



Request for Information:
Fully-Insured Group Medical Plans

NOTE: An organization MUST respond to this RFI to be eligible to bid on a subsequent competitive solicitation for a fully-insured medical insurance product that will be released later this year.

RFI 2646
Washington State Health Care Authority

April 2, 2018

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Section 1: RFI Goals and Objectives

This Request for Information (RFI) is seeking information that will assist the Washington State Health Care Authority (HCA) in the prospective procurement and implementation for fully-insured group medical insurance plans for the School Employees Benefits Board (SEBB) Program, and potentially any other programs administered by the Employees and Retirees Benefits (ERB) division of HCA.

For an organization to be eligible to bid on a subsequent competitive solicitation for a fully-insured medical insurance product that may result from this RFI, a Respondent MUST respond to this RFI.

The goals of this RFI are:

- **Inform** – With this RFI, HCA hopes to inform the Carrier community of its intent to procure for fully-insured group medical insurance plans, and to provide some general business context regarding the project, with the end goal of creating a portfolio of benefits for approval by the SEBB.
- **Learn** – HCA is issuing this RFI to collect information from the Carrier community on its knowledge, experience, and expertise with group medical insurance plans. Areas of particular interest include:
 - The benefit plans currently being offered as fully-insured group medical insurance;
 - Hearing from entities that cover (currently or previously) Washington State school employees and their dependents (it is not a requirement to have covered Washington State school employees to respond to the RFI);
 - Additional benefit plans being offered under alternative risk arrangements;
 - Information regarding plan design and cost, geographic coverage of these plans, and details regarding provider network adequacy for such plans.
- **Guide** – HCA hopes to use this RFI to promote interest in our effort to design, procure, and implement a portfolio of group medical insurance plans in the following ways:
 - Inform the overall design of fully-insured group medical insurance plans that fit the needs of SEBB Program members;
 - Provide a range of premium rates to help inform the summer 2018 school employee collective bargaining process;
 - Inform the creation of a competitive solicitation to procure such plan(s) for the SEBB Program population; and
 - Identify entities potentially interested in bidding on a subsequent competitive solicitation.

Section 2: Background

A. Overview of ERB Programs

HCA is a cabinet-level agency within the Washington State executive branch and governed by chapter 41.05 of the Revised Code of Washington (RCW). The agency is the largest purchaser of health care services in Washington through its management of the Public Employees Benefits Board (PEBB) and Apple Health (Medicaid) Programs. This purchasing influence will

grow even larger with the implementation of the SEBB Program. The ERB division of HCA will administer benefits designed for both the SEBB and PEBB Programs. Today, the PEBB Program covers all eligible Washington State employees and their dependents, which includes school employee retirees. The PEBB Program also covers employees and dependents of over 300 counties, municipalities, political subdivisions, tribal governments, and even some school districts and educational service districts (ESD) that contract with HCA for PEBB Program benefits.

The SEBB Program was created within HCA pursuant to the passage of Engrossed House Bill (EHB) 2242 (Laws of 2017, 3rd sp.s., Part VIII¹) in July 2017. EHB 2242 directs the SEBB and HCA to develop and administer a suite of benefits for eligible Washington State school employees and their dependents. During the 2018 Legislative session, SEBB Program statutes were amended by Engrossed Substitute Senate Bill 6241.²

Starting January 1, 2020, all Washington State school districts, educational service districts, and charter schools (approximately 314 separate entities) will be required to participate in the SEBB Program. School districts, ESDs, and charter schools accessing PEBB Program benefits prior to January 1, 2020 will transition to SEBB Program benefits starting January 1, 2020. SEBB will design and approve insurance benefit plans and establish eligibility criteria for participation in these plans. HCA will conduct the procurement of these benefit plans for SEBB approval. SEBB may or may not choose to adopt some or all of the benefit plans that PEBB currently offers and may choose to direct HCA to procure some or all of its own benefit plans independent of the PEBB Program. Under EHB 2242, benefit plans and rules must be in place and fully effective on January 1, 2020, and HCA must follow the state procurement process to put the benefit plans in place.

On March 15, 2018, SEBB adopted resolutions that, among other things, requires HCA to “perform a fully-insured medical plan procurement for multiple carriers with widespread coverage offerings.” This RFI is only the first step being taken by HCA in fulfillment of this resolution.

