

## **PEBB RFP 3872 Exhibit K – Cost & Plan Design Instructions v1.0**

*PMPM rates provided by Bidders are to be not-to-exceed (NTE) rates. The resulting ASB(s) will be required to honor their Proposal's NTE rates during contract negotiations.*

### **[General Inputs]**

The rate review process involves the comparison of a Medicare fee-for-service (FFS) medical plan design (Baseline FFS Medical) combined with the Defined Standard Part D plan design (Baseline Pharmacy). These two baseline rates represent the primary pricing components, proposed by the Bidder. These components, in addition to the Per Member Per Month (PMPM) premium for Minimum Supplemental Benefits (see WS2), will be used for establishing Bidders' cost scores under this RFP.

HCA would also like to see examples relating to innovative methods of Value Based Purchasing (VBP), including value-based insurance design (VBID) and Supplemental Benefit designs. This worksheet provides inputs for Bidders to identify at least one (1) but no more than three (3) proposed Enhanced Alternative Medical and Pharmacy plans each, including the names of the plans and key elements of cost sharing for consideration during the rate review process. Bidders must complete all inputs throughout this workbook for all proposed Enhanced Alternative Medical and Pharmacy plans. Bidders must also include as an attachment to this RFP one sample Certificate of Coverage (COC) associated with the proposed Enhanced Alternative Medical and Pharmacy plans with the highest levels of covered benefits.

The remaining worksheets summarize the rate development for the Baseline FFS Medical and Baseline Pharmacy rates, the Minimum Supplemental Benefits rates, and the proposed rates for the Enhanced Alternative Medical and Pharmacy plan(s).

### **[Worksheet (WS) 1]**

This worksheet provides inputs for Bidders to enter their projected medical allowed claims. These projections could be based on prior claims experience for PEBB Uniform Medical Plan Classic - Medicare or reflect the assumptions underlying the manual rate. PEBB UMP Classic - Medicare is a Coordination of Benefits (COB) plan that offers secondary coverage, with Medicare as the primary payer. The experience summary reflects the utilization for the Bidder's Baseline FFS Medical plan. This form also calculates the plan paid PMPM for evaluation of the mandatory Baseline FFS Medical plan, based on CMS defined Medicare cost sharing.

Bidders may also receive Bonus points if they include a Health Education program and/or an Annual Physical Exam in their Baseline FFS Medical plan, as described in RFP Section 4.2(C) – Evaluation Weighting and Scoring.

Unless otherwise noted, definitions for benefits in Exhibit K – Cost & Plan Design are consistent with the Centers for Medicare and Medicaid Services' definitions for Medicare Covered Services and Supplemental Benefits.

### **[Worksheet (WS) 2]**

This worksheet provides inputs for Bidders to develop proposed PMPM premium rates for all proposed medical plans. The Bidder's rate proposal should include an actuarial memorandum to explain the development of all adjustment factors. HCA and its contracted actuary will review the adjustments for reasonableness and may request further revisions to the rates submitted. This worksheet has six (6) general sections.

1. Plan-Specific Allowed Adjustments

This section includes inputs for benefit design induced utilization as well as any other factors for consideration in the development of the allowed claims PMPM for the proposed Enhanced Alternative Medical plan(s). Bidders may not make adjustments under this section for the Baseline FFS Medical plan.

2. Plan-Specific Paid Adjustments

This section includes inputs for the pricing actuarial value as well as any other factors for consideration in the development of the paid claims PMPM for the proposed Enhanced Alternative Medical plan(s). For the Baseline FFS Medical plan, these adjustments were calculated on WS1. For the Enhanced Alternative Medical plan(s), the Bidders must input an estimate of the CMS Risk Adjusted Payment. This factor is used to adjust the paid amounts to reflect the revenues provided by CMS.

