subcontractor partner, HMA, are described in further detail below.

Qualifications

Oliver Wyman Qualifications

Oliver Wyman is a wholly-owned subsidiary of the Marsh & McLennan Companies with its headquarters located at 1166 Avenue of the Americas, New York, New York. Marsh & McLennan Companies is a global professional services firm providing advice and solutions in the areas of risk, strategy, and human capital. Marsh & McLennan Companies is a publicly-held company with over $11 billion in annual revenue. Marsh & McLennan Companies are active in the following sectors: risk and insurance services through Marsh, Inc. and Guy Carpenter, and consulting through Mercer and the Oliver Wyman Group.



The Oliver Wyman Group includes consultants with expertise in actuarial science, strategy, financial services (including insurance), brand management and economics. Oliver Wyman's 3,300 professionals operate in more than 40 cities globally. The firm works with clients across a range of industries to deliver sustained shareholder value growth.

The Oliver Wyman Actuarial Consulting practice is part of Oliver Wyman Group and provides actuarial, financial, operational, and risk management services to a variety of clients including: insurance and financial service companies, health care providers, insurance regulators, governments, trusts, law firms, and corporations that retain risk. With over 70 members of the American Academy of Actuaries, Oliver Wyman, is one of the largest actuarial practices in North America. Oliver Wyman has actuaries that specialize in health, life and property and casualty lines.

The Oliver Wyman Actuarial Consulting Health Practice advises clients on the key business areas that will be affected by health care reform and recommends actions to proactively prepare for the post-reform marketplace. Oliver Wyman staff has experience working with other States to plan for their Exchange (in The District of Columbia, Connecticut, Maryland, Massachusetts and Vermont). Oliver Wyman has built a market-leading actuarial and economic micro-simulation model to evaluate the impact that Federal insurance reforms will have at the State level. Oliver Wyman's model has been utilized to assist States (including Connecticut and the District of Columbia) and insurance companies plan for the changes ahead.

Oliver Wyman has built a market-leading actuarial and economic micro-simulation model to evaluate the impact that Federal insurance reforms will have at the State level.

With more than 20 years experience serving our clients, Oliver Wyman provides innovative solutions to the ever-changing health care environment; its consultants are trusted advisors. Clients turn to Oliver Wyman for our high-level strategic advice and our ability to model proposed health care reforms and respond to changes in regulations at both the State and Federal levels. In addition to many actuarial projects for State agencies, Oliver Wyman regularly provides services related to:

- Health insurance product development and pricing
- Feasibility studies including financial planning
- Development of claim liabilities and reserve certifications, including annual statement certifications
- Development of rating models
- Medicare Advantage and Medicare Part D pricing and attestations
- Due diligence and expert witness testimony
- Development of provider contracting models

Mercer Government Human Services Consulting is a specialized government health care consulting practice with over 130 dedicated professionals with backgrounds in Medicaid/Child Health Insurance Program (CHIP) administration and operations, actuarial rate work, Federal health care policy and reform, large data/information management, pharmacy reimbursement, clinical quality, mental/behavioral health needs, actuarial/financial analyses and project management.

Mercer's Government Human Services Consulting practice has been providing consulting services to State payers of health care services for more than 25 years.

Mercer's Government practice specializes in creating innovative solutions to transform health care by assisting government-sponsored programs to become more efficient purchasers of health care services. Mercer teams include actuaries, accountants, clinicians, and information technology professionals who can assure a coordinated approach to actuarial, financial, administrative, and operational components of public-sponsored health care programs.

The broad scope of this Request for Proposal (RFP) as it relates to health care reform necessitates bringing together a broad range of expertise. Fortunately, much of that expertise is available within Oliver Wyman. However, even the impressive experience and broad expertise of internal resources cannot address all of the issues for which the State of West Virginia may need assistance. Oliver Wyman is partnering with an exceptional independent subcontractor to provide additional resources and depth of experience to meet any need that might arise under this RFP. For this additional expertise we will draw on the health care policy expertise of Health Management Associates, Inc.

Oliver Wyman intends to partner with an extraordinary subcontractor in Health Management Associates, Inc. to help address the complex issues and opportunities in health care reform.

Health Management Associates (HMA), Inc. Qualifications

Health Management Associates (HMA), Inc. is a research and consulting firm specializing in the fields of health system restructuring, government program development and evaluation, health economics and finance, program evaluation and data analysis. The firm is widely regarded as a leader in providing policy analysis and technical and analytical services to States, purchasers, payers and providers, with a special concentration on policy initiatives that address the needs of the medically indigent and underserved. HMA has a breadth and depth of Medicaid knowledge and understanding that is virtually unmatched. The firm regularly provides expertise on quality measurement, payment reform, coverage expansions and financing issues in Medicaid to State governments, foundations, associations, hospital systems, managed care organizations and other providers and health care organizations.

The staff of HMA is comprised of professional health care managers and analysts with up to 30 years of experience in health policy design and implementation and backgrounds in health economics, public policy and administration, health care finance and reimbursement, managed care, health information technology and program development and evaluation. HMA staff includes former State Medicaid and CHIP directors, former State budget directors, State insurance department officials and other seasoned State, Federal and private sector health care officials.

HMA offers staff with hands-on experience in designing, developing and operating a Health Insurance Exchange (in Massachusetts), former State officials responsible for initial Health Insurance Exchange planning (in Texas), and experience working with other States to plan for an Exchange (including Michigan, Illinois, Nebraska, Tennessee, Puerto Rico and Connecticut).

More specifically, HMA staff includes individuals with hands-on experience in designing, developing and operating a Health Insurance Exchange (in Massachusetts), former State officials responsible for initial Health Insurance Exchange planning (in Texas and Colorado), and experience working with other States to plan for an Exchange (including Michigan, Illinois, Nebraska, Tennessee, Puerto Rico and Connecticut). HMA has longtime experience working with the States on health care and health insurance reform.

HMA's corporate headquarters are in Lansing, Michigan and the company also has offices in Chicago, Illinois; Tallahassee, Florida; Indianapolis, Indiana; Columbus, Ohio; Washington, D.C.; Austin, Texas; Sacramento, California; Los Angeles, California, Oakland, California, Harrisburg, Pennsylvania, Denver, Colorado, New York, New York; Atlanta, Georgia and Boston, Massachusetts.

Summary of Relevant Experience and Past Projects Completed

Oliver Wyman Experience – Health Care Reform

Oliver Wyman consultants and actuaries have been at the forefront of Federal health care reform efforts to date. In October 2009, the Blue Cross/Blue Shield Association (BCBSA) published a study, "Insurance Reforms Must Include a Strong Individual Mandate and Other Key Provisions to Ensure Affordability." This paper was written by Oliver Wyman and was based on analyses that Oliver Wyman performed for BCBSA estimating the impact of the Senate Finance Committee's health reform bill (which was very similar to the law that was ultimately passed). The resulting report was widely cited as a credible estimate of the impact of reform. Oliver Wyman believes the reinsurance program that was included in the final legislation was a direct result of the modeling, which showed there was a high likelihood the individual market would collapse absent a strong mandate or other means to stabilize that market.

Oliver Wyman is nationally recognized for its work in assessing and modeling the impact of health care reform on the insurance market.

As a result of Oliver Wyman's work with BCBSA, Oliver Wyman consultants have participated in press conferences, met with key policy makers including White House staff and provided testimony to the United States Senate regarding these reforms.

Massachusetts Reforms

Oliver Wyman has first-hand experience with the health care reforms that passed in Massachusetts. Oliver Wyman supported a Massachusetts health plan during the implementation of health care reform, including the introduction of plans through the Connector. One of Oliver Wyman's actuaries worked for Blue Cross/Blue Shield of Massachusetts during the passage and implementation of Massachusetts health care reform. Oliver Wyman has been active in the Massachusetts market and has supported several State agencies, including the Connector. Most recently, Oliver Wyman worked with the Department of Insurance to develop regulations implementing Section 29 of Chapter 288 of the Acts of 2010 giving the Department of Insurance considerable oversight responsibilities, similar to those the Secretary of Health and Human Services is looking for all States to implement as part of an "effective rate review program."

District of Columbia

In 2011, Oliver Wyman, Mercer, and other consultants formed a team lead by Mercer that was hired by the District of Columbia to assist them in the planning, research and data analytics necessary to establish the District's Health Insurance Exchange. The work performed by Oliver Wyman and Mercer as part of that project included:

- An assessment of the State's current insurance marketplace including the Medicaid, individual small employer and uninsured populations
- A survey of the health insurance carriers offering coverage in the District to understand the current premiums and rating methodologies used in the individual and small group markets
- Economic and actuarial modeling around questions such as whether the small group and individual markets should be merged, the impact of reforms on premiums in these markets, and the potential enrollment in the Exchange
- The development of a financial model and recommendations for the Exchange so it could be self-supporting by January 2015
- Potential sources of adverse selection and how the Exchange could address them
- An analysis of the effects of a Basic Health Plan option on premium and enrollment in the Exchange
- An evaluation of options for multi-State and/or Federal collaboration

Mercer and Oliver Wyman are currently assisting the District in further exploring the option of establishing a Basic Health Plan by performing an in-depth feasibility study which examine the

Connecticut

In 2011, a team of Oliver Wyman, Mercer and HMA consultants was hired by the State of Connecticut Office of Policy and Management to provide projections and guidance related to the planning, research, and data analytics necessary to establish Connecticut's Health Insurance Exchange. This work included:

- An assessment of the State's uninsured and underinsured populations
- A survey of the health insurance carriers offering coverage in the State to understand the plans being sold and the premiums
- A survey of the small employer market to identify small employers' needs
- Economic and actuarial modeling around questions such as whether the small group and individual markets should be merged and the impact of the exchanges on insurer profitability
- The interaction of the Exchange with other health system initiatives in the State
- The development of a financial model and recommendations for the Exchange so it could be self-supporting by January 2015
- An assessment of the technical requirements and the development of specifications for accounting and financial systems
- An assessment of the existing Medicaid eligibility system and requirements for integrations with the Exchange information infrastructure
- An analysis of the effects of a Basic Health Plan option on premium and enrollment in the Exchange
- An evaluation of options for multi-State and/or Federal collaboration

In 2011 Oliver Wyman was part of a team that included Mercer Health & Benefits that was retained by the Maryland Health Benefit Exchange to conduct a study related to Market Rules and Risk Section related to Maryland's Exchange planning efforts. This work included the following items:

- The impact of requiring qualified health plans to offer benefits beyond the essential health benefits
- The impact of requiring carriers operating outside of the Exchange to sell products inside the Exchange
- A Study of effect of applying the qualified health plan (QHP) requirements to dental plans,
- Potential sources of adverse selection and how the Exchange could address them
- Strategies to managing rate changes in the individual and small group market, and methods for keeping premiums affordable
- How risk adjustment, reinsurance, and the risk corridors should be coordinated
- The role of the Maryland Insurance Administration in the selection and oversight of QHPs

The US Center for Consumer Information and Insurance Oversight

Oliver Wyman is currently engaged by the US Center for Consumer Information and Insurance Oversight (CCIIO) to assist with the development of certain aspects of the Federally Facilitated Exchange (FFE). States that are not able to demonstrate that they will meet all of the approval standards and their readiness to execute an Exchange Blueprint in the required timeframe will utilize the FFE, at least initially. Due to the highly confidential nature of this assignment, specific details of our work cannot be provided.

Analysis of Proposed Legislation in Massachusetts

In 2005 the Massachusetts Association of Health Plans (MAHP) engaged Oliver Wyman to perform multi-year modeling of proposed legislation in Massachusetts that would impact the non-group and small group markets. In this analysis, Oliver Wyman gathered data from insurers and HMOs in Massachusetts that represented about 85 percent of the targeted markets. Oliver Wyman incorporated assumptions regarding the elasticity of demand for health insurance that varied by market, impact of various rating and underwriting rules and the impact of new, lower cost products on the uninsured. The range in assumptions was supported through reviews of previous pertinent studies adapted to the specific needs of the modeling.

North Carolina

Oliver Wyman is currently assisting the State of North Carolina in selecting a plan to serve as its benchmark plan. Based on the essential health benefit bulletin released by HHS in December of 2011, and other guidance, Oliver Wyman is utilizing its benefit pricing model to develop the relative cost for each benchmark plan option. These results will help the State assess the relative impact that selecting each of the options would have on insurance costs in the individual and small group markets in the State, as well as any cost to the State resulting from mandated benefits which are not part of the essential health benefit package. State specific costs were gathered through a carefully designed carrier survey, focused on the cost and utilization of specific benefits currently covered under one benefit option but not others. For several benefits,

additional research was performed in order to examine the medical efficacy and social impact of covering or not covering a certain benefit. This additional research will aid the decision maker when deciding among two plans with different benefits that have similar cost impact on premiums.

Market Reforms in Vermont

During the past several years, Oliver Wyman has provided modeling and impact analyses for multiple proposed market reforms in Vermont including:

- Expanded rating bands for the individual and small group market for the Vermont Department of Banking, Insurance Securities and Health Care Administration (BISHCA)
- Tax incentives for small employers and individuals in Vermont
- Premium subsidies for individual insurance in Vermont
- Expanding a Medicaid-like program to small employers

These impact analyses took into consideration the effect some of the proposals would have had on the private health insurance market. In addition, Oliver Wyman provided a review of cost estimates prepared by another consultant. Oliver Wyman testified before the Legislature regarding the results.

In 2006, Vermont passed health care reform that resulted in the creation of a new program, Catamount Health Insurance. These reforms were an attempt to increase the availability of affordable health insurance and reduce the number of uninsured. Oliver Wyman has been and continues to assist BISHCA in developing the initial and modified guidelines for the implementation and ongoing administration of these reforms. Oliver Wyman provides cost analyses of proposed changes in benefits, eligibility rules and pre-existing conditions.

Vermont's latest health care reform legislation, Act 48, was signed into law in 2011. Act 48 creates Green Mountain Care which will put Vermont on a path to a single payer system if it can be demonstrated that the cost will be less than the current system. Oliver Wyman has been the State's actuary for over 20 years

Virginia Hospital and Health Care Association

Oliver Wyman recently provided a qualitative study to the Virginia Hospital and Health Care Association that addressed the impacts on the insurance market of Federal reforms. Oliver Wyman discussed many issues including pros and cons of merging the individual and small group markets, decisions pertaining to Exchanges to mitigate selection, how Federal reforms will impact self-funded entities and whether or not more entities will elect to become self funded. The impacts of Federal reform will vary materially by state and will be primarily driven by the pre-reform rating and underwriting environment.

Massachusetts Division of Health Care Finance and Policy Trend Study

In 2009 and 2010, Oliver Wyman completed the premium trend analysis for the Division of Health Care Finance and Policy's (DHCFP) cost trend study. This study included analysis of the

change in premiums separately for individuals that purchased coverage before versus those that purchased coverage after the merger of the non-group and small group markets. Oliver Wyman studied the portion of the premium trend that was attributable to changes in demographics and benefits, administrative expenses and profit, and the underlying cost of care. Oliver Wyman also supported DHCFP through the hearing process, including providing expert testimony.

