Washington State Health Care Authority

Request for Information (RFI) Amendment

Fully-Insured Group Medical Plans

RFI No. 2646

Amendment No. 1

Date Issued: April 16, 2018

Purpose: Questions & Answers and a corrected Exhibit 3.

Amendment need not be submitted with Proposal. All other Terms, Conditions, and Specifications remain unchanged.

1. Attached are the RFI questions received and HCA's answers.

2. A corrected Exhibit 3 has been included as discussed in the answer to question #19. This Exhibit 3 replaces the previous one included with the RFI.

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1. QUESTIONS AND ANSWERS

#	Section	Bidder Questions	HCA Answers
1	N/A	Could you please provide the following information in order to produce the required rates for our response: • Full Census • 24 months of claims experience, or at minimum 12 months • Large Claims accompanying the claims experience • Current Rates if at all possible	The goal of this RFI is to collect information from carriers based on the experience they have for currently covered groups in the Washington State School Employee population. We will normalize rates based on the information we receive from all interested parties that respond to the RFI. For carriers who do not currently serve the Washington State School Employee population and need census and claims information, we suggest that you refer to the OIC data from the K-12 Carrier Data Call (link provided below). This information is publicly available and should have relatively complete census, aggregate claims, and premium information over a multi-year period. These non-binding rates should be identified as 'manually rated' as they are not based on actual experience of currently covered groups. OIC data link: https://www.insurance.wa.gov/legislative-and-commissioner-reports
2	N/A	Will HCA be providing any demographic or utilization data for the initial rate development process in this RFI?	HCA will not be providing this data but you may refer to the publicly available OIC data received from the K-12 Carrier Data Call (link provided in question #1 above).
3	N/A	Is there a consultant involved in any steps of the procurement process?	HCA is not using a benefit consultant as a broker or intermediary for the procurement process. Milliman Inc. serves as an actuarial consultant and will provide financial review of the rates and coordination of the overall financial management of the risk pool. HCA employees will be responsible for the evaluation of all responses to this RFI, as well as the evaluation and scoring of all responses to any subsequent RFP.
4	N/A	Is there a limit on number of carriers offered?	Not at this time. There are multiple factors that will be considered when determining the number of carriers offered. We will know more after we evaluate responses to the RFP we are anticipating.
5	N/A	Is dental coverage a requirement?	Dental coverage is not a requirement at this time.

6	N/A	Should we include dental & vision in our quote(s)?	The SEB Board voted on March 15, 2018 to leverage the current dental plans offered under the PEBB Program for the SEBB Program population. They also voted to procure for a separate group vision plan, but at this time, HCA is requesting the carriers bid with vision included and vision excluded. If a carrier would like to describe (not quote) a plan or plans that integrate medical and dental, HCA would welcome that information.
7	Section 4	Our question relates to an organization that offers K-12 schools both HMO and PPO medical coverage products, but due to health carrier licensure requirements, must do so through two separate legal entities operating within an organization. The RFI explicitly states in Section 4, "responding to all mandatory elements of this RFI is a requirement for any organization that wants to respond to any future HCA competitive solicitation for a fully-insured group medical plan that may result from this RFI." Please confirm if it is the intent of this language for both legal entities to submit proposals in response to the SEBB RFP. In other words, does HCA require each legal entity within an organization that intends to submit a SEBB proposal to respond separately to the RFI, or does HCA desire a single RFI response from organizations even if such organizations include multiple legal entities that intend to submit a SEBB proposal?	If the two organizations have separate geographical coverage, provider networks, customer service centers, rate setting, etc., and they intend to bid or have to bid on any subsequent RFP separately, then yes, they will need to submit two separate RFI responses.
8	Section 4 Subsection A Question 1	Section 4, A.1. – Our HDHP plans are also PPO or HMO plans; should we only count these under the HDHP count and not also under the HMO or PPO count?	The HCA wants to know the number of HDHP plans offered, regardless of whether they utilize a PPO network or an HMO network. If any such HDHP plans are also in the count of PPO or HMO plans reported, please note that so HCA understands the duplication/overlap.