B. SEBB Program Population

The SEBB Program will offer benefits to Washington State school employees and dependents who meet the eligibility criteria defined by the SEBB and codified in the Washington Administrative Code (WAC), which are currently in the process of being developed. In state law (RCW 41.05.740(6)(d)), the primary SEBB benefits eligibility criteria is set as any employee anticipated to work at least six hundred and thirty (630) hours during the school year. Currently, when a Washington State school employee retires and meets eligibility requirements, they become eligible for benefits under the PEBB Program. Therefore, the SEBB Program population does not include retirees at this time.

Based on Washington State school employee data received from the Office of Financial Management (OFM) for the 2015-16 school year, there were approximately 134,000 school employees statewide who worked at least 630 hours and at least 10,500 additional employees who worked less than 630 hours. The number of dependents covered through school employee groups will likely increase from current levels as the employee premium

¹ [http://lawfilesexext.leg.wa.gov/biennium/2017-18/Pdf/Bills/Session%20Laws/House/2242.SL.pdf?cite=2017 3rd sp.s. c 13 § 801.](http://lawfilesexext.leg.wa.gov/biennium/2017-18/Pdf/Bills/Session%20Laws/House/2242.SL.pdf?cite=2017%203rd%20sp.s.%20c%2013%20%24%20801)

² <http://lawfilesexext.leg.wa.gov/biennium/2017-18/Pdf/Bills/Senate%20Passed%20Legislature/6241-S.PL.pdf>

contribution methodology will change under the SEBB Program to be relatively more favorable to employees with dependents. While the exact number of members will not be known until the end of open enrollment in late fall of 2019, it is known that the subscriber population is largely female (roughly 75%), and the median age is approximately thirty-seven (37). HCA estimates that total SEBB enrollment (eligible subscribers and dependents) is between 200,000 and 300,000.

While all school districts, educational service districts, and charter schools may contract with HCA for PEBB benefits, currently only seventy-two (72) school districts and five (5) ESDs to participate in these benefits. This is approximately three to five percent (3-5%) of all Washington school employees. Currently, most active K-12 teachers and school employees have benefits arranged by their individual employing districts and local collective bargaining units. EHB 2242 requires state consolidation of benefits purchasing, benefits administration, and collective bargaining.

Section 3: Purchasing Goals

HCA is committed to promoting the health and wellness of SEBB and PEBB members and expects Carriers to continue to develop strategies and programs that support the triple aim of better health, better care, and lower costs.

Purchasing goals include:

- **Member Satisfaction**
 - Maintain access to choice of health plan and provider, and provide timely, person-centered care for members.
 - Improve member health literacy so that members can effectively use their benefits to meet their health goals.
 - Promote health equity among the diversity of SEBB and PEBB members.
 - Promote primary care by encouraging members to have a primary care physician.
- **Clinical**
 - Design benefits that support providers in delivering evidence-based, standardized care. Specific examples include:
 - Implementing the recommendations of the Bree Collaborative;
 - Limiting low-value care;
 - Supporting providers in the move to team-based care; and
 - Implementing the Governor's Executive Order 16-09 Addressing the Opioid Use Public Health Crisis, which includes effective screening for opioid use disorder and increased management of medication-assisted and other needed treatments.
- **Financial**
 - Increase the long-term financial sustainability of state health programs.
 - Support HCA's goal of connecting 90% of payments to quality and value as defined by HCP-LAN 2c-4b by 2021 (See Exhibit 1 - CMS Framework for Value-based Payments or Alternative Payment Models).
 - Improve management of underlying cost and reduce health care waste.
 - Reward improved performance of the contracted health systems within the ERB division's contracted Carriers.

Section 4: Content of Responses

This section outlines the elements requested in response to this RFI. Respondents must provide an answer to all elements outlined in each section below that is designated as **MANDATORY** in order for the response to be considered responsive. HCA would appreciate answers to the elements outlined in the final section designated as **OPTIONAL**, but doing so is not a requirement. After reviewing the responses, HCA may contact some or all Respondents with follow up questions, or a request to make a presentation at HCA.

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. However, any information provided in response to this RFI **WILL NOT** be considered when evaluating bidders responding to any future solicitation.

Please respond to the following elements specific to your organization's **fully-insured group medical insurance plan(s)**.

A. Types of Plans and Contracts (MANDATORY)

1. Identify all of the following plans that are offered by your organization: HMO, PPO, ACO, HDHP, High Performance Network, or other? If "other" please provide a brief description. Of the plans identified, which are offered in Washington State?
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.
3. Given the response to item 2, does your organization have a preference for contracting as a fully-insured HMO or a fully-insured PPO plan under a consolidated statewide procurement? If yes, please explain your preference.