3. Non-Benefit Expense Percentages  
The Non-Benefit Expense Percentages must be equal for all proposed plans. The Bidder's attached actuarial memorandum should describe any enrollment considerations across the Enhanced Alternative Medical plan(s) used in the development of these percentages.
4. Minimum Supplemental Benefits Premium PMPM  
Premiums for Supplemental Benefits provided in this section are calculated separately from (i.e., in addition to) the Baseline FFS Medical premium. It is mandatory that the Bidder's proposal include pricing for these benefits, which will be included as part of the Bidder's total cost score. While there are no maximum levels of cost sharing, these benefit coverage levels must be consistent across all proposed Enhanced Alternative Medical plan(s). The Premium PMPM proposal for Supplemental Benefits should be inclusive of both benefit and non-benefit cost. HCA is under no obligation to select any of these supplemental benefits for final inclusion in the PEBB Medicare Retiree benefits portfolio.
5. Enhanced Supplemental Benefits Premium PMPM  
Premiums for the enhanced Supplemental Benefits in this section are also calculated separately from (i.e., in addition to) the Baseline FFS Medical premium. Bidders should provide pricing for all Supplemental Benefits listed in this section, and up to four (4) additional Supplemental Benefits, that they are capable of offering to HCA. HCA is under no obligation to select any of these Supplemental Benefits for final inclusion in the PEBB Medicare Retiree benefits portfolio.
6. Summary Calculations – Premium PMPM Components  
This section calculates a summary of the various premium levels for all proposed Medical plans.

### **[Worksheet (WS) 3]**

This worksheet provides inputs for Bidders to enter the projected pharmacy allowed and paid claims. These projections should reflect a Defined Standard Part D plan design and could be based on prior claims experience for PEBB Uniform Medical Plan Classic - Medicare or reflect the assumptions underlying the manual rate. The current PEBB UMP Classic - Medicare plan includes Creditable Prescription Drug Coverage. The experience summary reflects the current UMP utilization by drug category (generic, single source brand, multi-source brand). Bidders will report drug categories for the projection of future cost.

### **[Worksheet (WS) 4]**

This worksheet provides inputs for Bidders to develop the proposed premium rates for all proposed pharmacy plans. The Bidder's rate proposal should include an attached actuarial memorandum to explain the development of all adjustment factors. HCA and its contracted actuary will review the adjustments for reasonableness and may request further revisions to the rates submitted. This worksheet has four (4) general sections.

1. Plan-Specific Allowed Adjustments  
This section includes inputs for benefit design induced utilization as well as any other factors for consideration in the development of the allowed claims PMPM for the proposed Enhanced Alternative Pharmacy plan(s). Bidders may not make adjustments under this section for the Baseline Pharmacy plan.
2. Plan-Specific Paid Adjustments  
This section includes inputs for the pricing actuarial value as well as any other factors for consideration in the development of the paid claims PMPM for the proposed Enhanced Alternative Pharmacy plan(s). For the Baseline Pharmacy plan, these adjustments were calculated on WS3. For all Enhanced Alternative Pharmacy plan(s), the Bidders must input an estimate of the CMS Risk Adjusted Direct Subsidy. This factor is used to adjust the paid amounts to reflect the revenues provided by CMS.
3. Non-Benefit Expense Percentages  
The Non-Benefit Expense Percentages must be equal for all proposed plans. The Bidder's attached actuarial memorandum should describe any enrollment considerations across the Enhanced Alternative Pharmacy plans used in development of these percentages.
4. Summary Calculations – Pharmacy Premium PMPM  
This section calculates a summary of the various premium levels for all proposed pharmacy plans.

### **[Worksheet (WS) 5]**

This worksheet provides a summary of the scored premium components that include the Baseline FFS Medical plan, Minimum Supplemental Benefits, and the Baseline Pharmacy plan. Enhanced Supplemental Benefits are not included in the scoring.

### **[Worksheet (WS) 6]**

This worksheet provides an illustrative summary of the premium components for different Enhanced Alternative Medical and Pharmacy plan combinations, including different selections of Supplemental Benefits. Bidders should not provide inputs for this worksheet in their Proposals. HCA will use this worksheet to evaluate different benefit offerings.

### **[Worksheet (WS) 7]**

This worksheet provides inputs for Bidders to describe the benefit design structure for each of their proposed Enhanced Alternative Medical plan(s). Separate inputs are provided for each type of service within the Baseline FFS Medical, Minimum Supplemental Benefits, and Enhanced Supplemental Benefits categories. Bidders should input the following for each benefit:

- Whether the benefit is subject to the medical deductible
- Co-insurance and or Co-Pay amount and structure (e.g. per day for the first 3 days)
- Out-of-pocket maximum
- Maximum visits per plan year

### **[Worksheet (WS) 8]**

This worksheet provides inputs for Bidders to describe benefit design structure for each of their proposed Enhanced Alternative Pharmacy plan(s). Separate inputs are provided for each pharmacy tier. Bidders should input the following for each benefit:

- Whether the benefit is subject to the prescription drug deductible
- Initial coverage limit (ICL)
- Tier description
- ICL cost sharing
- Gap coverage
- Gap cost sharing
- Out-of-pocket maximum

## **Supporting Actuarial Memorandum**

An actuarial memorandum documenting data, methodology, and assumptions underlying all proposed bid rate assumptions must support a completed bid rate form. Bidders should provide support for all plans within their Proposals in a single memorandum, and note any differences between plans in the relevant sections.