Oliver Wyman Carrier Trend Survey Report

Semi-annually, Oliver Wyman conducts a survey of the trends that health care insurers and managed care companies use in their pricing. Most of the BlueCross/BlueShield plans around the country (including their subsidiaries) participate in this survey. Together, the survey participants represent more than 100 million insured lives in the group market alone and over 100 different companies operating in various markets, such as individual, group, Medicare supplements, Medicare Advantage, health savings accounts/high deductible health plans, Medicaid and stop loss. The survey includes some of the largest health insurers in the country as well as small, localized HMOs. This survey provides valuable information as we advise our clients and assess other carriers' pricing trends.

Experience Working with Health Insurance Carriers

A large part of the work that Oliver Wyman performs is done on behalf of health plans. This includes health benefit design and pricing, budgeting and reserving. While Oliver Wyman specializes in the small group and individual markets, Oliver Wyman also has extensive experience in the large group and self-insured markets. As part of this work, Oliver Wyman periodically prepares actuarial memoranda for filing with States in support of rate revisions. Oliver Wyman has also prepared small group actuarial certifications in over thirty States. Through these experiences Oliver Wyman has become familiar with the filing requirements of many other States.

Members of Oliver Wyman's staff fill the role of appointed actuary for several health plans, signing their annual reserve opinions. In addition, for many smaller clients that do not have actuaries on staff, Oliver Wyman fills this role. For these clients, Oliver Wyman is responsible for all aspects of rate development including preparation of rate filings, pricing strategy, and rate model maintenance. Oliver Wyman also assists clients with product development and underwriting strategy.

Supporting State Departments of Insurance and Attorney General Offices

Oliver Wyman has an extensive history of providing actuarial services to State regulators and insurers. Oliver Wyman has provided and continues to provide life and health actuarial services as advisors to regulators on various actuarial engagements including rate filing reviews, reserves and liabilities, and capital adequacy and sufficiency. Recently, Oliver Wyman has helped States develop their health reform strategies.

Professional Committees and Other Activities

In addition, Oliver Wyman staff is highly involved on professional committees. Several Oliver Wyman actuaries are currently on American Academy of Actuaries (AAA) committees

developing questions and suggestions for HHS regarding those components of the PPACA that are effective in the short term. We are active on committees related to premium review, new benefits required under PPACA, the newly implemented minimum loss ratio requirements and exchanges.

Oliver Wyman staff have also been involved in other professional committees through the AAA such as the small group medical task force, the individual health committee, the defined contributions committee and the mandate committee. In addition, staff are regular speakers at professional actuarial conferences, like the Blue Cross/Blue Shield National Actuarial, Financial and Underwriting conferences, the Small Group Forum conferences and the Society of Actuaries Health Care conferences.

HMA Experience

The HMA team has worked with a number of States to support planning for the implementation of health insurance Exchanges. The team has worked with States and other public and private sector clients, including foundations, to analyze PPACA and to support the creation of new health insurance reform initiatives. Additionally, several members of the team directed Exchange implementation as State officials.

HMA staff has worked with many States, including Michigan, Indiana, Maryland, Florida, West Virginia, California, Texas, and Delaware, to identify, assess and design policy reforms to cover the uninsured. HMA has experience analyzing broad ranges of policy options such as tax credits, purchasing pools, incremental expansion of public programs, employer "play or pay", individual mandate and single payer. Additionally, HMA has worked with many communities to develop new and innovative coverage expansion programs for individuals and employers. The following items provide specific descriptions of HMA work in the area of health insurance Exchanges and the related policy and operational issues:

HMA and Mercer partnered to provide the State of Michigan with comprehensive Exchange planning services.

HMA, completed a comprehensive Exchange planning project for the **State of Michigan**, funded by that State's Exchange planning grant award. This work included: stakeholder facilitation; research and analysis to inform Exchange planning options; an assessment and pro/con analysis of governance options for the Exchange; a report on Exchange business operations and necessary resources, with an implementation plan for State Exchange implementation; an analysis of opportunities for program integration between the Exchange and State health programs; and an assessment of technical needs and existing technical infrastructure necessary to run an Exchange in Michigan. (December 2010 – December 2011). HMA has recently extended this agreement and is conducting detailed insurance market analysis and modeling of the planned MiHealth Marketplace.

- HMA was awarded a contract by the **State of Illinois** to complete a needs assessment to support Illinois Health Insurance Exchange planning and the development of an enrollment, verification and eligibility (EVE) system for individuals seeking subsidized Exchange and Medicaid coverage. HMA's work included a projection of likely costs associated with implementing an Illinois-based Exchange; development of a summary of necessary changes in insurance regulation to accommodate the operation of an Exchange; identifying a source of long-term Exchange financing; analyzing the impact that Illinois' Exchange would have upon other State programs; reviewing current processes and IT systems used to determination of eligibility for Medicaid and other assistance programs; identifying requirements for the design of an EVE system and identifying available options for the implementation of required EVE functions.

- HMA lead a team tasked with assisting the **State of Nebraska** with its Health Insurance Exchange planning efforts. Specifically the HMA team completed a demographic analysis of insurance coverage status in the State; assessed the insurance market in Nebraska including an analysis of the affordability of health coverage; projected the likely cost of operating an Exchange and developed economic models detailing the affect a State operated, regional or Federally operated Exchange would have upon insurance regulation, premium cost and caseload in Nebraska.

- HMA subcontracted with Mercer on an Exchange planning project for the **State of Connecticut**. HMA completed an assessment of the uninsured and underinsured in Connecticut under differing types of public and private health insurance coverage; assessed the impact that an Exchange would have upon enrollment levels within the State's Medicaid program and developed a sustainable model for funding the Exchange.

Mercer Experience

In addition to working with a number of States to support planning and implementation of health insurance Exchanges (Connecticut, The District of Columbia, Massachusetts, Michigan, Nebraska) Mercer has been engaged by State Medicaid programs and other clients to perform large and complex projects for more than 25 years. Since 1985, Mercer's Government Human Services Consulting practice has worked with more than 35 States and currently holds active contracts with more than 20 States. Mercer is the actuary of record for the three States in the US with the largest Medicaid expenditures[1]: California ($38 billion), New York ($31 billion) and Pennsylvania ($17 billion). To date, Mercer has helped ten 10 States implement or administer some form of risk adjustment in their Medicaid-managed care programs. Being a sister company, Oliver Wyman is positioned to draw on Mercer's unique expertise in this area.

Florida

Mercer has worked with the Florida Agency for Health Care Administration (AHCA) to design and implement its Medicaid reform initiative. This reform incorporated a number of

[1] KAISER STATE HEALTH FACTS, 2008. *STATE MEDICAID EXPENDITURES.* HTTP://WWW.STATEHEALTHFATS.KFF.ORG.

ground-breaking components to Medicaid, such as Enhanced Benefit Accounts to reward recipients for specified healthy behaviors, flexible benefit packages that met actuarial equivalence standards, and innovative incentives for the development of Provider Service Networks to provide viable managed care service delivery organizations in rural areas – entities that are similar to the Accountable Care Organizations currently being encouraged through the Patient Protection and Affordable Care Act (ACA) demonstrations.

Louisiana

In Louisiana Mercer developed multi-year projections of potential enrollment and costs of Medicaid expansion populations for the State. These analyses build on years of experience working with states as they have expanded their Medicaid programs or considered other types of state coverage initiatives. Over the last few years, Mercer has performed these coverage analyses for North Carolina, Massachusetts, Pennsylvania, Missouri, Kansas, New York, and New Mexico, to name a few. This experience, as well as their access to eligibility and cost information from many states with varying coverage levels, means that Mercer is well informed about key characteristics of expansion populations, including relative acuity levels and historical enrollment ramp-up patterns.

Massachusetts

The Commonwealth of Massachusetts passed the Health Care Reform Act of 2006, establishing the Commonwealth Care Health Insurance Program (Commonwealth Care). The Massachusetts Health Reform Law served to a significant degree as the model for the ACA, as it included an insurance Exchange, subsidies for coverage, an individual mandate and an employer mandate. Commonwealth Care provides subsidized health insurance for low income, uninsured adults below 300 percent of the FPL. Mercer worked with the Commonwealth Health Insurance Connector Authority (Connector) to develop the first-year actuarially sound capitation rate ranges for Commonwealth Care for each of four plan designs. Mercer also assisted the Connector with implementation plans, and the development of the health plan contract and rate negotiations.

References

North Carolina Department of Insurance
Julia Lerche
Actuary
North Carolina Department of Insurance
919-807-6644
Julia.lerche@ncdoi.gov

Michigan Department of Licensing and Regulatory Affairs
Christopher Priest
Project Manager
Michigan Department of Licensing and Regulatory Affairs
517-373-1820
priestc1@michigan.gov

District of Columbia Department of Healthcare Finance

Bidemi Isiaq
Legislative Analyst/Project COTR
D.C. Department of Healthcare Finance
202-442-9202
bidemi.isiaq@dc.gov

Illinois Department of Insurance
Kate Gross MPH
Assistant Director for Health Planning
Illinois Department of Insurance
James R. Thompson Center
100 W. Randolph Street, Suite 9-301
Chicago, IL 60601-3395
312-814-1236
Kate.Gross@Illinois.gov

Approach and Methodology

In this section we present our approach and methodology for completing the many tasks outlined in the RFP. We discuss how we will collaborate with the State to work with insurance carriers to gather additional information needed for our actuarial and economic model, as well as other tasks. We discuss the primary data sources and tools available for performing our work, as well as our proposed approach for designing survey tools and conducting stakeholder interviews. We discuss each major task outlined in the RFP and present our proposed approach to performing the requested analysis. We conclude with our proposed project deliverables, staffing plan and approach to project management.

While we present our proposed approach and methodology for each of these items, we will work with the WVOIC during the kick-off meeting and throughout the project to ensure our approach will result in providing the WVOIC with the information it needs to make the many decisions associated with establishing the West Virginia Exchange.

Access to Data Sources

Being part of a large international corporation, Oliver Wyman has access to a vast amount of information, including several data sources which are valuable in performing the type of modeling the WVOIC is requesting. Among these are:

- The American Community Survey
- The Current Population Survey
- US Census Bureau
- The Medical Expenditure Panel Survey
- The Bureau of Labor Statistics
- Dun & Bradstreet
- Thompson Reuters MarketScan Data
- SNL Financial Data -
- Mercer's National Employer Survey

Oliver Wyman's Microsimulation Model

At the center of our approach and methodology is Oliver Wyman's Healthcare Reform Microsimulation Model (HRMM). Our model is a leading edge tool for analyzing the impact of various health care reform provisions, as well as proposed legislation. Economic modeling that captures the flow of individuals across various markets based on their economic purchasing decisions is integrated with actuarial modeling designed to assess the impact that the various aspects of the ACA have on insurance markets and premiums. It is this rare integration of economic and actuarial modeling that allows us to capture the complex migration likely to occur as a result of the ACA.

The model has three primary modules. The first module characterizes the current population; the second module calibrates the simulated population to the current market; and the third module projects the simulated population in future years given coverage options, choice and market reforms.

In the first module, the current population is built from several data sources. The American Community Survey (ACS) is selected as the primary data source which covers the entire population. The ACS includes information for each person's age, gender, income, insurance coverage type, employment status, geographic place of work, geographic place of residence, industry in which they are employed, and many other characteristics. The ACS requests information on households, however our model is built on decisions made at the Health Insurance Unit (HIU) level. An HIU is defined as any grouping of family members where each person within the HIU might be eligible for coverage under the same policy. Therefore, when preparing the ACS data for our model, it is adjusted to reflect HIUs.

The ACS data is supplemented and synthesized with several other data sources in order to produce the current marketplace. Information from Dun and Bradstreet is used to create the current employer market. Synthetic groups are created by assigning working individuals from the ACS data to the Dun and Bradstreet employers. Individuals are strategically placed into groups based on their occupation. Information from the Insurer/Employer component of the Medical Expenditure Panel Survey (MEPS) is used to simulate which groups offer insurance coverage and which employees within those groups are covered. A synthetic rating manual used to produce current premiums and benefit coverage distributions by market is created using information from statutory financial statements, insurer rate filings, information obtained from carrier data calls, and other available reports. Finally, health status is strategically assigned to various sub-populations based on statistical analysis of self reported health status obtained from the Current Population Survey (CPS),

Once the current market has been created, it is used to calibrate the HRMM. The purpose of the calibration module is to solve for the model parameters that replicate the characteristics (e.g., size, premium, claims cost) of the known insurance markets during the base period. The model is calibrated to ensure the known market is replicated at several levels, such as by broad age and income ranges within various markets. This step is critical to the modeling as without such calibration reliability of the results is diminished significantly.

Once the model has been calibrated, the model is ready to be used to project the markets into which individuals will enroll based on the coverage options available to them, and the resulting premiums for those markets. The process of determining which coverage option each HIU elects to enroll in is based on the application of economic utility maximization. Employer decisions as to the level of coverage offered, if any, are based on an elasticity curve.

The model incorporates the various aspects of the ACA and other economic assumptions that will impact premiums and enrollment. These items include but are not limited to:

- Premium and cost sharing subsidies available to low income individuals
- Individual coverage mandate and penalties for not taking coverage (unless exempt)
- Medicaid expansion to include childless adults up to 133% of the Federal poverty level (138% when including a 5% income disregard)
- Application of an affordability test to determine whether individuals offered employer coverage are eligible for subsidized coverage in the individual exchange
- Changes in Federal poverty levels in future years
- Regional population growth estimates consistent with the US Bureau of the Census projections
- Medical inflation
- CPI growth consistent with the Social Security Trustees Report
- Wage inflation consistent with the Social Security Trustees Report
- Income tax rates specific to each state including State, Federal, FICA, and Medicare taxes
- Pent up demand for newly insured individuals
- Differences in utilization between individuals with insurance and similarly situated individuals without insurance, based on a study by the Congressional Budget Office
- An interia factor to model the likelihood of an individual switching to alternate coverage

The Oliver Wyman HRMM has the following advantages over other models commonly used in the market today:

An important distinction to our model and philosophical approach to economic modeling is the detailed calibration undertaken to ensure it accurately replicates the current insurance market enrollment and premiums.