B. Cost and Plan Design (MANDATORY)

1. Based on the assumptions listed in Exhibit 2 – Financial Assumptions, please provide premium quotes for each Sample Plan listed in Exhibit 3 – Cost Sharing, Benefits, and Covered Services (Table 1 and 2). To provide insight into the population used to develop premiums and the adjustments used to project required revenue for that population to calendar year 2020, please complete Exhibit 4 – SEBB Rate Form. Instructions for the rate form are contained within the Excel document. HCA acknowledges Carriers must make significant assumptions (e.g., with regard to the number of covered dependents that will enroll once the employee contribution methodology is changed) in completing the SEBB Rate Form. Please provide any additional assumptions or insights that inform your organization's RFI response.
 - o Quotes for each plan must have the same service area, include all counties in which the Carrier participates, and be based on the experience of all currently covered lives. If you have Washington State school employee covered lives, please base your quotes on this population. If you do not,

- please provide a written description of the population used for development of rates.
- Quotes should include a screen snapshot of the Federal actuarial value (Federal AV) calculator used to calculate the Federal AV section of the form, including inputs and results.
 - The pricing actuarial value (Pricing AV) for any plan quoted should reflect only the following:
 - Plan Type (HMO, PPO, POS, etc.)
 - Provider network reimbursement levels
 - Provider network utilization management
 - Both point of service cost sharing and overall plan level cost sharing
 - Benefit induced utilization
 - All premium quotes should include the same non-benefit expense load as a percentage of premium.
2. Based on the Assumptions in Exhibit 2—Financial Assumptions, please provide up to four (4) plan options in addition to the Sample Plan quotes. At least one of the four (4) plan options must be a tax qualified High Deductible Health Plan (HDHP) with a health savings account (HSA). The benefits and covered services outlined in Exhibit 3 – Cost Sharing, Benefits, and Covered Services (Table 2) is to be used as starting point. Any proposed carve-outs and additions to benefits and covered services must be included and captured in the attached SEBB Rate Form.
- Quotes for the alternative plan options must include the same coverage area as the Sample Plans, and be based on the same experience.
 - Quotes should include a screen snapshot of the Federal AV calculator used within the individual market.
 - The Pricing AV for any of the other plan options you have proposed is under all the same restrictions as Sample Plans, and must reflect only the following:
 - Plan type
 - Provider network reimbursement levels
 - Provider network utilization management
 - Both point of service cost sharing and overall plan level cost sharing
 - Benefit induced utilization
 - The Federal AV of any such plan option should not be lower than 76 percent (76%). The 76% Sample Plan should have the lowest premium rate of all proposed premium rates. When developing the Pricing AV for such plans, assumptions should be developed on a consistent basis with the Sample Plans.
 - For any HDHP, note the impact on AV from any assumed HSA contribution.
 - The goal of providing information on other plans is to help HCA understand what Carriers believe will be viable, meaningful options for the SEBB Program. Therefore, such plans must have Federal AVs that are separated by at least two percentage points from any of the other plans provided in your response.
 - All plans should be loaded with the same non-benefit expense load.
3. HCA currently uses the risk model by Verscend Technologies DxCG® Intelligence

Commercial All-Medical Predicting Total Risk version 5.1.0 to measure morbidity differences within the PEBB Program population. Please provide feedback on the use of this model to adjust the plans' rates within the risk pool for the SEBB Program population and whether a concurrent or prospective risk score is preferred for 2020.

C. Geographic Coverage (MANDATORY)

1. HCA would like to know how many fully insured HMO, PPO, and other plan types your organization currently offers in Washington, Oregon, and Idaho counties, as well as any changes anticipated for the future. Please complete columns c-h in Exhibit 5 – County Coverage, with the information listed below. It is not HCA's intent to develop new markets in Oregon or Idaho, but it would not be unusual for a Washington State school employee to reside in one of those states. Only complete the Oregon and Idaho counties where you already have coverage or are anticipating adding coverage in those counties by January 1, 2020.
 - Column "c": The number of HMO plans you currently offer within each county listed;
 - Column "d": The number of PPO plans you currently offer within each county listed;
 - Column "e": The number of other plan types you currently offer within each county listed;
 - Column "f": The number of HMO plans you anticipate for 1/1/2020 within each county listed;
 - Column "g": The number of PPO plans you anticipate for 1/1/2020 within each county listed.
 - Column "h": The number of other plan types you anticipate for 1/1/2020 within each county listed.

Carriers that later choose to bid on an RFP for a SEBB insured health plan **will not** be locked into providing coverage in the counties they provide in their response to this RFI.