9	Section 4 Subsection A Question 2	Section A, question 2 asks: *2.* Please identify how many accounts (employer or purchaser) you have for each type of plan, and the total number of covered lives for each plan. For purchaser contracts, please identify any limitations to providing employer level data. Can I please get a definition of 'purchaser contract'? Is this referring to associations, trusts, and FEP?	A purchaser is any group (of employers, an association, trust, consortium, etc.) that purchases health insurance from your organization.
10	Section 4 Subsection A Question 2	As found in Part A, question 2 of RFI 2646: Can the HCA please define what a 'purchaser' is?	A purchaser is any group (of employers, an association, trust, consortium, etc.) that purchases health insurance from your organization.
11	Section 4Subsection AQuestion 2	Section 4, A.2. – Is HCA looking for the total number of insured commercial purchasers or employers (small group, large group, local/state/federal government employee groups or programs, K-12 school districts) or a subset thereof to describe an organization's Book of Business? Additionally, for insured association or trust programs which include a number of employers under a single group contract, does HCA want respondents to report a single contract or the number of participating employers within an association or trust?	HCA would like to know the total number of individual accounts, by plan type, held by the responding organization, not just a subset.In the case of an insured association or trust program, you do not need to include the individual number of employers, since it is the insured association, trust program, etc. that is purchasing benefits on behalf of the group (assuming each entity in the group has the same plan offerings, networks, etc.). Only report on the single contract.
12	Section 4 Subsection B Question 3	What is the risk-adjustment model? We need more detail to better understand the mechanics behind the risk-adjustment model outlined in the financial assumptions.	HCA is planning to use risk and area normalization in the calculation of monthly premium contributions. Details on specific elements of risk adjustment will be outlined further as part of the anticipated RFP.
13	Section 4 Subsection C Question 1	For the Geographic Coverage file specific to Part C in Section 4: Does 'plan type' mean 'network'?	Yes.

14	Section 4 Subsection C Question 1	Section 4, C.1. – Is county in this question referring to where the employer's headquarters are located or where the member resides? By "county of coverage", do you mean where we officially offer coverage regardless of what county the member lives in? Additionally, if an employer has more than one HMO plan would this be counted as 1 HMO plan or do you count each plan individually?	County means where the respondent officially offers coverage, regardless of where the member lives. Count each plan individually. HCA is interested in the breadth of options.
15	Exhibit 2	Exhibit 2 – Financial Assumptions – Employee Premium Contributions: You mention on page 3 that the contribution methodology will be relatively more favorable to employees with dependents. In Exhibit 2, Item 3e – "assume the employer contribution will be close to 100% for the 76AV plan" – Does this mean 100% for both employee and dependents? Or employee only?	The plan is for employee contribution percentages to be the same for all tiers.
16	Exhibit 2	Will the choice of carrier and benefit be made by each school district or individual school employee?	The school employee will choose their health plan based on the plans available to them.
17	Exhibit 2	In the case of offering self-funded and fully insured medical plans, will school employees be able to select plans from both fully insured carriers and self-funded carriers? Will each school district be responsible for the risk when school employees select the self-funded medical plan?	On March 15, 2018, the SEBB voted to approve offering a self-insured medical plan with features similar to the Uniform Medical Plan, subject to final financing decisions by the state. Therefore, school employees across the state may have access to a self-insured medical plan, regardless of the county they live or work in. It is HCA's hope that there will be fully-insured offerings available throughout the state for school employees to select from as well. The financing and risk bearing arrangements for a potential self-funded medical plan are yet to be determined.

18	Exhibit 3	Can you better explain what you mean by “default coinsurance”? In what way would the default coinsurance apply?	“Default coinsurance” can be specified for plans that have a similar coinsurance for all benefits. It is assumed that cost sharing will use that coinsurance unless otherwise specified for a specific benefit.
19	Exhibit 3	Exhibit 3 – Benefit Specific Cost Sharing: The Coinsurance appears to be identical for Plans 1-3, although in the previous grid “general Cost Sharing” it looks as if the default cost sharing should be different for Plans 1-3. Can we assume that all cost sharing in the Benefit Specific Cost sharing that shows as 15% for Plan 1 should actually be 30% for plan 2 and 35% for Plan 3, or alternatively can you provide a corrected “Benefit Specific Cost Sharing” grid?	You are correct. The default cost sharing in the "benefit specific cost sharing" should match that which is outlined in the "general cost sharing" for each plan. Plan 1- 15%, Plan 2- 30%, Plan 3-35%. This amendment includes an updated Exhibit 3 that confirms this clarification.
20	Exhibit 3	Exhibit 3 – Prescription Drugs: Will Prescription drugs accrue to the same out of pocket maximum as medical? For example, for Plan 1, is the individual out of pocket maximum $2,500 for medical and Prescription drugs?	Yes, it is combined drug and medical.
21	Exhibit 3	In Exhibit 3 the sample plan designs only provide in–network benefit level. Is the intent that these be an HMO style plan design? If we may quote these as a PPO style product is there a desired level of out-of-network benefit for us to assume?	You can quote PPO style cost sharing. The restrictions on benefit levels are all defined by federal AV, which is for in-network benefits. Out-of-network cost sharing would not affect the AV of a plan. Bidders can review the out-of-network cost sharing for the UMP Classic plan to understand one possible option, but should propose the level of coverage that they determine is most appropriate for the Washington State School Employee population. While the federal AV only includes in-network cost sharing, the pricing AV should reflect the expected mix of in-and out-of-network benefits in order to calculate overall required revenue.