- The model is a State-based model rather than a national model. The calibration process allows the model to capture unique dynamics of the local market which are not directly captured by other models.
- Using vast amounts of State specific data, the model is calibrated to reproduce the State's current insurance marketplace. The parameters of the utility function used by the model to predict individual behavior in 2014 and beyond are solved for as part of the calibration process. Other models utilize utility curves based on research and as a result may not fully capture the unique dynamics of the local market.
- The model utilizes the ACS as the primary source for sizing the current population by market (e.g., uninsured, Medicaid, individual insurance, group insurance), age, gender, income, and family composition. Many other models utilize data from the Current Population Survey, the

Survey of Income and Program Participation or the Medical Expenditure Panel Survey as their primary data source. The ACS has the following advantages over these other sources:
  - Conducted by the Census Bureau, the ACS includes responses from approximately 1.3 million housing units and 3.1 million residents nationwide. This compares to approximately 60,000 households included in the Current Population Survey and roughly 40,000 households in the Survey of Income and Program Participants
  - The ACS attempts to correct for the well documented Medicaid undercount phenomenon
  - ACS questionnaire requests 'current' insurance status, not all forms of insurance status over the prior year as the Current Population Survey does
  - Enrollees are legally obligated to respond to the ACS (98% response rate in 2009)
  - If necessary, the ACS includes measures that permit calculation of standard errors
- The Oliver Wyman HRMM utilizes information on actual firms within the State by size, industry and average income from Dun and Bradstreet to create groups into which employed individuals are placed. Other models rely primarily on employer survey data such as the Bureau of Labor Statistics National Compensation Survey or the Kaiser Family Foundation's Employer Survey.

The modeling results include premium, claims and enrollment by market and projection year. The model is driven based on several input assumptions and as a result has the flexibility and power to help answer many policy related questions. Some of the question the model has been used to answer in previous assignments include but are not limited to:

- What is the size of the individual, small group, Medicaid and uninsured populations pre- and post-reform? Where do the shifts in enrollment occur?
- What is the take-up rate in the individual and SHOP exchange under various assumptions?
- What are the premiums in the individual and small group markets pre- and post reform?
- What is the impact on premiums from changes in morbidity of the pool, and from other effects such as essential health benefits, taxes, fees, and reinsurance?
- What is the impact on premiums and enrollment if the individual and small group markets are merged?
- What is the impact on premiums and enrollment in the small group market if the definition of small group is expanded to 100 in 2014?
- What is the income distribution within a given market before and after 2014?
- What do the uninsured look like before and after 2014 by age? By income?

Oliver Wyman's HRMM has been recently used to assist States model State specific health insurance reforms for projects similar in scope to the services requested by the WVOIC in this RFP. An earlier generation of our model was used to model proposed Federal legislation in 2009 and the results were used in conversations with policymakers, including staff at the Senate Finance Committee and the Congressional Budget Office (CBO), and with our health plan clients. We believe that this modeling was instrumental in shaping the Affordable Care Act, particularly provisions related to the small group and individual markets. Our modeling demonstrated the importance of, and the difficulty in, stabilizing the individual market when it moves to a guarantee issue environment with a relatively weak mandate.

2.4.1 Background Research

In order to properly plan for the establishment of its Exchange, West Virginia must develop a thorough understanding of its current insurance marketplace, as well as the population of additional individuals likely to enroll as a result of provisions in the Affordable Care Act, such as premium and cost sharing subsidies and the mandate that most individuals have health insurance. Therefore, as with other States planning for their Exchange, the WVOIC is seeking a significant amount of information to support their background research, as well as economic and actuarial modeling to assess what the insurance marketplace could reasonably be expected to look like in 2014 and beyond, under various scenarios.

a. Study of the Uninsured and Underinsured in West Virginia

As demonstrated through its enabling legislation passed in 2011, West Virginia understands the advantages and disadvantages of allowing individuals and small firms to access coverage that is portable, choice-based and tax advantaged. In fulfilling this objective West Virginia must first understand the insured, the uninsured, and the underinsured populations. The definition of insured and uninsured are fairly, though not perfectly, clear. The definition of "uninsured" is more straightforward than the definition of "underinsured."

As a first step, the Oliver Wyman team will work with the State to assure that the definitions that we use are practicable for the purposes of this project and yield the analytic insights required to accomplish the State's goals and objectives. The Agency for Healthcare Research and Quality (AHRQ) publishes State-specific results for its Medical Expenditure Panel Survey (MEPS) Insurance Component, with results for both uninsured at a point-in-time and uninsured at any time during the past year. The American Community Survey (ACS) by the Census Bureau also includes State-specific data on sources of insurance coverage and on being uninsured. Given survey data generally undercounts Medicaid coverage, the ACS attempts to correct for this. However, additional adjustments may be needed based on other sources such as State Medicaid enrollment data, in order to more accurately reflect the uninsured count.

For underinsurance, one possible definition is for those individuals who have insurance, but who report that they could not go to a doctor for medical treatment due to cost, to be considered underinsured. This approach has been used in the Centers for Disease Control and Prevention (CDC) Behavioral Risk Factor Surveillance System (BRFSS). Such a definition will not produce the same results as an economic definition.

The economic definition would define underinsured in terms of the level of cost-sharing (deductibles, coinsurance, copays, and limits on specific services) compared to family income. When considering income, the Oliver Wyman team will work with the WVOIC to develop the desired definition. We propose evaluating income as gross, disposable, and discretionary. Disposable income is total personal income minus personal current taxes. In national definitions, personal income, minus personal current taxes, equals disposable personal income.

Discretionary income is income after subtracting taxes and normal expenses (such as rent or mortgage, utilities, insurance, medical care, transportation, property maintenance, child support, inflation, food and sundries, etc.).

Discretionary income = Gross income – taxes – necessities

Thinking about income in multiple dimensions allows us to better estimate the real world trade offs individuals make when evaluating the cost of insurance.

The ACA provides, starting in 2014, income-based premium tax credits and cost-sharing reductions to help certain qualifying individuals better afford Exchange coverage. This financial aid will not be available to anyone eligible for "minimum essential coverage" through certain public programs or employer-sponsored plans. These public programs include Medicare, Medicaid, CHIP, TRICARE, Indian Health Service, veterans' health care programs, and Peace Corps. Those eligible for employer-sponsored coverage but who do not enroll in an employer plan will still be able to receive the assistance if either of the following is true – the plan pays less than 60 percent of total allowed benefit costs or the employee's contribution for single coverage is considered unaffordable (more than 9.5 percent of household income, starting in 2015). Those below 400 percent of the FPL have lower affordability thresholds, with the lowest eligible persons having to pay no more than 2 percent of household income for premiums. We will use the detailed benefit, premium and claims cost information we anticipate gathering through a carrier benefit survey and a carrier data call to perform our microsimulation modeling described later in this proposal to estimate the anticipated out-of-pocket costs.

The ACS survey data will provide details on many of the demographic and socioeconomic characteristic the WVOIC desires to obtain for this population. This includes information on household income, household size, geographic location, age, gender, race and employment status, and occupation if employed.

b. Study of the Insured Population in West Virginia

In this task we will provide a descriptive analysis of the current insurance market in the State of West Virginia. This analysis will provide the WVOIC with information on how the current population breaks down by market, as well as additional demographic and socioeconomic information about the individuals currently enrolled in each market. Again using the ACS information as our primary data source we will analyze the population currently covered by individual insurance, employer sponsored insurance, Medicaid, Medicare and Tri-Care. While the individual market analysis will be limited to West Virginia residents, the employer analysis will be based on individuals receiving coverage through a West Virginia employer regardless of their State of residence.

We will supplement the ACS information where possible with other data sources. We will work with the WVOIC to coordinate with the West Virginia Department of Health and Human Resources (DHHR) to obtain any additional information they can provide related to individuals currently enrolled in the Medicaid program. Additional information on the Medicare population,

including those with coverage through the Medicare Advantage and Prescription Drug programs, will be obtained from the Centers for Medicare and Medicaid Services (CMS) website.

Using this information, we will assemble various summaries for each these populations by household income, household size, eligibility for programs for which individuals are not enrolled (e.g., those eligible for Medicaid but not enrolled), geography, age, gender, race, employment status and occupation. We will compare current average premiums in the individual market to incomes of individuals current insured at various FPL levels.

In addition to analyzing the individuals currently enrolled in these markets, we will analyze the markets themselves. We will begin by sizing the individual, small group and large group fully insured markets relying on statutory financial statement information obtain from SNL Financial's database. We will report premiums, claims and membership information for each market by carrier. This will allow for an examination of the concentration of the current market, level and variance in premiums offered in each market today, as well as recent financial performance (e.g., loss ratio) by carrier within each market.

c. Study of the Small Business Options Program (SHOP)

Beginning in 2014 the Small Business Options Program (SHOP) will provide a new venue through which small employers may purchase health insurance for their employees. In order for the Exchange to properly prepare to support the SHOP, it is important to understand the size of the current small group market as well as the characteristics of the market.

Using Dun and Bradstreet data as a primary source for employer information, Oliver Wyman will analyze the current small group market. We will gather information about the employers in this size range by employer size, industry, geography within the State, and average payroll. Examining the average payroll of the groups size 25 and less will allow us to provide the WVOIC with an estimate of the number of groups that could potentially be eligible for temporary employer tax credits. We will discuss other information available on the Dun and Bradstreet data with the WVOIC to determine whether there is other information that they would like to have included.

Next, we will use a carrier data call (described in more detail later) to provide a significant portion of the information needed for actuarial and economic modeling. Information will be gathered from carriers on each small group including the number of employees covered, the number of members covered, the geographic location of the group, the industry of the group, as well as distributions by age and gender.

Some of the information the WVOIC seeks related to the small group market such as household income and race, is not gathered by carriers since they are not allowable characteristics by which rates may vary. Information on household size is also not typically maintained, but rather only information on the members of the household that enroll in the employer sponsored plan. If the WVOIC desires information on income and race the only way to gather that type of information for the small group is to estimate it. Using the American Community Survey (ACS) which contains information on household income and race, as well as indicators such as a

household insurance status and the occupation of the head householder, we will simulate the subset of individuals indicated in the survey as having employer coverage that could comprise the small group market.

The ACS data also contains information about individuals that live outside of the State of West Virginia but who work within the State and are enrolled in coverage provided by their West Virginia employer. We will use this information to provide distributions of individuals in this category by age, income and occupation. We will also compare the population that works in West Virginia but resides outside of the State to West Virginia residents that work in the State.

As stated above, the Dun and Bradstreet information will be used to identify groups that are potentially eligible for small business tax credits when offering insurance to their employees. Information will be developed for these groups including distributions by group size and average payroll. Using information from the Medical Expenditure Panel Survey we will provide the estimated employee contributions for this population. Information from the carrier data call will be used to provide information related to premiums for employers in this range currently offering coverage to their employees.

Finally, research will be performed to assess State and Federal efforts over the past ten years to provide assistance to small employers wishing to provide insurance coverage to their employees. Information will be reported on the type of programs, time period over which the programs were in place, and any financial assistance provided to employers.

d. Assessment of Coverage Affordability in West Virginia

We have addressed all of the information and analyses requested in this section of the RFP that we are including in our proposed scope of services elsewhere in our proposal. An assessment of the underinsured is addressed previously in section 2.4.1(a). A discussion of the current population by federal poverty level is included in sections 2.4.1(a) and 2.4.1(b) for the appropriate populations.

As part of our work in section 2.4.1(b) we will analyze average premiums in the current individual market and compare them with incomes of those currently insured in these markets. In section 2.4.1(f) that follows we discuss how our economic and actuarial modeling will project average premiums and income levels in 2014 and beyond, and coverage take-up rates based on individual utility functions and employer elasticity functions. The results of this analysis will then be used to examine future average premiums as a percent of income by FPL.

e. Assessment of Health Insurance Marketplace in West Virginia

Product Offerings and Premium Levels

Beginning in 2014, carriers offering coverage in the individual and small group markets will only be allowed to offer products at platinum, gold, silver, bronze and catastrophic levels, with actuarial values as prescribed in the ACA. The amount of market disruption caused by this required shift to standardized benefit levels will depend upon the coverage offered in the market today. By conducting an insurance market assessment, the State will be able to better understand the predominant products being sold in the State by market segment, the designs of

the products offered, including covered benefits, benefit limitations and cost-sharing provisions, and the premiums charged.

Initially, the Oliver Wyman team will meet with the WVOIC to discuss the goals of the survey in more detail to ensure that the results of the survey meet your needs. Although the following steps could change after meeting with the State, we anticipate that the survey process would include the following steps.

Background work. Oliver Wyman will conduct a high level assessment of the current individual and small group markets. Using statutory financial statements, information on premium, claims and membership for 2011 in each market will be gathered and summarized. This will allow for identifying carriers in each market with measurable market share for requested participation in the survey.

Identify specific information to include in the survey. In our experience, when developing surveys careful up-front planning makes all the difference to success. We want to understand precisely what information the State requires. Oliver Wyman can help strategically identify what information is required to ensure the results lend to policy decision making. For example, we envision the questionnaire to collect information on the following:

- Earned premium, incurred claims and member months by individual/group and for group by employer size range
- Benefit plan descriptions and actuarial values for plans with at least 5% of members in each segment
- Member months by market segment and age band
- Pricing claims trends and target loss ratios by market segment
- Retention by type of expense and market segment
- Provider payment methods

Identify possible sources for survey information. Oliver Wyman will review the information readily available to support and inform the survey questions. This information will also be used to help validate survey results once the information is collected.

Discuss the best survey delivery method for the targeted group (health insurance carriers that offer coverage to West Virginia residents). There are various ways to collect the information including online survey, in-person interview, mail survey, and telephone survey. However, since part of the survey will require more detailed information gathering to support our actuarial and economic modeling and will include submission of data files and Excel spreadsheets, we anticipate that the most efficient approach is a mailed survey with telephone follow up to ensure completeness and accuracy of the responses.

Build the survey. We will carefully craft the survey to ensure it will obtain all of the information desired by the WVOIC. The survey will also function as a means of gathering benefit, claims and demographic information required for the actuarial and economic modeling discussed later. Therefore, these needs will also be considered when developing the survey.

Release the survey to the target group. Upon final approval by the WVOIC, Oliver Wyman will request survey participation from the target group. Oliver Wyman will develop a letter for the WVOIC's distribution to carriers that describes the purpose of the survey as well as instructions for survey completion. Oliver Wyman will provide a phone number and e-mail address (Contact us) for carriers to answer questions regarding the survey.

Since the survey is not anonymous, Oliver Wyman will track survey completion by invited participants and follow up with one e-mail to each participant who has not completed the survey within the three week timeframe. Oliver Wyman will follow up with one phone call to each participant who has not completed the survey one week after the close date.

Extract data and create reports at survey close. Oliver Wyman will generate a report in the agreed upon format that contains the information required by the State. In the presentation of results, Oliver Wyman will summarize the survey results and provide written comment on the results.

Producers

The creation of Health Insurance Exchanges, as mandated in the Affordable Care Act, raises a number of important and complex questions about the role that insurance producers will play in the indiviudal and small group markets in West Virginia in 2014 and beyond. Planners for West Virgina's Exchange will need to carefully consider how to best interweave the functions of the Exchange into the existing capacity available to insurance purchasers – both individuals and employers – through producers. Appropriate consideration about how an Exchange should best interact with producers will require a combination of data analysis and a practical assessment of the market environment.