D. Provider Network (MANDATORY)

1. If a new client were transitioning members onto your plan(s), would your organization be open to the idea of adding providers to your current network(s)?
2. Please provide the typical timeframe for adding the following provider types to your network (e.g. 4-6 weeks, 2-3 months, etc.)?
 - a. Primary care physicians
 - b. Ancillary providers (physical therapists, occupational therapists, massage therapist, chiropractors, etc.)
 - c. Specialists
 - d. Urgent care
 - e. Hospitals

3. Do you add providers on a rolling basis throughout the year or only at set times during the year?

E. Administrative (MANDATORY)

1. Is your organization NCQA/URAC accredited? If yes, for what certification period, and what is your organization's status? If not, what is your organization's plan, if any, to become accredited?
2. Does your organization have experience in providing an employee assistance program (EAP) for subscribers to access through your fully-insured medical plans?
 - a. If yes, please provide a list of the types of EAP benefits you have experience providing (e.g. counseling/assessment/referral, management workplace consultation, employee workplace consultation, critical incident management and debriefing, training, additional work/life benefits such as legal or financial counseling, or other services).
 - b. What is the per employee per month (PEPM) cost to employers for providing EAP services to subscribers?
 - c. What is the average utilization rate of counseling services for school employees?
3. Please answer the following hypothetical questions regarding implementation, assuming HCA is a new client (this information will help HCA in the development of a procurement and implementation schedule):
 - a. After being provided with a HIPAA 834 eligibility file, on average how long would it take to collaborate to build the group structure framework and data layouts, assuming there are six (6) subgroups (Reference Exhibit 6 – Group Structure Example)?
 - b. After completion of the group structure framework and data layouts, on average how long would it take to program the groups into your organization's IT systems?
 - c. After completion of the programming, on average how long would it take your organization to test?
4. Does your organization contract directly with an HSA vendor to administer your subscribers' qualified HSA benefits? If so, which vendor do you use?
5. Please provide contact information (name, email, and phone number) for staff that HCA can follow up with for questions pertaining to this RFI.

F. Additional Questions (OPTIONAL)

1. What factors would you consider as you look to expand coverage into a new county?
2. What information would your organization typically need from a new client to be able to develop a proposal for a fully-insured group medical insurance plan (data requirements, file exchange requirements, claims and census data, timeline, etc.)?

Section 5: Definitions

“Carrier” means insurance company.

“Respondent” means an entity that responds to this RFI.

“Sample Plan” means a medical benefit plan proposal that complies with the requested cost sharing and covered services described within the RFI in Exhibit 3 – Cost Sharing, Benefits, and Covered Services.

Section 6: Administrative Terms and Conditions

A. RFI Coordinator

Please submit responses to the RFI Coordinator at the following address and/or email:

Lesley Houghton
RFI Coordinator
PO Box 42702
Olympia, WA 98501
Contracts@hca.wa.gov

B. RFI Schedule

Release RFI	April 2, 2018
Respondent Questions due	April 9, 2018
Answers to Respondent Questions	April 16, 2018
Respondent Submissions Due	April 27, 2018 at 2:00 p.m.

C. Response Instructions

Please do not cut and paste responses into this RFI. Instead, provide a response as a separate document. Responses should be ordered using the same numbering as presented in Section 4, including the section headings and questions. Respondents may include any preprinted materials that would provide the information HCA requests. Additionally, Respondents may attach a cover letter to provide additional pertinent information about the organization not requested in Section 4.

Responses should be provided in an electronic format, such as Adobe Acrobat or Microsoft Word. This will assist in HCA’s review process. You only need to provide a single copy of your response. Responses may be provided in more than one file and submitted in more than one email. While HCA prefers that all responses be submitted via email to the RFI Coordinator, a physical copy of responses and materials will also be accepted. However, faxed responses will not.

Please note that HCA will not accept zipped or compressed files in connection with this RFI. HCA will not open any such file. If individual files to a response are too large, please

send multiple emails instead of compressing files.

D. Cost of Response

You will not be reimbursed for costs associated with preparing or presenting any response to this RFI.

E. Response Property of HCA

All materials submitted in proposal to this RFI become the property of HCA. HCA has the right to use any of the ideas presented in any response to the RFI.

F. Public Records and Proprietary Information

Any information contained in the response that is proprietary or confidential must be clearly designated as such. The page and the particular exception(s) from disclosure must be identified. Each page claimed to be exempt from disclosure must be clearly identified by the word “confidential” or “proprietary” printed on the page. Marking the entire response as confidential will be neither accepted nor honored and may result in disclosure of the entire response.