At a minimum, Bidders must provide the following information:

### *Base Period Experience*

Bidders should include a description of the base period experience used for the experience projection, including a description of the source population, time period, and why the data is appropriate for use in projecting claims costs for PEBB Program Medicare Retiree Health Plan rates.

### *Projection Factors*

Bidders should include a description of the development of each adjustment factor, along with justification of why those factors are appropriate. Within those descriptions, Bidders should address the following specific items:

- The methodology for determining management factors, and any specific utilization management programs that are associated with management savings embedded in this factor.
- The Bidder's assumptions about the ultimate distribution of subscribers by tier in the PEBB Program Medicare Retiree population, and how that assumption affects the population's morbidity profile.
- The methodology and reasoning behind any changes in plan specific morbidity, and how these changes relate to Membership shifts between plans offered within the PEBB Program Medicare Retiree portfolio.

### *Retention*

The carrier should include a description of the development of each retention item, including the source information used for the administrative costs and a breakdown of relevant administrative costs (e.g. claims processing, commissions, etc.).

The description of retention should also include a description of the Bidder's risk tolerance for similar Medicare coverage and how that translates into the margin assumption.

The carrier should include an explanation of how retention for the proposed bid rates compares to other lines of business, and how 2021 retention for the Bidder's proposed PEBB MA-PD Health Plan(s) compares to historical retention for the Bidder's employer group MA-PD Book of Business for calendar year 2018.

### *Membership*

Bidders should include a description of the development of Membership assumptions and the associated conversion factor, particularly as it relates to the distribution of Subscribers across tiers. Bidders should also include a description of any differences in tier distribution from calendar year 2018, the basis of those differences, and why they are appropriate for creating the conversion factor. HCA will calculate the 2021 Retiree premiums as the difference between the proposed premiums for the PEB Board approved plan(s), less the amount of the Medicare Explicit Subsidy. The Subsidy amount is always set at a fixed amount established by the Legislature, but may never exceed more than fifty (50) percent of the applicable plan(s)' premiums.

## Data Reliance and Limitations

The terms of Milliman's contract with the Washington Health Care Authority, effective December 15, 2017, apply to this report and its use.

This analysis is intended for the use of the State of Washington (HCA) in support of the procurement for Medicare Advantage plus Prescription Drug plan(s) under the PEBB Program. We understand that this information will be shared with eligible Bidders. This report may not be distributed to other third parties without the prior consent of Milliman. To the extent that the information contained in this report is provided to third parties, the document should be distributed in its entirety. Any user of the data must possess a certain level of expertise in actuarial science and health care modeling so as not to misinterpret the data presented.

Milliman makes no representations or warranties regarding the contents of this report to third parties. Similarly, third parties are instructed that they are to place no reliance upon this report prepared for HCA by Milliman that would result in the creation of any duty or liability under any theory of law by Milliman or its employees to third parties. It is the responsibility of any health plan to make an independent determination of the proposed capitation rates for their organization.

This bid rate proposal template has relied extensively on data and assumptions provided by HCA and its vendors. We have not audited or verified this data and other information. If the underlying data or information is inaccurate or incomplete, the results of our analysis may likewise be inaccurate or incomplete. We performed a limited review of the data used directly in our analysis for reasonableness and consistency and have not found material defects in the data beyond those discussed above. If there are material defects in the data, it is possible that they would be uncovered by a detailed, systematic review and comparison of the data to search for data values that are questionable or for relationships that are materially inconsistent. Such a review was beyond the scope of our assignment.

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. The authors of this report are members of the American Academy of Actuaries and meet the qualification standards for performing the analysis presented herein.

Bidders should refer to all applicable Actuarial Standards of Practice, including the following:

ASOP 8: [http://www.actuarialstandardsboard.org/wp-content/uploads/2014/08/asop008\\_176.pdf](http://www.actuarialstandardsboard.org/wp-content/uploads/2014/08/asop008_176.pdf)

ASOP 41: [http://www.actuarialstandardsboard.org/wp-content/uploads/2014/02/asop041\\_120.pdf](http://www.actuarialstandardsboard.org/wp-content/uploads/2014/02/asop041_120.pdf)