Working with Oliver Wyman, HMA will begin by working with the WVOIC to understand the following baseline information:

- The number and distribution of producers in West Virginia.
- Current mechanisms used to compensate producers for products sold through the individual and small group markets.
- Current producer sales by carrier.

To provide this baseline, HMA will work with the appropriate licensing and regulatory agencies to review the publicly available files of licensed and credentialed agents/brokers, health care insurance companies and HMOs. Documents reviewed will include, but not be limited to, annual financial filings and corporate record filings. A review of published data and data available from the State relative to current health care market place will include:

a. Statewide and regional penetration by type of carrier
b. Range of health care benefit plans available by line of business
c. Enrollment by contract type - single, two person and family.

In addition to reviewing this publicly available information, HMA will work with the State to develop two complementary approaches to collect more detailed information about the role and penetration of producers in the individual and smallgroup markets.

Stakeholder Interviews

First, HMA will develop a process to interview external market participants. With this approach HMA will:

1. Work with the State to select key stakeholders from the following categories:

    a. Admitted health care insurance companies
    b. Licensed HMOs
    c. Registered agents/brokers
    d. Small employers

2. Design, develop and finalize, with input from the State, an interview guide to provide to identified key stakeholders in advance of stakeholder interviews.

These interviews will be intended to buttress information from publicly-available information, including by expanding HMA's and the State's understanding of the role of producers in the market geographically, by individual and small group market, and by product line.
Because of the importance to West Virginia of assessing the kinds of scenarios laid out in sub-section 2.4.1(iv) of the RFP, HMA will also seek to assess attitudes and expectations of these stakeholders about the impact of the ACA. Specifically, with respect to **Health Insurance Producers,** stakeholder interviews will focus upon the following:

1. The current role of insurance producers in the sale of small group and individual insurance coverage
2. The commissions currently available to producers assisting small groups and individuals in obtaining coverage
3. Services provided to consumers in addition to "selling" health care benefits
4. The perceived adequacy of current commission/fee schedule for services provided
5. The extent of planned functions and responsibilities for producers in the Exchange environment
6. The role of "value added" offerings to purchasers in an Exchange environment
7. The anticipated infrastructure expenditures necessary for producers to coordinate with West Virginia's Exchange

With respect to **Insurance carriers or HMO** stakeholders, discussions will focus upon the following:

1. The current role and responsibility of agent/brokers in the small group and individual market segment
2. The allocation of administrative expense for distribution split between to agents/brokers, other external entities and internal staff

3. The anticipated structure of distribution system in the Exchange environment
4. The anticipated infrastructure expenditures necessary to coordinate with West Virginia's Exchange

Targeted Data Request

Second, HMA will work with the State to design a targeted data request of carriers. HMA recognizes that some of the information sought by the State of West Virginia may be proprietary and confidential. While we believe there is great value in talking directly with market participants to get a better sense of the environment, we also recommend a targeted data call focused on producer commissions and distribution channels utilized by carriers. Ideally, we will work with the State to establish that the material gathered will be treated as proprietary, in order to help ensure an efficient and timely collection effort.

HMA believes this approach – reviewing publicly available information, designing an interview process of market participants, and seeking sensitive information directly from carriers – is most likely to result in the best data to inform West Virginia planning. However, we do not see this effort as solely a data-gathering one. Implementation of West Virginia's Health Insurance Exchange will provide consumers new access to information about their health coverage choices. The availability of an Exchange, as well as the likelihood that a portion of premium revenue will need to be allocated to support its operation, may make changes in how producers are reimbursed necessary or even inevitable. Alongside our efforts to collect information, HMA will review leading industry literature and assess, informed by our team's experience with exchange development, the strengths and weaknesses associated with new approaches for compensating insurance producers with particular emphasis upon mechanisms that would reimburse producers through a flat or time based fee.

f. Economic Modeling and Fiscal Analysis

Beginning in 2009, the Oliver Wyman team began building a robust migration model to help clients understand the impact of various provisions of the then proposed health care reform legislation. We have used the results of this model in conversations with policymakers, including staff at the Senate Finance Committee and the Congressional Budget Office (CBO), and with our State and health plan clients. We believe that this modeling was instrumental in shaping the Affordable Care Act, particularly provisions related to the small group and individual markets. Our modeling demonstrated the importance of, and the difficulty in, stabilizing the individual market when it moves to a guarantee issue environment with a relatively weak mandate. We believe our work was, at least in part, responsible for the transitional reinsurance program in the individual market and the risk corridors in the individual and small group markets in the final legislation.

We have continually enhanced our modeling capabilities as reforms have unfolded and today have a market-leading actuarial and economic microsimulation model. As previously described, our model is based on a database of claims, premium, and underwriting information from actual insurance policies. It also makes use of publicly available ACS and MEPS data, and data available through third-party providers (e.g., Dun & Bradstreet).

The model differs from many other models currently in use because it allows us to analyze the impact of insurance reforms on actual insurance policies. This is critical because, for example, the rating reforms under the ACA (e.g., 3:1 limits, oldest to youngest, for age and the elimination of gender as a rating variable) has most of its impact at the "ends of the distributions." For example, the medical claims for the healthiest 10 percent of members are typically less than a quarter of average claims, and the claims of the costliest 10 percent are often four to seven times the average. With actual insurance policy data, we can see how much premiums will shift, and therefore how enrollment is likely to shift, across the full distribution of policies.

In our model, actuarial analysis is used to determine how changes in rating regulations will affect premiums by market over a five-year period after reform is implemented. This multi-year view allows us to capture the impact of cumulative adverse selection, carrier reaction to price competition and other factors that affect prices.

Our model estimates the costs of coverage choices available in the market under a given Exchange scenario, determines market reaction and predicts shifts among sources of coverage (i.e., individual market, small-employer market, and government programs) and the uninsured. To evaluate market reaction to reform scenarios, we apply elasticities of demand for employers that are consistent with the academic literature and ranges used by CBO and other models. Behavior of individuals and health insurance purchasing units (i.e., family groups eligible to purchase coverage on a combined family policy) are modeled using an elasticity curve calibrated to the actual insurance market data.

We incorporate this understanding of the responsiveness (or elasticity) of the quantity demanded of a good or service relative to a change in its price, combined with estimated cost changes to the employer or individual, to determine how many members will enter or exit the market under various scenarios. We are able to track membership inflow and outflow based on the health status and income levels of individuals. In addition to rating and premium changes, we also account for the savings individuals realize from subsidies and the cost of foregoing coverage under the individual mandate and the employer penalties.

An important distinction to our model and philosophical approach to economic modeling is the incorporation of stratified premium and cost estimates instead of average cost used in more simplistic modeling.

An important distinction to our model and philosophical approach to economic modeling is the incorporation of individual health insurance purchasing units rather than average cost used in more simplistic modeling. We capture a potential member's different decisions based on his or her unique circumstances. For example, a lower income family of four will make different choices compared to the "average" This will affect their plan selection (e.g., deductibles and other cost sharing features), and participation. A model that does not examine these differences in decision making by cohort has a risk of not incorporating the underlying economic realities of the uninsured and can thereby inaccurately estimate cost and take-up rates.

In addition to modeling the impact on both enrollment and premiums under a baseline scenario, our model has significant flexibility to model many different "what if" scenarios including those outlined in the RFP. We are able to model the following scenarios for the WVOIC.

a. Separate individual and small group risk pools
b. Merged individual and small group risk pools
c. 2014 definition of small group at either 1 – 50 or 1 – 100
d. Impact that the presence of a basic health plan option has on enrollment and premiums in the Exchange
e. Impact of an individual mandate penalty

For each scenario our model will produce information on the projected enrollment and premiums in the individual and small group markets, separately for the Exchange/SHOP and outside markets. Year by year projections for the years 2014 – 2018 can be provided. The details of the modeling allow us to segment the various components impacting changes in premium. For example, we can separately analyze the impact that changes in the morbidity of the individual market will have on premiums in that market in 2014.

Additional output of our model will allow us to look at shifts in certain sub-segments of the population. For example, changes in the distribution of the uninsured population by income level can be examined. We will work with the WVOIC to determine the type of output that would be most beneficial in making the policy decisions that need to be made related to the West Virginia Exchange.

In addition to our actuarial and economic modeling, we will analyze the potential impact of various other policies that are not handled directly through our model. These will be integrated into task 2.4.3(b) and will include:

- A discussion of adverse selection risks inside and outside of the Exchange and strategies for mitigating this risk. We will discuss pros and cons of each approach and the impact each may have on insurer participation in the Exchange and consumer choice
- A discussion of adverse selection that could occur between benefit tiers (i.e., Platinum, Gold, Silver, Bronze
- A discussion of different open enrollment strategies that could be used in the outside market and the impact of utilizing different open enrollment periods than those prescribed for the Exchange as outlined in Federal regulation
- A discussion of various options for risk adjustment and approaches for complying with State and Federal goals
- A discussion of potential regional rating factors and anticipated age rating bands that will be used by carriers in 2014 and beyond

2.4.2 Exchange Design Options

The analysis requested in this section of the RFP will flow from our actuarial and economic modeling described above. Specifically, we will provide the WVOIC with the following analysis for the years 2014 through 2018:

- The impact on premiums and enrollment in the individual and small group markets from merging the risk pools
- The impact on premiums and enrollment in the individual and small group markets from increasing the definition of small group to 100 in 2014 as opposed to 2016 when it will be required to increase by law
- Projected average premiums for Platinum, Gold, Silver, and Bronze coverage sold through the exchange
- Projected changes in the size of various markets (i.e., individual, small group, Medicaid, Uninsured)

The results for each of the scenarios above will be presented in a series of graphs and charts, including a narrative discussion around key results and market impacts.

2.4.3 Exchange Organizational and Impact Analysis

a. Implications of Organizational and Business Issues

Implementation of a Health Benefits Exchange (Exchange) in West Virginia will impact health care providers, small businesses, consumers and existing State agencies responsible for administering Medicaid coverage and insurance regulation. The project team will provide the West Virginia Insurance Commission with a detailed view of the necessary structural changes and resources required for the State to properly establish an Exchange. This analysis will be largely centered around a projection of the Exchange's likely administrative funding needs for each of the years between 2013 and 2017, with an emphasis on leveraging existing State resources.

The ACA, and subsequent Federal regulatory guidance, has established a framework of structural requirements for State-administered Exchanges. This framework provides implementing States with a roadmap of the necessary consumer services and supports that the Exchange must provide, the structure of information technology systems that interface with consumers and existing State eligibility and enrollment systems that will need to be developed, and the needed interactions between an Exchange and other public agencies that will be necessary to run an effective Exchange.

Language within the ACA and relevant regulatory guidance released since enactment of the health reform law has established the following requirements for operation of an Exchange. Any budget projection for a State-administered Exchange should account for the cost of fulfilling the following functions:

- **Consumer Eligibility and Enrollment:** The Federal law requires Exchanges to enroll consumers into the program (Medicaid, SCHIP, subsidized Exchange coverage) they qualify

for on a "real time" basis. Additionally, consumers plan choices will need to be supported by IT enrollment products and customer support services (i.e., a call center). This requires Exchange investment into new and existing IT systems as well as staff resources devoted to a call center and other consumer support options. The project team will provide estimates of the likely cost for IT system development and create budget estimates (tied to projections of Exchange caseload) of likely call center volume and cost. The project team will also consider partnerships as well as the outsourcing possibilities for these functions.

- **Health Coverage Plan Management:** Under the ACA, Exchanges are required to administer the certification, recertification and decertification of participating health carriers. The ACA, and Exchange planning efforts in other states, typically envisions that this task would be best completed through a partnership between an Exchange and its State's insurance regulator. The project team will generate projections of likely effort necessary of an Exchange as well as the West Virginia Insurance Commission to manage the health plan certification process.

- **Customer Service:** A State Health Insurance Exchange is envisioned by the Federal government to be a single source of support for consumers seeking health coverage. Regulations require that the Exchange's web portal correctly link consumers to the coverage option they best qualify for (for example Medicaid eligible consumers must be linked to a Medicaid enrollment function). Additionally, the Exchange should serve as an easily navigated resource that will provide consumers necessary information about their options. The project team will detail the financial and staff resources necessary to support a web portal that meets the Federal requirement. Estimates of likely staff need and funding for consumer education will also need to account for required customer service tasks that the Exchange will need to complete.

- **Communications, Outreach and Education:** Exchange planning efforts in other States have focused upon the value that aggressive outreach and education will have upon an Exchange's financial performance. Federal financial support for an Exchange is not available as of January 1, 2015. A financially viable Exchange will have to reach a critical mass of consumers during this initial year to ensure a large enough base of members to provide sufficient revenue support the Exchange's administrative costs. Continued political and popular support for West Virginia's Exchange will also require aggressive outreach and education activities. Our staff will draw upon experience in other Exchange planning activities to identify the levels of investment that will be necessary to ensure broad-based consumer participation in the Exchange in 2014 and beyond.

- **Financial Management:** A West Virginia based Exchange will likely be required to facilitate the sale of billions of dollars in health coverage premiums each year. This will require strong financial management capability to guarantee the Exchange meets Federal requirements. Specifically the Exchange will have to administer a risk adjustment process between participating health carriers, meet Federal reporting requirements, handle the distribution of premium and cost sharing subsidies guaranteed through the ACA and manage a process to ensure sufficient funding to support the Exchange's administrative costs. Budget and

planning processes for West Virginia's Exchange will need to provide sufficient IT and staff capacity to meet these requirements. Our budget estimates for staffing and consulting support will account this need for expertise to ensure appropriate management of the Exchange's finances.

- **Oversight and Reporting:** The Exchange will be required to provide performance data and relevant member information to the Federal Department of Treasury (tasked with administering the individual mandate), the Federal Centers for Medicare and Medicaid Services (related to Medicaid and SCHIP administration), the State of West Virginia (to ensure compliance with any State statutory requirements) and to inform the activities of the Exchange's senior management. The Exchange will need to have processes in place to quickly and accurately collect, organize and distribute this information to the relevant party. The project team will account for necessary resources to provide this data when identifying budget needs.