To the extent consistent with chapter 42.56 RCW, the Public Records Act, HCA shall maintain the confidentiality of your information marked confidential or proprietary. If a request is made to view your proprietary information, HCA will notify you of the request and of the date that the records will be released to the requester unless you obtain a court order enjoining that disclosure. If you fail to obtain the court order enjoining disclosure, HCA will release the requested information on the date specified in its notice to you.

HCA’s sole responsibility shall be limited to maintaining the above data in a secure area and to notify you of any request(s) for disclosure for so long as HCA retains your information in HCA records. Failure to so label such materials, or failure to timely respond after notice of request for public records has been given, shall be deemed a waiver by you of any claim that such materials are exempt from disclosure.

G. Revisions to the RFI

HCA reserves the right to amend this RFI at any time. In the event it becomes necessary to revise any part of this RFI, addenda will be provided via e-mail to all individuals who have made the RFI Coordinator aware of their interest. Addenda will also be published on Washington’s Electronic Bid System (WEBS). The website can be located at <https://fortress.wa.gov/ga/webs/>. For this purpose, any documented questions and answers and any other pertinent information shall be provided as an addendum to the RFI and will be placed on the website.

HCA reserves the right to cancel or reissue this RFI at any time, without obligation or liability.

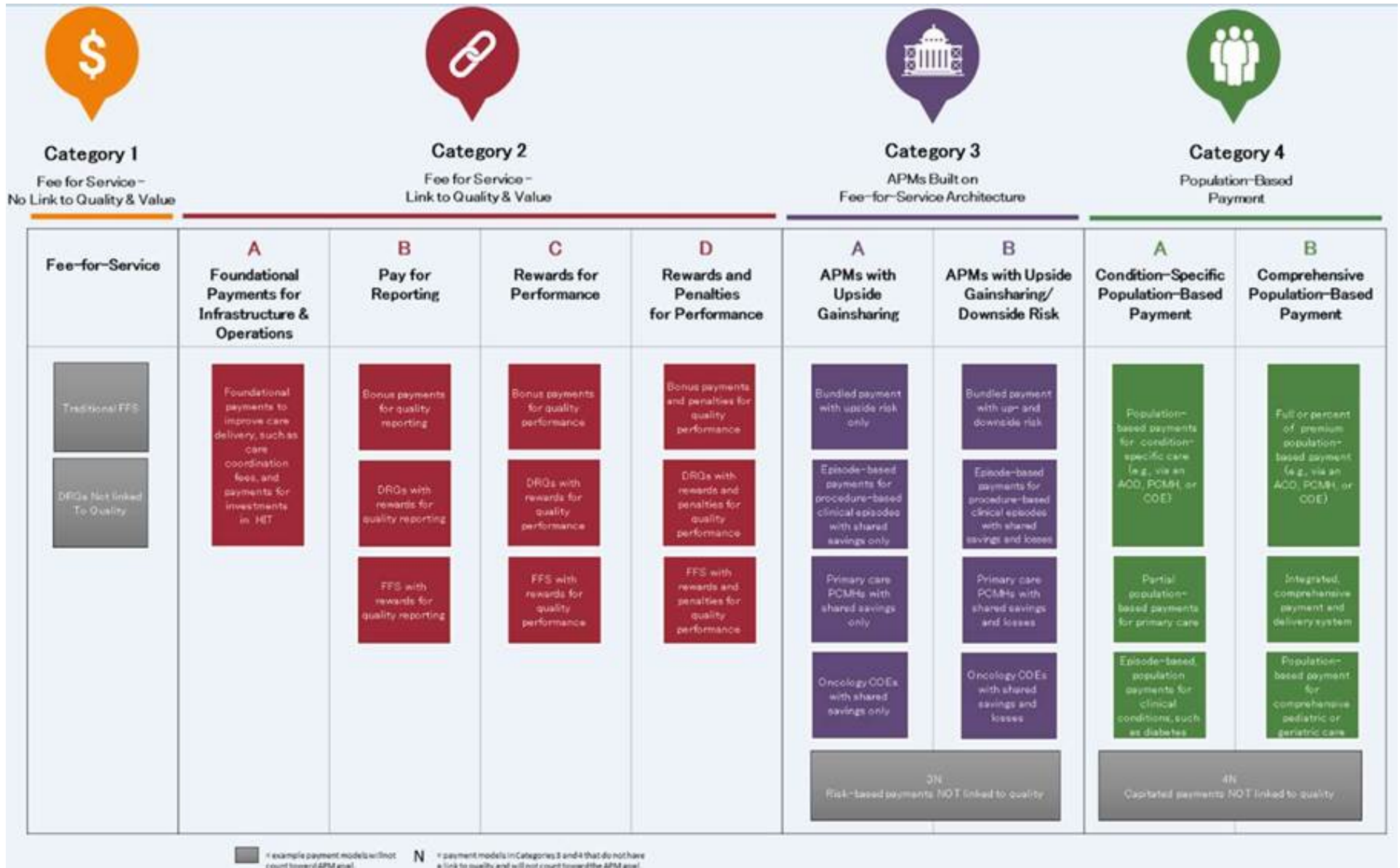
H. No Obligation to Buy or Procure

HCA **WILL NOT** enter into any contract as a result of this RFI. While HCA may use responses to this RFI to develop a competitive solicitation for the subject of these services, issuing this RFI does not compel HCA to do so.

I. Mandatory RFI Response

As previously stated, responding to this RFI will be a requirement for any organization to be eligible to respond to a future competitive solicitation for a fully-insured group medical plan that may result from this RFI. Responses and information provided in response to this RFI **will not** be considered when evaluating bidders responding to any future solicitation.

Exhibit 1 – CMS Framework for Value-based Payments or Alternative Payment Models (CMS LAN APM)



For more information, see CMS LAN APM Framework White Paper, go to: <https://hcp-lan.org/workproducts/apm-whitepaper.pdf>

Exhibit 2 - Financial Assumptions

For purposes of this RFI only, the Carrier should assume the following when developing premium quotes for Sample Plans and the Carriers other plan options:

1. Risk Pool