EXHIBIT 3 – COST SHARING, BENEFITS, AND COVERED SERVICES

The table below is to be used as insight when developing rate quotes for the Sample Plans and as a comparison tool for us when distinguishing between the Sample Plan design and an alternative plan design.

1. Please refer to the table below for cost sharing information to consider while developing Sample Plan rates.
2. Please refer to the table for benefit and covered services to consider while developing Sample Plan and other plan rates.
3. In a separate document, provide any additional detailed descriptions for any deviations from the information provided in the tables below within your proposed alternative plan(s).

General Cost Sharing	**Plan 1**	**Plan 2**	**Plan 3**
Federal AV	88%	82%	76%
Deductible			
Single	$300	$500	$1,000
Family	$900	$1,500	$3,000
OOP Maximum			
Single	$2,500	$4,000	$5,500
Family	$7,500	$12,000	$16,500
Default Coinsurance	15%	30%	35%

	Plan 1		**Plan 2**		**Plan 3**	
Benefit-Specific Cost Sharing	**Cost Sharing**	**Subject to Deductible**	**Cost Sharing**	**Subject to Deductible**	**Cost Sharing**	**Subject to Deductible**
Ambulance	15% Coins	Yes	30% Coins	Yes	35% Coins	Yes
Acupuncture	15% Coins	Yes	30% Coins	Yes	35% Coins	Yes
Applied Behavior Analysis (ABA) Therapy	15% Coins	Yes	30% Coins	Yes	35% Coins	Yes
Chemical dependency treatment:						
Inpatient; and	*Inpatient	Yes	*Inpatient	Yes	*Inpatient	Yes

2. CORRECTED EXHIBIT 3

	Plan 1		Plan 2		Plan 3	
Benefit-Specific Cost Sharing	**Cost Sharing**	**Subject to Deductible**	**Cost Sharing**	**Subject to Deductible**	**Cost Sharing**	**Subject to Deductible**
Outpatient services	15% Coins	Yes	30% Coins	Yes	35% Coins	Yes
Chiropractic physician services	15%	Yes	30%	Yes	35%	Yes
Contraceptive services	0% /15% coins	No/Yes	0% /30% coins	No/Yes	0% /35% coins	No/Yes
Dental services	20% Coins	Yes	35% Coins	Yes	40% Coins	Yes
Diabetes care supplies	15% Coins	Yes	30% Coins	Yes	35% Coins	Yes
Diabetes Control Program	0% Coins	No	0% Coins	No	0% Coins	No
Diabetes Prevention Program	0% Coins	No	0% Coins	No	0% Coins	No
Diagnostic tests, laboratory, and x-rays	15% Coins	Yes	30% Coins	Yes	35% Coins	Yes
Durable medical equipment, supplies, and prostheses	15% Coins	Yes	30% Coins	Yes	35% Coins	Yes
Emergency room (ER)	$75 Copay (unless admitted as inpatient)	Yes	$75 Copay (unless admitted as inpatient)	Yes	$75 Copay (unless admitted as inpatient)	Yes
End-of-life counseling (part of hospice)	0% Coins	Yes	0% Coins	Yes	0% Coins	Yes
End-of-life counseling (Outside of hospice)	15% Coins	Yes	30% Coins	Yes	35% Coins	Yes
Family planning services	15% Coins	Yes	30% Coins	Yes	35% Coins	Yes
Headaches, chronic migraines or tension	15% Coins	Yes	30% Coins	Yes	35% Coins	Yes
Hearing aids (Not subject to medical deductible)	Any dollar amount over $800	No	Any dollar amount over $800	No	Any dollar amount over $800	No
Hearing exams, routine	0% Coins	No	0% Coins	No	0% Coins	No
Home health care	15%	Yes	30%	Yes	35%	Yes
Hospice care: (Includes respite care and prescription drugs)	• Medical services paid	Yes	• Medical services paid	Yes	• Medical services paid	Yes