Financial Model

To establish and operate its Exchange, plus meet the structural requirements outlined above, the State will need a robust financial model to ensure that there are sufficient resources for the Exchange to succeed. The project team has developed a financial modeling tool that creates a comprehensive projection of the costs, revenues and likely cash reserves available to a Health Insurance Exchange over multiple years. The tool is based on the experience of the current functions and expenses of the Massachusetts Exchange, and can be easily modified to meet West Virginia's needs. This flexible tool can recognize a range of cost inputs and yield a range of financial projections. The financial modeling tool has been used in several large-scale State Exchange planning projects and the methods for developing budget estimates have been refined through our team's experiences during each of these projects. The financial tool will rely upon inputs specific to West Virginia to generate budget projections. Specific inputs that would be used to generate our budget estimates include:

- The Exchange caseload and premium estimates described in Section 2.4.2.f of this response
- Existing State contracts for purchased services like a call center and information technology support
- Civil service salary and benefit data, cross-checked against State-specific data available through the Federal Bureau of Labor Statistics
- Current rental rates and other reported administrative costs specific to West Virginia

The final authorizing legislation that creates the Exchange and decides how an Exchange will be governed and structured will influence the organization's likely operating costs. Any useful budget projection must be flexible enough to recognize the range of costs that could be incurred. Our tool is flexible and can be modified when these are known, to generate the appropriate budget estimates. Our budget estimates will be provided as a deliverable to the West Virginia Insurance Commission. The financial tool will make all inputs and assumptions explicit and provide planners with the opportunity to modify inputs as more complete information becomes

available. The final budget projections will provide estimates to the West Virginia Insurance Commission of the following:

- The likely cost to the State of West Virginia for supporting the planning and administration of West Virginia's Exchange
- Staff levels necessary to properly operate the West Virginia Exchange as well as the salary and benefit cost for staffing the Exchange
- The cost of contracting with outside vendors to fulfill necessary Exchange functions
- The cost of developing and maintaining IT products to support the operation of the Exchange
- The cost of financial, accounting, and Federal and State reporting systems
- The likely need for consulting support related to legal services, information technology development, actuarial analysis and policy development and design
- Estimates of the administrative, equipment and supply costs associated with the operation of the Exchange

Our project team will provide a high and low estimate for each of these costs for each year between 2013 and 2017. The model will provide estimates of both start-up and ongoing operating costs. Additionally, the budget model will also complete two levels of sensitivity analysis to demonstrate how changes in assumptions will impact the final cost projections. The analysis will measure:

1. How changes in estimates of likely Exchange membership impact our projections of likely Exchange cost
2. How changes in current Federal requirements governing the an individual insurance mandate and the expansion of Medicaid services to all individuals with incomes below 133.0% Federal Poverty Level impact Exchange membership, revenue and cost

Finally, the budget projections will be accompanied by a comprehensive budget narrative, providing a detailed rationale for each of the cost estimates.

b. Potential Impacts of Substantive Options on the Insurance Market

The State is afforded some flexibility by the ACA as to how it designs and implements its Exchange, as well as the establishment of market rules. These decisions will impact not only enrollment in the Exchange but also the potential for adverse selection and therefore premiums in the market. While some of the analysis requested in this section of the RFP will be provided in the work plan of other sections of our proposal (e.g. the impact of reforms on premiums and market stability, the impact of merging the risk pools on premiums in the individual and small group markets, etc.) others are not. In this task we propose providing an analysis of the following:

- A discussion of the likely impact of an incremental phase-in of market reforms, such as age rating bands, on premiums
- A discussion of the likely impact on competition if the Exchange were to function as an active purchaser

- A discussion of the likely impact on competition if the Exchange were to function as a market organizer
- A discussion of the likely impact of reforms on the manner by which individuals purchase insurance (i.e., through a broker, direct from carriers, etc.)
- A discussion of the likely impact of an Exchange on large employers dropping coverage and the impact it could have on the Exchange
- A discussion of the likely impact of pooling risk with surrounding States
- A discussion of the potential for adverse selection risk inside and outside of the Exchange and strategies for mitigating this risk. We will discuss pros and cons of various approached and the impact that each could have on insurer participation in the Exchange
- A discussion of adverse selection that could occur between benefit tiers (i.e., Platinum, Gold, Silver, Bronze
- A discussion of different open enrollment strategies that could be used in the outside market and the impact of utilizing different open enrollment periods than those prescribed for the Exchange as outlined in Federal regulation
- A discussion of various options for risk adjustment and approaches for complying with State and Federal goals, based upon forthcoming regulations to be released by HHS
- A discussion of potential regional rating factors and anticipated age rating bands that will be used by carriers in 2014 and beyond

c. Finance

States have a number of options for financing the administrative cost of operating an Exchange. Review of efforts in other States suggests that a number of approaches have been explored to fund an Exchange. The project team has worked with several large States in identifying the most promising funding approaches, outlining the strengths and weaknesses of each approach (with a specific focus upon how local legal, structural and cultural factors would impact each funding concept) and providing estimates of likely revenues associated with each approach.

The project team will provide the West Virginia Insurance Commission with an overview of funding strategies and provide analysis about how each of these concepts would impact consumers, participating health insurance carriers and the small group and individual insurance markets. Detailed revenue estimates associated with each of these concepts would be integrated into the budget estimates described in 2.4.3.a of this response. The combined revenue and budget estimates will provide Exchange planners with a detailed view of the financial status of West Virginia's Exchange for each year between 2013 and 2017, and its financial sustainability beginning in 2015.

The project team will also include a plan for key financial functions in the Exchange, including accounting and providing secure systems for confidential data and transactions.

d. Impact on Other State Programs

Basic Health Program

Various State programs may be impacted directly or indirectly by the implementation of reforms. States will have various optional reforms that they may or may not choose to implement. One of these is the Basic Health Program (BHP). If the State decides to establish a BHP, individuals

with incomes between 139-200% of FPL will not be eligible for subsidized premium and cost sharing through the Exchange but rather they are eligible to enroll in the State established BHP. The State will receive payments equal to 95% of the premium and cost sharing subsidies that a BHP enrollee would have received had they been eligible to and enrolled in the Exchange.

Since final regulations have not been released addressing the BHP and how premium subsidies will be adjusted for differences in risk between the population in the individual market (the population upon which the premiums and there premium subsidies are based) and the population enrolling in the BHP, we are not proposing a full feasibility study related to the BHP at this time. Instead, our analysis will provide the WVOIC with necessary information on the number of individuals eligible to enroll in the BHP in 2014 by income level, information about the demographics of this group, and estimated premium and cost sharing subsidies that would be redirected to the State if a BHP were established. This will provide the WVOIC with preliminary information as to the potential size and funding for the program, and will aid the WVOIC in determining whether expending further funds on a feasibility study of a BHP program are justified.

Through our actuarial and economic modeling, we will generate a scenario where a BHP program is established. This will result in individuals with incomes less than 200% of FPL not enrolling in the Exchange through our modeling. The resulting Silver premium would then be used to calculate the premium subsidies for individuals at the two income ranges (139-150% and 151-200%) eligible to enroll in the BHP, which would then be used to calculate the premium and cost sharing subsidies that would be paid by the Federal government to the State.

Early Implementation of Consumer Protections or Medicaid Expansion

We understand the request in subsection iv to concern the costs to the State of the early implementation of

1) insurance-related consumer protection reforms in the ACA; and
2) the Medicaid expansion required by the ACA. We address the two topics in turn.

Consumer Protections

The ACA institutes a wide range of insurance market reforms. While certain insurance reforms in the ACA are effective before 2014, the substantial consumer protection reforms that affect the individual and small group markets and take effect in 2014 include:

- Prohibition of pre-existing condition exclusions
- Guaranteed issue and renewal
- Limits on waiting periods to no more than 90 days
- Required coverage of certain qualified clinical trials

These reforms, concerning benefits that must be available to insurance consumers, work alongside a set of rating reforms, including the institution of adjusted community rating standards and a limitation on the use of rating factors.

All of these reforms are intended to be implemented in 2014 alongside the requirement that individuals purchase insurance, known as the insurance mandate. In fact, the individual mandate is essential to the operation of these reforms, since without that requirement, a relatively sicker pool of purchasers would cause the premium impact of the reforms to be significantly higher. We do not recommend, nor do we assume that the State is seriously considering wholesale adoption of the ACA insurance market reforms in the absence of an individual mandate. In terms of its market impact, early implementation of the sweeping insurance reforms in the ACA is likely to cause unwelcome and not well understood turmoil in market, generally speaking by increasing premiums.

However, there are potential partial steps to smooth the path to the 2014 insurance reforms. Most notably, the ACA required that rate bands be limited to 3 to 1 in the individual and small group markets. We will review whether West Virginia ought to could consider introducing or constricting, between now and 2014, rate bands in the individual or small group market. Under this task, we will identify potential methods to begin the introduction of market reform in West Virginia and address the advisability and the potential impact on premiums of those methods.

Medicaid Expansion

Section 2001 of the ACA expands Medicaid eligibility, effective January 1, 2014, to individuals with incomes below 133 FPL, and sets enhanced Federal matching rates (starting at 100% from 2014-16, declining to 90% by 2020) for the costs of the expansion. The same section also authorizes States to implement the expansion earlier than January 1, 2014. An early expansion may be approved by means of a State plan amendment – for Medicaid a relatively simple process – but the State is required to bear the cost of the early expansion at its prevailing Federal medical assistance percentage rate, not the enhanced rates that begin in 2014.

According to the Kaiser Commission on Medicaid and the Uninsured (see *Medicaid Coverage and Spending in Health Reform: National and State-By-State Results for Adults at or Below 133% FPL,* the Urban Institute, May 2010; available at: http://www.kff.org/healthreform/8076.cfm), the ACA will result in an increase of Medicaid enrollment in West Virginia of 29.5% by 2019. While roughly comparable to the increase in Medicaid enrollment nationally (27.4%), this estimate indicates a substantial impact to the State from the ACA's Medicaid expansion – and therefore likely a substantial cost to implementing the Medicaid expansion under current Federal matching rules in 2013.

Our team is capable of quantifying that cost, and will do so in coordination with the effort undertaken to assess potential savings to the State post-2014 (addressed in subsection vi of this response). However, we approach this component of the RFP with a recognition that West Virginia, like many States, has seen its overall State budget negatively affected by the recession since 2009 and may be unlikely to be interested in taking on new State funding obligations in advance of 2014.

Nevertheless, it is important to recognize that the January 1, 2014 implementation date also creates significant operational challenges, particularly given the size of the Medicaid expansion in West Virginia. We will provide the State with potential approaches to consider that could ease

the administrative difficulties (a flood of applications, calls, and enrollments) that could result from a "big bang" implementation of the Medicaid expansion in 2014. We believe that there are approaches that may support the State's operational goals while not creating additional demands on the State budget, and we will identify and address them from an administrative and operational perspective as a component of this task.

Impact of Income Eligible Medicaid Recipients Moving to the Exchange

Our team is composed of individuals and organizations with expertise in Medicaid, the ACA, and the integration of Medicaid and CHIP in the implementation of an Exchange. We also recognize that the impact of movement of current Medicaid recipients into the Exchange market is related to the projections our team will undertake in the Background Research component as part of the actuarial and economic modeling. In particular, our projection of the number of individuals who will be covered by Medicaid and by Exchange subsidies and how the changes in coverage options created under the ACA will affect individuals currently enrolled in Medicaid in West Virginia are crucial inputs to the analysis that our team will undertake.

Building on this information developed through our background research, we will identify possible populations that could move from the Medicaid program into the Exchange. We will work with the State to identify the most appropriate and up-to-date data sources for the costs of the population. We will also suggest from our experience, and work with the State to confirm, necessary growth rates to fully assess the financial impacts.

Generally speaking, to the extent that West Virginia is able to move individuals from Medicaid to the Exchange, the State will save money – because Exchange subsidies are entirely Federally funded. We will quantify that savings for the State so that it is fully informed about its choices, and the impacts of those choices.

The ACA creates a variety of important new influences associated with insurance coverage, including new insurance reforms, the individual mandate, and the ACA's small business tax credit incentives. As described in our response to these related tasks, the team will bring both an understanding of the ACA and an informed understanding of the West Virginia market and public programs to bear on that work. In addition, an important factor to consider in modeling these projections is the overall coverage and enrollment scheme of the ACA, under which streamlined eligibility systems are required for applicants for Medicaid, CHIP and exchange-based subsidized coverage. As a team we have a sophisticated understanding of the influence that enrollment strategies may have on coverage take-up in both public and private coverage options, but most relevant for this task is an analysis of the changed (and easier) pathways to coverage that are intended to be created by and through State exchanges. In sum, we understand that an appropriate analysis under this task begins with close integration with the other research and analytical modeling necessary to fully inform the State about Exchange planning options.

2.4.4 Ad Hoc Services in Support of Continued Exchange Planning

The Oliver Wyman team is ready to provide the WVOIC with additional ad hoc services in continued support of its Exchange planning. These services could include but are not limited to additional updated actuarial and economic modeling, a BHP feasibility study, assistance with risk adjustment strategy, and analysis of various market rules for both the Exchange and outside market. We will work with the WVOIC to mutually develop a scope of work and budget for any additional ad hoc services.

2.4.5 Vendor Experience

As demonstrated throughout this proposal, Oliver Wyman has assembled a team of experts with the experience needs to assist the WVOIC with all of the efforts requested. Our team has extensive knowledge of both public and private health insurance marketplaces and is continually involved with the many aspects of health care reform and its implementation. Together we have executed many types of primary research and have expertise is using both primary and secondary research in modeling efforts. Our team possesses all of the expertise outlined in this section of the RFP, specifically:

- A comprehensive knowledge of the ACA including all related statutes, rules and regulations released to date by HHS
- A comprehensive understanding of the health insurance markets, both public and private
- A comprehensive knowledge of the ACA mandated enrollment provisions and the approaches taken to implementation
- A deep understanding of eligibility and enrollment processing for public programs
- Significant expertise in actuarial and economic modeling
- Previous experience assisting other states with projects of similar size and scope
- Familiarity with approaches being taken by other states and the West Virginia insurance marketplace

Deliverables

We intend to provide a written report for each of the deliverables that rolls up to a final report. While each of the deliverables is a very different task, each focuses on actionable initiatives – survey, assess, analyze, model. Our "chapter" report for each deliverable will be standardized with the following content:

- Descriptive statement of the task
- Methodology employed to complete the task
- Findings and results
- Summary/Conclusions

For each "chapter" report, Oliver Wyman will provide a draft to the State, solicit feedback, and then finalize the report.

For the final report, Oliver Wyman will assemble the individual "chapter" reports on each deliverable into a single final report. Oliver Wyman will provide an Executive Summary in the final report that highlights the most significant findings of the engagement.

We have assembled all of the analysis requested in the RFP into the project deliverables listed below to acknowledge our understanding of the expectations. We envision that each of the individual reports could stand alone if the State needs to communicate specific information on the specific findings of each deliverable.

1. Study of the uninsured and underinsured in West Virginia
2. Study of the insured population in West Virginia
3. Study of the small group market in West Virginia
4. Survey and Analysis of current insurance market in West Virginia – Products and premiums
5. Survey and Analysis of current insurance market in West Virginia – Producers
6. Economic and Actuarial Modeling and Exchange Design Options
7. Exchange Financial Sustainability
8. Impact of substantive options on the Insurance Market
9. Impact on other State programs

At the beginning of this section of our proposal, we provided specific tasks to ensure the completion of each deliverable. The work plan is provided beginning on page 6

The deliverables delineated above are robust and comprehensive. The depth and breadth of the Oliver Wyman team, our networks of skilled professionals, and our approach to project management (described in further detail below) ensures that we will be able to produce the mandatory deliverables under this engagement.