 - a. A single risk pool that includes only active SEBB members, i.e. no retirees.
2. Rating Area Structure
 - a. Premium quotes based on current enrollment will be normalized for morbidity and geographic cost differentials.
 - b. For purposes of this RFI, geographic area factors will be developed after taking into consideration the quotes received in response to this RFI. In addition, an independent area factor study will be performed over currently available data for the PEBB population and requested data of the Washington State school employee population.
 - c. For purposes of this RFP, any plan will be offered to all school districts located predominately in a geographic rating area based on the county or counties that make up a rating area within Washington's individual market.
 - d. In compliance with Engrossed Substitute House Bill (ESHB 2408) of the 2018 session, a SEBB Carrier must also be prepared to file a Silver plan and a Gold plan on the individual ACA market for any county where they participate in the SEBB Program.
3. Employee Premium Contributions
 - a. With the implementation of the SEBB Program, the employee premium contribution is changing from a local district model to a single statewide model that will be collectively bargained through a statewide coalition.
 - b. At this time, HCA anticipates that through collective bargaining a fixed dollar amount on a per adult unit basis will be negotiated as the state contribution.
 - c. Premium quotes based on current enrollment will be standardized for area based on area factors and morbidity through risk adjustment. Anticipate that the only purpose for these adjustments will be for calculating statewide employee premium contributions.
 - d. All employee premium contributions will be calculated at the risk-normalized rate for the plan less the state contribution. This means that employees will be paying the marginal difference in price for all benefit differences compared to a minimum (floor) plan value – which for purposes of this RFI, Carriers should assume is the 76 AV plan, outlined in Exhibit 3, table 1—Sample Plan 3.
 - e. For purposes of this RFI, assume the employer contribution will be close to 100% for the 76 AV plan, but that will depend on the actual cost of the finalized rates. For budgetary reasons the 76 AV plan may change at a later date.
4. Self-insured Plan(s)
 - a. At this time, the HCA anticipates a self-insured plan(s) will be included in the SEBB benefits portfolio.
 - b. The plan(s) will be available statewide.
 - c. The HCA will have an independent actuary certify the premium rates based upon the same principles outlined above. The actuary will likely rely upon the experience for the self-insured plans in the Public Employees Benefits Board (PEBB) Program.