2. CORRECTED EXHIBIT 3

Benefit-Specific Cost Sharing	Plan 1		Plan 2		Plan 3	
	Cost Sharing	Subject to Deductible	Cost Sharing	Subject to Deductible	Cost Sharing	Subject to Deductible
	at 100% after meeting deductible. • Prescription drugs paid at 100% after meeting drug deductible. • End-of-life counseling paid at 100% after meeting deductible.		at 100% after meeting deductible. • Prescription drugs paid at 100% after meeting drug deductible. • End-of-life counseling paid at 100% after meeting deductible.		at 100% after meeting deductible. • Prescription drugs paid at 100% after meeting drug deductible. • End-of-life counseling paid at 100% after meeting deductible.	
Hospital services: Inpatient; and Outpatient services	*Inpatient 15% Coins 0% Coins	Yes Yes	*Inpatient 30% Coins 0% Coins	Yes Yes	*Inpatient 35% Coins 0% Coins	Yes Yes
Immunizations (Vaccines)	(usually)	No	(usually)	No	(usually)	No
Joint replacement surgery Inpatient; and Outpatient	*Inpatient 15% Coins	No Yes	*Inpatient 30% Coins	No Yes	*Inpatient 35% Coins	No Yes
Mammograms (Diagnostic)	15% Coins	Yes	30% Coins	Yes	35% Coins	Yes

2. CORRECTED EXHIBIT 3

	Plan 1		Plan 2		Plan 3	
Benefit-Specific Cost Sharing	**Cost Sharing**	**Subject to Deductible**	**Cost Sharing**	**Subject to Deductible**	**Cost Sharing**	**Subject to Deductible**
Mammograms	0% Coins	No	0% Coins	No	0% Coins	No
(Screening)	15% Coins	Yes	30% Coins	Yes	35% Coins	Yes
Massage therapy						
Mastectomy and breast reconstruction	Covered as *inpatient; otherwise 15% coins for outpatient visits	Yes	Covered as *inpatient; otherwise 30% coins for outpatient visits	Yes	Covered as *inpatient; otherwise 35% coins for outpatient visits	Yes
Mental health treatment:						
Inpatient; and	*Inpatient	Yes	*Inpatient	Yes	*Inpatient	Yes
Outpatient services	15% Coins	Yes	30% Coins	Yes	35% Coins	Yes
Naturopathic physician services	15% Coins	Yes	30% Coins	Yes	35% Coins	Yes
Obstetric and newborn care	*Inpatient; 15% coins for related outpatient visits	Yes	*Inpatient; 30% coins for related outpatient visits	Yes	*Inpatient; 35% coins for related outpatient visits	Yes
Office visits	15% Coins	Yes	30% Coins	Yes	35% Coins	Yes
Physical, occupational, speech, and neurodevelopmental therapy	15% Coins	Yes	30% Coins	Yes	35% Coins	Yes
Prescription drugs	**Prescription drugs	**Prescription drugs	**Prescription drugs	**Prescription drugs	**Prescription drugs	**Prescription drugs

2. CORRECTED EXHIBIT 3

	Plan 1		Plan 2		Plan 3	
Benefit-Specific Cost Sharing	**Cost Sharing**	**Subject to Deductible**	**Cost Sharing**	**Subject to Deductible**	**Cost Sharing**	**Subject to Deductible**
Preventive care: Includes vaccines, routine exams, some screening tests	0% Coins	No	0% Coins	No	0% Coins	No
Skilled nursing facility	*Inpatient	Yes	*Inpatient	Yes	*Inpatient	Yes
Spinal and extremity manipulations	15% Coins	Yes	30% Coins	Yes	35% Coins	Yes
Surgery:						
Inpatient; and	*Inpatient	Yes	*Inpatient	Yes	*Inpatient	Yes
Outpatient services	15% Coins	Yes	30% Coins	Yes	35% Coins	Yes
Telemedicine services	15% Coins	Yes	30% Coins	Yes	35% Coins	Yes
Tobacco cessation services	0% Coins	No	0% Coins	No	0% Coins	No
Transgender services	15% Coins	Yes	30% Coins	Yes	35% Coins	Yes
Urgent care	15% Coins	Yes	30% Coins	Yes	35% Coins	Yes
Vision care: (Diseases and disorders of the eye)	15% Coins	Yes	30% Coins	Yes	35% Coins	Yes
Vision exams, routine	0% Coins	No	0% Coins	No	0% Coins	No
Vision hardware, adults (over age 18): Glasses, contact lenses	Any amount over $150 every 2 years	No	Any amount over $150 every 2 years	No	Any amount over $150 every 2 years	No
Vision hardware, children (age 18 and under):						
Glasses *(plan pays for 1 pair per year at 100% of the allowed amount)*	$0	No	$0	No	$0	No
Contact lenses	15% Coins	No	30% Coins	No	35% Coins	No
Well-Child Visits	0%	No	0%	No	0%	No