Project Management

Oliver Wyman has been engaged by other State and Federal clients to perform large and complex projects. We have found that the success of our projects, particularly larger engagements such as these, is highly dependent on our ability to effectively coordinate, manage and monitor the efforts of assigned staff. Our subcontractor also boasts an impressive list of large, complex projects on which they have participated and are all familiar with the importance of a strong project management approach.

Our staffing plan identifies Tammy Tomczyk, FSA, MAAA, as the Project Manager. Tammy will schedule, monitor and control the engagement process to enable our team to deliver a project on time and on budget through communication and facilitation that meets or exceeds your expectations. Our team will employ our project management tools and techniques to effectively coordinate and manage work efforts of the assigned staff, ensuring all tasks, activities and functions are completed effectively and in a timely manner. Without thorough project planning, there is a greater likelihood of overruns, failure to achieve desired results, unfavorable media / litigation, and other detrimental outcomes.

Our project management approach strives to balance three project drivers – resources, results and time – inherent in all projects as depicted in the graphic below.

Project Drivers –
The Key Elements of All Projects

We will continually measure and monitor the three project drivers: results (deliverables), resources (people and information) and time (project timeline). We have found that these interdependent project drivers are the key elements to all projects. Oliver Wyman will ensure the State is receiving appropriate communication and status reports throughout the life of the project. Our team will utilize tools that we routinely employ to improve efficiency and communication. These tools are described below.

Kick-off Meetings

Upon announcement of award, we schedule an internal kick-off meeting. At this internal meeting, we review the RFP and our proposal and answer questions from our team. At this internal meeting, we develop:

Our primary goal at the kick-off meeting with the State will be to *listen*. We want to hear first-hand about your experiences and expectations.

- A contact list with names, roles and contact telephone numbers
- An initial calendar
- A preliminary kick-off agenda for consideration and approval by the State
- A list of "rules" for the project, i.e., how documents are named, where they are posted, how deliverables will be peer reviewed, etc.

After our internal meeting, we will meet with the State for a kick-off meeting. The kick-off meeting will include key personnel assigned to major tasks. We will submit an agenda for the State's review and approval. At the kick-off meeting, our main goal is to *listen*. We know that you know the most about your program and your expectations for this project, so we want to hear first-hand from you.

Project Plan

Within five working days of the kick-off meeting, we will provide a preliminary Project Plan. The Project Plan is the "master plan" of work to be completed and identifies key milestones, target completion dates and an explicit list of expected deliverables. We will submit monthly status reports in a format prescribed by the State. The monthly report will summarize major accomplishments for the month and track progress to date against the Project Plan.

Communication

We strongly encourage a standing, weekly or bi-weekly meeting between our team and the WVOIC. Oliver Wyman will provide a toll-free dial-in meeting number and code for the meetings. The written status reports will also be utilized as a communication tool with the State. The Project Plan will be updated with changes highlighted as issues are identified or resolved.

Internal Quality Control Processes

Peer review at various steps in product development is an Oliver Wyman standard professional practice. We ensure our work is consistent with best practice and conforms to our objective of delivering work that is both excellent and error free. Peer review plays a pivotal role in protecting and enhancing the reputation of Oliver Wyman overall, as well as individual consultants. All professional work must be thoroughly peer reviewed by properly qualified colleagues before being released to the client. This process and standard will also be extended to the work conducted by our subcontractors. Oliver Wyman will work closely with our subcontractors throughout any projects and will ensure peer reviews are completed and work is of the highest quality before it is provided to the State.

All professional work must be peer reviewed at various steps of the deliverable development. This requirement holds for Oliver Wyman staff as well as our subcontractors.

Oliver Wyman deploys a comprehensive peer review process for all analyses, documents and deliverables. All work products will be peer reviewed for:

- Technical accuracy of all calculations and work products including overall reasonableness
- Consulting appropriateness to ensure soundness of the approach and that the appropriate issue/question has been completely addressed in a clear manner
- Editorial readability
- Final look to ensure a professional work product appearance that meets delivery and other specifications

Budget Tracking

To monitor the budget, Oliver Wyman utilizes our web-based Client Accounting System (WebCAS) to track all time spent on specific projects for individual clients. The WebCAS system was developed with the needs of our clients in mind and has been refined over the years to most appropriately meet those needs. WebCAS allows us to track our work effort (in quarter hour increments) at a very detailed level (by task, sub-task and staff person) to ensure

responsible and accurate invoicing. This includes the ability to track projects at the individual staff person level, as well as at a sub-task level, where appropriate, by day, week, month or other timeframes that may be necessary. The system includes both standardized codes that characterize the nature of the work performed, as well as a field for a more specific description of the work performed (this field must be completed or the system will reject the entire entry of hours). This provides a clear audit trail and support for all hours recorded in the system. We will request subcontractors provide detailed billing reports to us.

On a monthly basis, the Oliver Wyman billing consultant assigned to each client generates reports from the WebCAS system that details the charges for a given client project during the previous month. These reports show all hours and expenses recorded by project code, by individual, and by activity code and description. This provides extensive detail for the creation of accurate monthly billing invoices.

Staffing Plan

This scope of work calls for a multi-disciplinary project team with in depth knowledge and experience in the areas of health insurance, Medicaid, State and Federal regulations and risk management. The Oliver Wyman team, comprised of experts from Oliver Wyman Actuarial Consulting, Mercer's Government practice, and HMA, will provide West Virginia with wide-ranging expertise, leveraging our years of experience with State insurance departments, State Medicaid agencies, Federal programs, employers, health plans and providers across the country. We understand that West Virginia has many unique characteristics and challenges that will require customized solutions and our exposure to programs and data from across the country provides us with a rich palette of strategies and options for the State to consider.

Oliver Wyman's proposal represents the best "one-stop shop" consulting partner for the State of West Virginia.

The Oliver Wyman team constructed in response to this RFP clearly shows that our proposal represents the best "one-stop shop" with access to firms and individuals with the necessary technical, operational, industry and health care skills and expertise to serve as the State's health care reform and health insurance exchange planning consultant.

Key Personnel

Identify the key personnel that will be assigned to this project. Attach resumes reflecting their qualifications and work experience in the subject area.

Key Staff – Oliver Wyman

Tammy Tomczyk, FSA, MAAA, is a Principal with Oliver Wyman and has over 20 years of health care experience working with health insurers and various State and Federal agencies including CMS and CCIIO, and will serve as the overall relationship manager for the project. Tammy will oversee the project to ensure that all work is completed in a timely manner and to the State's satisfaction. Tammy will also serve as the project lead for tasks 2.4.1(b), (d) and (f) and 2.4.2. Tammy is the primary author of Oliver Wyman's HRMM model which has been

utilized on projects of size and scope similar to the services requested by the WVOIC in The District of Columbia and Connecticut. She is actively involved in many aspects of health care reform and has assisted other States with various aspects of Exchange planning, as well as implementation of effective rate review programs as defined in the ACA.

Kurt Giesa, FSA, MAAA, will provide additional project support, oversight and peer review. Kurt is a Director in the Milwaukee office of Oliver Wyman and is available to provide additional insight into the health insurance market and has completed analyses similar to those required by the Department. He has spent more than 20 years working with health insurers, regulators and providers on group health and HMO rating techniques, HMO creation and the development of business strategies to anticipate/respond to the changing health care environment. Recently, Kurt analyzed the impact of health reform on premiums for a large, national association of health plans and studied the impact of health insurance reform in Massachusetts on the individual market. His work has also included writing papers and speaking to professional groups on health care reform.

Dianna Welch, FSA, MAAA, is a Principal with Oliver Wyman and will lead task 2.4.1(a), a study of the uninsured and under insured in West Virginia, as well as 2.4.1(e) survey and analysis of the current insurance market. Dianna has over 10 years of experience as a health actuary and has several years of experience working for health insurers, as well as supporting State regulators since joining Oliver Wyman in 2008. Dianna has performed several studies on the Massachusetts market, and is part of the team currently assisting the State of Massachusetts in implementing their expanded role in reviewing and approving small group health insurance premium rates. Dianna recently was part of a team that assisted the Massachusetts Connector in planning for the transition to an ACA-compliant exchange as it relates to QHP offerings to individuals and small employers.

Josh Sober, FSA, MAAA, is a Senior Consultant and will lead task 2.4.1(c), a study of the small group population in West Virginia, and support other tasks as needed. Josh has 10 years of experience and is the co-author of Oliver Wyman's HRMM model. Josh has several years of experience working for health insurers, as well as supporting State regulators since joining Oliver Wyman in 2005. He has utilized his extraordinary programming skills to develop many analytical tools for clients.

Karen Bender, FCA, ASA, MAAA, is a Principal with Oliver Wyman and will lead task 2.4.3(b), an assessment of potential impacts of substantive options on the insurance marketplace. Karen has over 30 years of actuarial experience and is considered an expert in the individual and small group markets. She testified before the U.S. Senate on results of modeling pertaining to small employer groups as well as reform modeling Oliver Wyman performed in 2009, summarized in the report "Insurance Reforms Must Include a Strong Individual Mandate and Other Key Provisions to Ensure Affordability." Karen is a very active member of the American Academy of Actuaries and currently chairs the Small Group Medical Task Force.

Key Staff - Mercer

Stacey Lampkin, FSA, MAAA, will serve in an advisory role as an additional resource for the Oliver Wyman team, particularly in the area of Medicaid and on project 2.4.3(d). Stacey's background includes a strong grounding in financial aspects of private sector and public sector health insurance products. Her prior commercial experience includes product development and pricing, along with small group compliance reviews. Since joining Mercer, she was lead actuary on both the Mercer team that assisted the Massachusetts Connector Authority in its initial development of the Commonwealth Care products and Mercer's evaluation of New Jersey's proposed private market reforms. She has also led numerous projects related to Medicaid expansions and State coverage initiatives. Finally, Stacey has been the vice chairperson of the American Academy of Actuaries' Uninsured Workgroup for several years, and has spoken at several actuarial conferences regarding the impacts of Federal health care reform proposals.

Key Staff – HMA

Tom Dehner, JD, will oversee HMA's effort on Tasks 2.4.1 and 2.4.3. As the former Medicaid Director in Massachusetts, Tom led the successful implementation of Medicaid-related components of the Massachusetts Health Care Reform Law. He provided strategic direction to over 700 staff and numerous stakeholders, negotiated with Federal regulators and MCOs, directed clinical policy and supervised oversight of MCO operations for a health insurance program that covers over 1 million members. Tom also managed the successful completion of an enterprise-wide IT systems development project.

Rosemarie Day, MS, will act as team Lead for Task 2.4.3(a) and 2.4.3 (c). As the former Deputy Director & Chief Operating Officer of Massachusetts' health insurance exchange, known as the Commonwealth Health Insurance Connector Authority, Rosemarie played a significant role in launching the organization in 2006 that established the first State-run health insurance exchange in the United States. She worked closely with many existing State agencies to implement key components of health care reform, and with insurers on developing products to sell to individuals and small businesses.

Larry Zbanek, MBA, will lead HMA's effort on Tasks 2.4.1(e) ii – iv. Mr. Zbanek has over 25 years of experience as a senior manager in the managed care and health insurance industry. This includes work experience as a Chief Executive Officer and Chief Operating Officer for managed care plans. Additionally, Larry is currently credentialed as a Licensed Insurance Consultant (LIC) and is a Certified Employee Benefit Specialist (CEBS), the highest recognition awarded by the International Foundation of Employee Benefit Plans.

Robert Buchanan, MPP, will model the impact of possible structural changes to West Virginia's Medicaid program as envisioned in Tasks 2.4.3(d) iv and 2.4.3(d) vi. Robert has ten years of experience in public policy, health care financing and quality measurement in both the private and public sector. Prior to joining HMA Robert served as Budget Director for Acute and Ambulatory Care for the Massachusetts Medicaid program and most recently served as Program Director for Performance Incentives for Partners Healthcare, an integrated health care delivery system in eastern Massachusetts.

Dianne Longley, will work on HMA's efforts on Task 2.4.1. As the Director of Health Insurance Initiatives for the Life, Health and Licensing Division of the Texas Department of Insurance, Ms. Longley directed research, data collection and analysis related to health coverage issues. Dianne directed the Texas Department of Insurance's implementation of Federal health insurance reform and oversaw the implementation of several legislative initiatives intended to improve transparency related to reimbursement and health insurance payment.

3

Attachment B: Mandatory Specifications Checklist

Attachment B: Mandatory Specification Checklist

The following mandatory requirements must be met by the Vendor as a part of the submitted proposal. Failure on the part of the Vendor to meet any of the mandatory specifications shall result in the disqualification of the proposal. The terms "must", "will", "shall", "minimum", "maximum", or "is/are required" identify a mandatory item or factor. Decisions regarding compliance with any mandatory requirements shall be at the sole discretion of the State.

A simple "yes" or "no" response to these sections is not adequate (Attachment B). Failure to meet mandatory items shall result in disqualification of the potential vendor's proposal and the evaluation process terminated for that bidder.

Decisions regarding compliance with the intent of any mandatory specification shall be at the sole discretion of the Agency.

- One or more members assigned to this contract must be a fellow of the Society of Actuaries (FSA) and/or a member of the American Academy of Actuaries (MAAA);
- Members assigned this contract must have at least 5 years of experience with health insurance products;
- Members assigned this contract must be knowledgeable to Actuarial Standard Practice No. 8, 23, and 25;
- The firm shall have no conflict of interest with regard to any carrier that is actively writing individual or group health products in the West Virginia market.
- This scope of work includes those tasks associated with overall planning and feasibility analysis supporting the State, and as appropriate, in the development, design, creation of an implementation plan for an Exchange in West Virginia. The following tasks are preliminarily identified as necessary for such planning and implementation, but it is expected that selected vendor will be assisting the State with identifying key questions, analysis, and decision points required for the analysis, and as appropriate, successful implementation of the Exchange. The state will require the successful vendor to describe how they will approach each requested outcome with the State retaining authority to modify approach as deemed necessary.
- The successful vendor must provide the WVOIC with data and trend analysis of health insurance coverage and the private health insurance marketplace as described below. The successful vendor must coordinate with the WVOIC to secure data necessary for the analysis detailed in this section. To the extent possible, the successful vendor must identify and collect primary data to fill the gaps in existing primary and secondary data sources. Any primary data collected in completion of the services identified in this section must be made available to the WVOIC for future use. The successful vendor must present findings in oral presentations and provide a written report with appropriate graphs and charts. The potential vendor shall provide a work plan for completion of this project.