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 Deductible	88%	82%	76%
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%

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
Ambulance	15% Coins	Yes	15% Coins	Yes	15% Coins	Yes
Acupuncture	15% Coins	Yes	15% Coins	Yes	15% Coins	Yes
Applied Behavior Analysis (ABA) Therapy	15% Coins	Yes	15% Coins	Yes	15% Coins	Yes
Chemical dependency treatment:						
Inpatient; and	*Inpatient	Yes	*Inpatient	Yes	*Inpatient	Yes
Outpatient services	15% Coins	Yes	15% Coins	Yes	15% Coins	Yes
Chiropractic physician services	15%	Yes	15%	Yes	15%	Yes
Contraceptive services	0% /15% coins	No/Yes	0% /15% coins	No/Yes	0% /15% coins	No/Yes

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
Dental services	20% Coins	Yes	20% Coins	Yes	20% Coins	Yes
Diabetes care supplies	15% Coins	Yes	15% Coins	Yes	15% 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	15% Coins	Yes	15% Coins	Yes
Durable medical equipment, supplies, and prostheses	15% Coins	Yes	15% Coins	Yes	15% 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	15% Coins	Yes	15% Coins	Yes
Family planning services	15% Coins	Yes	15% Coins	Yes	15% Coins	Yes
Headaches, chronic migraines or tension	15% Coins	Yes	15% Coins	Yes	15% 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	15%	Yes	15%	Yes
Hospice care: (Includes respite care and prescription drugs)	<ul style="list-style-type: none"> Medical services paid at 100% after meeting deductible. Prescription drugs paid at 100% after 	Yes	<ul style="list-style-type: none"> Medical services paid at 100% after meeting deductible. Prescription drugs paid at 100% after 	Yes	<ul style="list-style-type: none"> Medical services paid at 100% after meeting deductible. Prescription drugs paid at 100% after 	Yes

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
	meeting drug deductible. • End-of-life counseling paid at 100% after meeting deductible.		meeting drug deductible. • End-of-life counseling paid at 100% after meeting deductible.		meeting drug deductible. • End-of-life counseling paid at 100% after meeting deductible.	
Hospital services: Inpatient; and Outpatient services	*Inpatient 15% Coins	Yes	*Inpatient 15% Coins	Yes	*Inpatient 15% Coins	Yes
Immunizations (Vaccines)	0% Coins (usually)	Yes No	0% Coins (usually)	Yes No	0% Coins (usually)	Yes No
Joint replacement surgery Inpatient; and Outpatient	*Inpatient 15% Coins	No Yes	*Inpatient 15% Coins	No Yes	*Inpatient 15% Coins	No Yes
Mammograms (Diagnostic)	15% Coins	Yes	15% Coins	Yes	15% Coins	Yes
Mammograms (Screening)	0% Coins	No	0% Coins	No	0% Coins	No
Massage therapy	15% Coins	Yes	15% Coins	Yes	15% Coins	Yes
Mastectomy and breast reconstruction	Covered as *inpatient; otherwise 15% coins for outpatient visits	Yes	Covered as *inpatient; otherwise 15% coins for outpatient visits	Yes	Covered as *inpatient; otherwise 15% coins for outpatient visits	Yes
Mental health treatment: Inpatient; and	*Inpatient	Yes	*Inpatient	Yes	*Inpatient	Yes

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
Outpatient services	15% Coins	Yes	15% Coins	Yes	15% Coins	Yes
Naturopathic physician services	15% Coins	Yes	15% Coins	Yes	15% Coins	Yes
Obstetric and newborn care	*Inpatient; 15% coins for related outpatient visits	Yes	*Inpatient; 15% coins for related outpatient visits	Yes	*Inpatient; 15% coins for related outpatient visits	Yes
Office visits	15% Coins	Yes	15% Coins	Yes	15% Coins	Yes
Physical, occupational, speech, and neurodevelopmental therapy	15% Coins	Yes	15% Coins	Yes	15% Coins	Yes
Prescription drugs	**Prescription drugs	**Prescription drugs	**Prescription drugs	**Prescription drugs	**Prescription drugs	**Prescription drugs
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	15% Coins	Yes	15% Coins	Yes
Surgery:						
Inpatient; and	*Inpatient	Yes	*Inpatient	Yes	*Inpatient	Yes
Outpatient services	15% Coins	Yes	15% Coins	Yes	15% Coins	Yes
Telemedicine services	15% Coins	Yes	15% Coins	Yes	15% Coins	Yes
Tobacco cessation services	0% Coins	No	0% Coins	No	0% Coins	No
Transgender services	15% Coins	Yes	15% Coins	Yes	15% Coins	Yes
Urgent care	15% Coins	Yes	15% Coins	Yes	15% Coins	Yes
Vision care: (Diseases and disorders of the eye)	15% Coins	Yes	15% Coins	Yes	15% Coins	Yes
Vision exams, routine	0% Coins	No	0% Coins	No	0% Coins	No
Vision hardware, adults (over age 18):	Any amount	No	Any amount	No	Any amount	No

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
Glasses, contact lenses	over \$150 every 2 years		over \$150 every 2 years		over \$150 every 2 years	
Vision hardware, children (age 18 and under):						
Glasses (<i>plan pays for 1 pair per year at 100% of the allowed amount</i>)	\$0	No	\$0	No	\$0	No
Contact lenses	15% Coins	No	15% Coins	No	15% Coins	No
Well-Child Visits	0%	No	0%	No	0%	No

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***Inpatient:**

- The member pays the \$200 per day copayment at preferred facilities.
- Employees and retirees not enrolled in Medicare: Member pays \$600 maximum per calendar year.
- Retirees enrolled in Medicare: Member pays \$600 maximum per admission up to the medical out-of-pocket limit.

Note: The inpatient copay counts toward the member’s medical out-of-pocket limit.

When member is admitted to a preferred facility, they will pay:

- Any remaining medical deductible;
- The inpatient copay; AND
- Their coinsurance for professional services, such as doctor consultations and lab tests, which depends on the provider’s network status.
- Services are considered inpatient only when the member is admitted to a facility.

****Prescription Drugs:**

Tier	At all network pharmacies (retail and mail order), member pays	The most a member will pay (prescription cost limit) at Network pharmacies only
Preventive	0% coinsurance <i>No deductible</i>	\$0
Value Tier	5% coinsurance <i>No deductible</i>	\$10 – Up to a 30-day supply \$20 – 31-60 days’ supply \$30 – 61-90 days’ supply
Tier 1: <i>Select generic drugs</i>	10% coinsurance <i>No deductible</i>	\$25 – Up to a 30-day supply \$50 – 31-60 days’ supply \$75 – 61-90 days’ supply
Tier 2: <i>Preferred drugs</i>	30% coinsurance <i>Deductible applies</i>	\$75 – Up to a 30-day supply \$150 – 31-60 days’ supply \$225 – 61-90 days’ supply
Tier 3: <i>Nonpreferred drugs</i>	50% coinsurance <i>Deductible applies</i>	Specialty drugs* only : \$150 No cost-limit for non-specialty drugs

*Specialty drugs must be purchased through the plan’s network specialty pharmacy.

Exhibit 4 – SEBB Rate Form

The SEBB Rate Form workbook has been included as part of the RFI for collecting preliminary non-binding information on the development of rates. The data is intended to be informational in nature, with its primary function being preliminary development of employee contribution rates based on the Sample Plans and proposed alternative plan options. Given the nature of the program and the data that will most likely be available at the time, the Rate Form is structured around providing rates for a portfolio of plans based on a common base rate with limited sources of variation for each plan, and limited information for the rate normalization process (which will be performed by HCA). Results of the preliminary analysis will be used to inform discussion with Carriers around potential ranges for employee contributions and statewide rate normalization methodology to be used in the development of employee contribution rates.

The workbook includes four primary worksheets with an instructions tab that includes detailed instructions for completing each item in the workbook. Worksheets are as follows:

- **Worksheet 1 – Base Rate Development:** Development of projected base allowed claims for the currently covered Washington State school employee subscribers or another applicable based period population, projected retention percentage, and tier mix. The Carrier is expected to use data from a single fixed base population to inform the pricing of all plans. Base period experience is to be adjusted by the Carrier to reflect a projection of experience to calendar year 2020, for the specified package of covered benefits described in Exhibit 3 – Cost Sharing, Benefits, and Covered Services.
- **Worksheet 2 – Plan-Level Details:** Starting with the CY2020 base allowed amount calculated on Worksheet 1, Worksheet 2 details differential factors that are specific to each plan, including plan factors, other adjustments, carve outs, and additions. Vision costs must be presented as both included in the plan(s), and carved out from the plan(s) (in the event vision is offered as a group vision plan separate from the medical benefits). The alternative plan offerings give your organization options to add or subtract other benefits. The retention and tier ratio assumptions calculated on Worksheet 1 are used to convert the claims expenses into plan-specific payment rates. Additional sections include the option for a mandatory HSA contribution and an informational section on expected subscriber mix by plan and tier.
- **Worksheet 3 – Demographics:** Defines the demographic makeup of the population used for base period experience.
- **Worksheet 4 – Area:** Defines the area distribution of the population by county that is used for base period experience.

Exhibit 5 – County Coverage

For ease of use this exhibit has been included as an excel document. Please reference section 4.C - Geographic Coverage when completing this table.

Exhibit 6 – Group Structure Example