I certify that the proposal submitted meets or exceeds all the mandatory specifications of this Request for Proposal. Additionally, I agree to provide any additional documentation deemed necessary by the State of West Virginia to demonstrate compliance with said mandatory specifications.

Oliver Wyman Actuarial Consulting, Inc.
(Company)

Tammy Tomczyk, Principal
(Representative Name, Title)

414·223·7988·, 414·223·3244
(Contact Phone/Fax Number)

April 9, 2012
(Date)

4

Conflict of Interest

Neither Oliver Wyman, nor its subcontractor HMA, have any current business relationships (or have within the past five years) in the State of West Virginia that would pose a conflict of interest.

5

Exceptions

Oliver Wyman reserves the right, if we win a work award pursuant to this RFP, to discuss mutually acceptable terms and conditions. Oliver Wyman is committed to taking a practical and efficient approach to the contracting process and reaching agreement without undue delay. At a minimum, we request to include a limitation of liability provision substantially similar to the following:

> "Notwithstanding anything herein to the contrary (i) neither Supplier nor the Client will be liable to the other in connection with the services to be provided by Supplier hereunder or any matter relating to such services for any indirect, special, punitive, consequential or incidental damages, including loss of profits, and (ii) except for any claim for personal injury or death or damage to tangible property arising out of the negligence or willful misconduct of Supplier, Supplier will not be liable to the Client to the extent any claim or claims individually or in the aggregate exceed the total professional fees paid to Supplier for the services pursuant to the applicable Statement of Work. This provision applies to the fullest extent permitted by applicable law and to all causes of action, including, without limitation, breach of contract, breach of warranty, negligence, strict liability, misrepresentation and other torts."

6

Appendix A: Resumes for Key Personnel

Tammy P. Tomczyk, FSA, MAAA

Tammy Tomczyk
Principal

411 East Wisconsin Avenue
Suite 1600
Milwaukee, WI 53202-4419

Tel 414.223.7988
Fax 414.223.3244
Cell 414.333.0796

www.oliverwyman.com

Professional History

- Principal / Oliver Wyman Actuarial Consulting Inc. (2000-Present)
- Actuary / United Wisconsin Services, Inc. (1994-2000)
- Underwriter / United Wisconsin Services, Inc. (1992-1994)

Professional Memberships

- Fellow of the Society of Actuaries (2004)
- Member American Academy of Actuaries (2001)
- Fellow of the Life Office Management Association (1995)
- Associate of the Health Insurance Association of America (1993)
- Member, American Academy of Actuaries Healthcare Reform Premium Review, Health Care Reform Benefits, and Insurance Exchanges workgroups

Education

- University of Wisconsin – Whitewater, B.B.A., Finance and Mathematics, *cum laude*

Tammy Tomczyk is a Principal in the Milwaukee, WI office of Oliver Wyman Actuarial Consulting, Inc. Tammy has over 19 years of experience and provides consulting services to insurers, providers and regulators on health insurance pricing, reserving, financial reporting, provider contracting, trend, and underwriting issues. In addition to having experience pricing both traditional and managed care products, Tammy has also priced dental, vision, Medicare supplement, limited benefit, critical illness and prescription drug programs.

Tammy has applied her programming experience to create pricing models that her clients use in developing quotes for new and existing groups. Tammy is heavily involved in health care reform. In addition to assisting states improve their rate review processes and in the development of state based exchanges, Tammy is assisting her commercial clients as they prepare for the changes that reforms will bring.

Tammy is a Fellow of the Society of Actuaries and a member of the American Academy of Actuaries.

Professional Experience

- Assisted several states with the implementation of effective rate review programs.
- Currently assisting states plan and implement state based Exchanges
- Tammy is considered an expert in the small group market and has prepared small group certifications in over 30 states.
- Responsible for the creation and maintenance of the Practice's medical rating software used nationwide to price traditional and managed care products, as well as the development of various quoting and merit rated underwriting models.
- Actuarial pricing reviews for commercial group blocks of business including the development of base rates, risk adjustment factors, and target loss ratios.
- Performed comprehensive reviews of new business and renewal underwriting strategies.
- Pricing, preparation, certification and audit of Medicare Advantage Part C and Part D Bids.
- Review of regulatory health filings for several state departments of insurance.

Publications

- Tammy has authored several study manuals and other materials used by students preparing for the Society of Actuaries exams.

Speaking Engagements and Professional Activities

- Expert witness, Virginia Bureau of Insurance Credit Insurance Hearing, June 2009.
- Expert witness, Maryland Insurance Administration Effective Rate Review Hearing, June 2011.

Kurt J.F. Giesa, FSA, MAAA

Kurt Giesa
Partner

411 East Wisconsin Avenue
Suite 1600
Milwaukee, WI 53202-4419

Tel 414.223.2280
Fax 414.223.3244
Cell 414.688.0686

www.oliverwyman.com

Professional History
- Partner / Oliver Wyman Actuarial Consulting, Inc. (1990 - Present)

Professional Memberships
- Fellow of the Society of Actuaries (1993)
- Member, American Academy of Actuaries (1991)

Education
- University of Wisconsin - Madison, M.B.A, Actuarial Science
- University of Washington, Bachelor of Arts, mathematics, and English, *cum laude*

Kurt Giesa is a Partner in the Milwaukee, Wisconsin office of Oliver Wyman Actuarial Consulting, Inc. He works with health insurers, regulators, and providers. Recently, Kurt's work with health insurers has been focused on helping them understand and respond to the changes that will result from the Affordable Care Act. His work with insurers also includes the design of group health and HMO rating techniques, rating specialized coverages, provider contracting, Medicare Advantage and Medicaid risk contracting, product design, regulatory filing, and mergers and acquisitions. His work with health care providers includes assistance in contracting with payers, the design of risk-sharing mechanisms, HMO creation, and the development of business strategies to anticipate and respond to the changing health care environment. His work with regulators includes the design of health insurance exchanges, the review of health insurance rate filings, providing expert testimony at rate hearings, market analysis, and the development of regulation, specifically health insurance rate regulation.

Professional Experience

Kurt's recent assignments include the following:

- Support for a large national association of health plans in the association's efforts to inform and influence policymakers.
- Analysis of the impact of health insurance reform on premiums for the members of a large, national association of health plans.
- Analysis for the Massachusetts Division of Insurance of the impact of health insurance reform in Massachusetts on the individual market.
- Rehabilitation of a troubled health insurer.
- Modeling of the impact of insurance market reforms for a number of states in their exchange planning efforts.
- Development of a specialty benefits product strategy for a large, national carrier including pricing and product design.

Recent Publications

Kurt authored a paper titled "Impact of the Patient Protection and Affordable Care Act on Costs in the Individual and Small-Employer Health Insurance Markets" describing the likely impact of the Senate Finance Committee's health reform bill on risk pools and premiums.

Recent Speaking Engagements and Professional Activities

Kurt recently addressed both the Maryland and Connecticut Exchange Boards in support of their planning efforts. In 2011, he hosted a webinar covering health care reform issues. In 2010, he spoke at the BlueCross BlueShield Association's National Actuarial Convention about the impact of health insurance reform, and he gave talk sponsored by the Massachusetts Division of Healthcare Financing and Policy on trends in the Commonwealth.

Karen K. Bender, FCA, ASA, MAAA

Karen Bender
Principal

411 East Wisconsin Avenue
Suite 1600
Milwaukee, WI 53202

Tel 414 223 2289 (M&T)
Fax 414.223.3244 (M&T)
Tel 920 826 2422 (W-F)
Fax 920 826 2423 (W-F)
Cell 414 339 3083

www.oliverwyman.com

Professional History

- Principal / Oliver Wyman Actuarial Consulting, Inc. (1995 - Present)
- Associate Actuary / Employers Health Insurance Company (1989 - 1995)
- Director of MEGA Actuarial / State Mutual Life Assurance, Inc. (1985 - 1989)
- Manager of Actuarial and Large Group Underwriting / Wisconsin Physician's Service (1977 - 1985)
- Actuarial Analyst / Association Life Insurance Company (1974 - 1977)

Professional Memberships

- Fellow of the Conference of Consulting Actuaries (2000)
- Associate in the Society of Actuaries (1992)
- American Academy of Actuaries (1984)
- Qualified Health Actuary (1982)
- Chairperson of the AAA Small Group Medical Task Force (previously known as AHP Workgroup) and on the committee since inception
- Member of the AAA Individual Health Committee, the AAA Defined Contributions Committee, and the AAA Mandate Committee

Karen Bender is a Principal in the Milwaukee, WI office of Oliver Wyman Actuarial Consulting, Inc. She specializes in health care and supports the actuarial needs of the risk assuming entities in the insurance and managed care industry. This includes providing services to insurance and managed care companies, governmental entities as well as providers on traditional actuarial matters, underwriting issues, provider contracting, and reimbursement arrangements, capitation development, data requirements and reporting, product design and implementation, operational issues, as well as determining the impact of proposed and/or passed legislation.

Karen has provided actuarial consulting services for over 35 years and has been with Oliver Wyman since 1995. Karen's experience includes pricing of products for the individual, small group and large group markets, as well as the pricing or drug, vision, dental and specialty HMO products. She has developed underwriting manuals as well as policy forms; designed reporting and experience systems; forecasting models and pricing models for the entire spectrum of health care benefits.

Karen is a Fellow of the Conference of Consulting Actuaries, an Associate in the Society of Actuaries, a member of the American Academy of Actuaries, and is also a Qualified Health Actuary.

Professional Experience

- Karen is considered an expert in the small group and individual medical markets.
- Recognized as an expert in health care reform and has conducted and/or participated in modeling of many proposed reforms at both the state and national levels.
- Participated in many briefings of U.S. Congressional aides on topics pertaining to proposed reforms.
- Testified before U.S. Senate HELP committee regarding small employer health insurance issues.
- Active on many American Academy of Actuaries (AAA) committees and is the official spokesperson for the AAA on health issues.
- An active participant on the industry committee that assisted the National Association of Insurance Commissioners (NAIC) in the development of the initial small group compliance manual.
- A valuation actuary who is qualified to provide opinions for statutory annual statements. She helped formulate practice guidelines for the AAA and chaired the committee charged with developing standards for provider liabilities for the NAIC.

Publications and Speaking Engagements

Karen has authored and co-authored several papers and is frequently in demand to speak at professional meetings.

Dianna K. Welch, FSA, MAAA

Dianna K. Welch
Principal

411 East Wisconsin Avenue
Suite 1600
Milwaukee, WI 53202-4419

Tel 414.277.4657
Fax 414.223.3244
Cell 262.501.3600

www.oliverwyman.com

Professional History

- Principal / Oliver Wyman Actuarial Consulting, Inc. (2008-Present)
- Actuary / Blue Cross Blue Shield of Massachusetts (2004-2008)
- Actuary / Metropolitan Life Insurance Company (1999-2004)
- Actuarial Assistant / The Principal Financial Group (1996-1999)

Professional Memberships

- Fellow of the Society of Actuaries (2000)
- American Academy of Actuaries (2000)
- Member of American Academy of Actuaries Small Group Market Task Force (2010-Present)
- Member of American Academy of Actuaries Exchanges Workgroup (2010)

Education

- University of Wisconsin - Madison, B.B.A., Actuarial Science, *with distinction*

Dianna is a Principal in the Milwaukee, WI office of Oliver Wyman Actuarial Consulting, Inc. Her experience with health insurers includes the development of group medical and dental premium rates for small and midsize employers, the development of trends, administrative expense analysis, product design and new product pricing, setting of physician fee schedules, estimating actuarial liabilities, financial reporting, financial planning, preparing regulatory filings, responding to market conduct reviews, and performing legislative analysis including health care reform impact analyses. Her experience with regulators includes reviewing regulatory filings, performing mandated benefit studies, analyzing the financial condition of health insurers, and special studies such as market analyses, trend analyses, and student health plan analyses. She has extensive experience studying the impacts of Massachusetts' and national health reforms.

Dianna has provided actuarial services for over 15 years. Prior to joining Oliver Wyman, Dianna was a health pricing actuary at Blue Cross Blue Shield of Massachusetts. Her primary responsibilities were setting trends, setting rates for small and midsize employers, legislative analysis, and product design and new product pricing.

Professional Experience

- Setting group commercial health insurance trends and premium rates, including dental insurance.
- Analyzing the impact of legislative proposals on health insurers including Massachusetts and national health care reform initiatives.
- Setting incurred but not reported reserves for health insurers.
- Designing and pricing new group and individual health insurance products.
- Reviewing regulatory filings prepared and submitted by health insurance companies.

Recent Publications

- Camire, Jon and Welch, Dianna; Turning Debate Into Action, Contingencies September/October 2006
- Welch, Dianna, Premium Levels and Trends in Private Health Insurance Plans, February 2010
- Welch, Dianna and Giesa, Kurt, Analysis of Individual Health Coverage in Massachusetts Before and After the July 1, 2007 Merger of the Small Group and Nongroup Health Insurance Markets, June 2010

Speaking Engagements and Professional Activities

- Actuarial Society of Greater New York, MA Health Care Reform Legislation, November 2006
- Expert witness, Massachusetts Division of Health Care Finance and Policy Health Care Cost Trend Hearings, March 2010 and June 2011
- Keynote speaker at 2011 Casualty Loss Reserve Seminar

Josh Sober, FSA, MAAA

Josh Sober
Senior Consultant

411 East Wisconsin Avenue
Suite 1600
Milwaukee, WI 53202-4419

Tel 414.223.2298
Fax 414.223.3244
Cell 414.588.0013

www.oliverwyman.com

Professional History
- Consultant / Oliver Wyman Actuarial Consulting, Inc. (2005-Present)
- Actuary / Assurant Health (2001-2005)

Professional Memberships
- Fellow of the Society of Actuaries (2007)
- American Academy of Actuaries (2006)

Education
- Michigan State University, B.S., Mathematics, *with honors*

Josh is a Senior Consultant in the Milwaukee, WI office of Oliver Wyman Actuarial Consulting, Inc. He provides consulting services to health insurers, Medicare Advantage organizations, managed care organizations, health care providers and state regulatory agencies. His present responsibilities include reserving, renewal rating, reviewing health insurance rate filings, and pricing of health benefits. Josh also provides actuarial services related to the review and audit of Medicare Advantage bids for CMS.

Josh has provided actuarial consulting services for 10 years. Prior to joining Oliver Wyman, Josh was an actuary with Assurant Health. His primary focus was in the development of new experience monitoring systems in support of the pricing and sales areas. Josh's other responsibilities included periodic analysis of Assurant's small group product line, ad hoc analysis for upper management, and testing and development of proprietary software. He was also involved with the pricing and forecasting areas to aid in developing assumptions for their respective models.

Professional Experience

- Pricing, preparation, and certification of Medicare Advantage Part C and Part D Bids.
- Setting incurred but not reported reserves for health insurers and self insured plans.
- Setting year-end reserves for Medicare Advantage Part D reconciliation items.
- Reviewing regulatory filings prepared and submitted by health insurance companies.

Randall T. Fitzpatrick, ASA, MAAA

Randall Fitzpatrick
Consultant

411 East Wisconsin Avenue
Suite 1600
Milwaukee, WI 53202-4419

Tel 414.277.4605
Fax 414.223.3244
Cell 815.276.6608

www.oliverwyman.com

Professional History

- Consultant / Oliver Wyman Actuarial Consulting, Inc. (2007 - Present)
- Actuary / Assurant Health (2003 - 2007)

Professional Memberships

- Associate of the Society of Actuaries (2007)
- American Academy of Actuaries (2007)

Education

- Carroll College, B.S., Actuarial Science, *cum laude*

Randall Fitzpatrick is a Consultant in the Milwaukee, WI office of Oliver Wyman Actuarial Consulting, Inc. He provides consulting services to health insurers, Medicare Advantage organizations, managed care organizations, health care providers and state regulatory agencies. His present responsibilities include reserving, renewal rating, health insurance rate filings, pricing of health benefits and regional analysis of managed care organizations. Randy also provides actuarial services related to the review and audit of bid pricing tools for CMS.

Randall has provided actuarial consulting services for over 5 years. Prior to joining Oliver Wyman, Randall was an actuary with Assurant Health. His primary focus was in the completion of experience analyses to be used as a supplement in the development of individual medical renewal rate increases. Randall's other responsibilities included ad hoc analysis for upper management, monitoring lapse experience, sign off on rate implementation, and maintaining internal data sources. Randall started out his career at Assurant Health developing pharmacy reports and cost savings analyses for Preferred Provider Organizations.

Professional Experience

- Bid Review and Bid Audit experience for Medicare Advantage (MA) and Prescription Drug Plan (PDP) bid submissions.
- Development of MA-PD bids. Including responding to desk review and bid audit questions.
- Complete Creditable Coverage and Attestations for employer group and self-funded retiree prescription drug coverage.
- Pricing of individual and small group health products.
- Supporting the implementation of rates.
- Forecasting financial performance for individual, small group, and large group lines of business.
- Performing analyses and studies for retention initiatives.
- Reviewing regulatory health filings for several state departments of insurance.

Stacey Lampkin, FSA, MAAA

Stacey Lampkin
Principal

Mercer
Suite 600
2325 East Camelback Road
Phoenix, AZ 85016

Tel 602.522.6500
Fax 602.957.9573

Professional History
- Principal / Mercer

Professional Memberships
- Fellow of the Society of Actuaries (2004)
- Member, American Academy of Actuaries (2003)

Education
- Florida State University, Masters in Public Administration, Policy Analysis
- Mississippi State University, Bachelor of Arts, Political Science

Stacey Lampkin is a Principal in the Actuarial Sector for Mercer's Government Human Services Consulting (GHSC) group and serves as an actuary on Mercer's Medicaid teams for several states. In addition to rate setting and other Medicaid expense projections, Stacey provides actuarial analysis and support on reform policy and projects related to expanding health insurance coverage.

Prior to joining Mercer in 2004, Stacey worked in health care actuarial consulting for over six years, primarily in the commercial and Medicare sectors. In addition to her actuarial experience, Stacey worked for several years as a policy analyst for a program evaluation office of the Florida Legislature. In this role she became familiar with the state level policy-setting environment and the constraints and challenges faced by state agencies.

Professional Experience

- Developing rates for Medicaid and uninsured populations for use by states in contracting with managed care organizations, using both fee-for-service data and managed care organization (MCO) financial experience
- Modeling health care delivery system reform and National Health Expenditures for the Republic of Cyprus
- Modeling medical, dental and pharmacy costs for different types of benefit plan designs and member populations, for both self-funded plans and fully insured products
- Renewal rating analysis and new product design and pricing for small group and large group products
- Evaluation of actuarial and underwriting rating systems for small group and large group products
- Preparing projections related to reserve calculations for both fully-insured and self-funded health care products

Rosemarie W. Day

Rosemarie W. Day
President

Day Health Strategies
33 Grant Street
Somerville, MA 02145

Tel 617.666.5609

Professional History

- President / Day Health Strategies (2010-present)
- Visiting Fellow / University of Massachusetts, McCormack Graduate School of Public Policy (2010-present)
- Deputy Director & Chief Operating Officer / Commonwealth Health Insurance Connector Authority (2006-2010)
- Chief of Staff to the Dean / Harvard University, John F. Kennedy School of Government (2004-2006)
- Chief Operating Officer / Commonwealth of Masschusetts' MassHealth Program (2001-2004)
- Deputy Commissioner for Child Support Enforcement / Commonwealth of Massachusetts' Department of Revenue (2000-2001)
- Assistant Secretary / Commonwealth of Massachusetts Executive Office for Administration and Finance (1997-2000)
- Budget Director / Commonwealth of Massachusetts Department of Transitional Assistance (1994-1997)

Education

- Harvard University, John F. Kennedy School of Government, Masters in Public Policy

Rosemarie W. Day is President of Day Health Strategies, a consulting firm she launched, which has a focus on assisting private and governmental health care organizations to implement significant changes related to national health reform. Rosemarie has worked independently and with several large consulting firms, including McKinsey and Health Management Associates, to serve public and private sector clients.

Prior to launching Day Health Strategies, Rosemarie, as Deputy Director and Chief Operating Officer at Commonwealth Health Insurance Connector Authority, played a key role in implementing Massachusetts' landmark health care reform law. The company's efforts increased the rate of health insurance in Massachusetts to 97.4% in just two years and created the model for national health reform that was enacted in the United States.

Professional Experience

- Advises company leaders on health reform market strategy, and governmental organizations on establishing and operating health insurance exchanges
- Implemented two innovative health care programs on time, meeting the legislature's aggressive deadlines
- Responsible for operations of the Commonwealth of Massachusetts' Medicaid program, serving more than 900,000 members annually with a budget of over $6 billion, successfully leading the agency's $35 million project to achieve compliance with federal Health Insurance Portability and Accountability Act

Recent Speaking Engagements

- "Healthcare Reform Trends and Implications to Life Sciences Programs and Products," Keynote Presentation at BioPharmaPM Conference, September 2010
- "National Health Care Reform: Insights from the MA Health Connector," Healthcare South Executive Summit, September 2010
- "Online Retail Marketplace in Action: Insights from the MA Health Connector," America's Health Insurance Plans Conference, June 2010
- "Health Care Reform in the US: Massachusetts and National Reform," Inter-American Conference on Social Security, May 2010
- "Massachusetts Health Care Reform: State Innovation and Federal Reform," Medicaid Innovations Forum, April 2010

Thomas Dehner

Thomas Dehner
Principal

Health Management
Associates, Inc.
Boston, MA

Thomas Dehner is a Principal with Health Management Associates, Inc. Prior to joining Health Management Associates, Inc., Thomas was Chief Executive of Massachusetts' State agency responsible for administering MassHealth, the Commonwealth's Medicaid and CHIP program. He oversaw a $9 billion budget and a workforce of over 700, provided strategic policy direction, negotiated with Federal regulators and State stakeholders, directed clinical policy, and supervised plan operations for a health insurance program that covered over 1 million members.

Professional History

- Principal / Health Management Associates, Inc. (2010-present)
- Medicaid Director / Executive Office of Health and Human Services, Office of Medicaid, Commonwealth of Massachusetts (2004-2009)
- Chief of Staff / Division of Medical Assistance (2003-2004)
- Deputy General Counsel / Senate Committee on Ways and Means (1999-2003)

Professional Memberships

- Member of the Board, Massachusetts Health Insurance Connector Authority
- Member, Massachusetts e-Health Institute Council
- Co-Chair, Long Term Care Financing Advisory Committee
- Elected Northeast Region Representative, Executive Committee, National Association of State Medicaid Directors

Education

- Northeastern University School of Law, JD
- DePauw University, BA Political Science

Professional Experience

- Led implementation of Medicaid-related components of the Massachusetts Health Care Reform Law
- Negotiated the successful renewal of federal Medicaid (Section 1115) Demonstration waiver, the source of federal authority and financing for the Massachusetts Health Care Reform model
- Implemented the Children's Behavioral Health Initiative, a transformative restructuring of services and care coordination supports for children with serious emotional disturbances, incorporating the wraparound process model
- Managed to successful completion an enterprise-wide IT systems development project, the NewMMIS, to develop a state-of-the-art claims payment system
- Led a fundamental re-shaping of MassHealth's managed care programs, by managing a new health plan procurement and designing a project to enhance the state-operated Primary Care Plan
- Implemented an enterprise document imaging and management solution to enable more accurate and efficient capture and distribution of member and provider documentation
- Designed first-in-nation acute hospital pay-for-performance reimbursement program and implemented value-based purchasing strategies across major MassHealth providers
- Managed an agency-wide initiative to enhance and leverage program integrity efforts, including the creation of a Fraud Prevention Unit and an EOHHS Office of Compliance
- Directed the MassHealth Enrollment Outreach Grant program, which has awarded over $8 million in grants to community-based organizations
- Led an interagency negotiating team in response to a major lawsuit involving children's behavioral health services

David F. Fosdick

David F. Fosdick
Consultant

Health Management
Associates, Inc.
Lansing, MI

Professional History

- Consultant / Health Management Associates, Inc. (2010-present)
- Fiscal Analyst / Senate Fiscal Agency (2004-2010)
- Research Associate / Health Management Associates, Inc. (2003-2004)
- Executive Office Intern / Michigan State Medical Society (2003)
- Project Assistant, University of Wisconsin – Madison (2001-2002)

Education

- University of Wisconsin – Madison, Robert M. La Follette School of Public Affairs, Concentration: Public Policy Analysis
- Western Michigan University, B.A., Public Administration and History

David F. Fosdick is a Consultant with Health Management Associates, Inc. Prior to joining Health Management Associates, Inc., David served as a non-partisan analyst and provided subject matter expertise on fiscal questions related to Medicaid, public health, mental health and human services to the Michigan Senate. He also provided estimates of the fiscal impact associated with proposed statutory changes and anticipated program caseloads in assistance programs.

Professional Experience

- Created Michigan Senate versions of annual appropriations bills and conference reports
- Researched and wrote issue papers and articles
- Worked on efforts to restructure employee health benefits for public sector clients

Recent Publications

- Drivers of Caseload Change in the Family Independence Program
- How the Children's Rights Settlement Will Affect the State of Michigan
- The Role of Medicaid Special Financing in Changes in State Expenditure, 1991-2007
- A Summary of Quality Assurance Assessment Programs
- A Review of Medicaid Reform Efforts in Other States
- Medicaid Enrollment in the State of Michigan 1999-2004

Donna Strugar-Fritsch

Donna Strugar-Fritsch
Principal

Health Management Associates, Inc., Lansing, MI

Professional History

- Principal / Health Management Associates, Inc. (2003-present)
- Independent Consultant (2000-2003)
- Director of Planning and Development / Michigan Public Health Institute (1998-2002)
- Director of Planning and Operations / Michigan Public Health Institute (1996-1997)
- Director / Michigan Health Care Institute (1994-1996)

Professional Memberships

- American Society for Public Administration
- Michigan Rural Health Association
- Michigan Public Health Association

Education

- Western Michigan University, Masters in Public Administration
- Michigan State University, Bachelor of Science, Nursing

Donna Strugar-Fritsch is a Principal at Health Management Associates, Inc. She works with clients on a wide range of issues, using her systems analysis and facilitation skills to help clients achieve their objectives. Her clients include county health plans, business and government coalitions, county jails, hospitals, and others. She also works extensively with public employer coalitions in managing health care and pharmacy benefits and expenses.

Ms. Strugar-Fritsch has 25 years of health care experience, spanning clinical nursing, managed care, program development, research, policy analysis and administration. A private consultant before joining HMA, she served clients in health care associations, public health, rural health, foundations, and community-based programs. She also has extensive experience in public-private-academic partnerships, and was director of planning and operations for a large public health institute.

Professional Experience

- Responsible for strategic corporate initiatives for non-profit research and policy think-tank with $19 million budget and 170 FTEs
- Directed operations of grant and policy-related activities of non-profit subsidiary of the Michigan Health & Hospital Association
- Principal Investigator of 3-year, $1.5 million grant-funded initiative to advance delivery of health services in seven rural multi-county sites in Michigan. Directed projects in public/private cancer care coordination, long term care
- Directed state-wide member task forces on health care quality, utilization, behavioral health services, and rural health
- Analyzed Medicaid provider appeal process to rectify claims backlog of $10 million

Larry Zbanek, LIC, CEBS, ASM

Larry Zbanek
Senior Project Advisor

Health Management
Associates, Inc.
Lansing, MI

Professional History

- Health Management Associates, Inc. (2004-present)
- Midwest Health Plan (2001-2004)
- Health Management Associates, Inc. (1996-2001)
- Superior Consultant, Inc. (1994-1996)
- NCAS Midwest (1993-1994)
- Health Plus of Michigan (1987-1993)
- Mercy Alternative (Mercy Health Services) (1984-1987)
- Blue Care Network (Blue Cross Blue Shield of Michigan) (1980-1984)

Education

- University of Detroit, Master of Business Administration
- University of Detroit, Bachelor of Arts, Business Administration

Larry Zbanek is a Senior Project Advisor with Health Management Associates, Inc. He has assisted clients: in the design, development and implementation of operational infrastructure enhancements; developing and implementing systems to measure and monitor operational efficiencies against industry best practice benchmarks; pre-site accreditation/regulatory agency visit operational assessments; and the design, development, evaluation of administrative infrastructure request for proposals.

Larry has established his health care executive credentials with over twenty years of experience in the managed care and health insurance industry. He is a recognized expert in the area of managed care strategic and organizational planning and development, and has credentials and professional experience in indemnity and self-funded health care programs.

Larry has served as the CEO and CFO of a community-based HMO and executive director/COO of multi-state provider sponsored HMO and PPO. He has held senior management positions with responsibility for marketing, planning, provider network development, and capitation/risk sharing contracting, as well as managed care product design and evaluation. He also has experience in managed care market assessment, advertising, and sales strategies. He is a Licensed Insurance Consultant (LIC), Certified Employee Benefit Specialist (CEBS) and a licensed Third Party Administrator (TPA).

Professional Experience

- Development of a managed care infrastructure for a national insurance company
- Successful development and implementation of a financially multi-state provider sponsored HMO and PPO
- Development of an organizational/financial recovery plan for a major regional health care organization that resulted in a financial turnaround within 18 months
- Development of provider contracting strategies that resulted in controlled profitable growth and marketplace expansion
- Implementation of strategic long-range planning processes
- Introduction of Medicare and Medicaid capitated managed care concepts to communities
- Due diligence for heath care provider mergers and acquisitions
- Marketplace assessment, benefit plan development, and marketing/sales strategies for new and established managed care organizations