Allentown School District

Request for Reference-Based Pricing Proposals

For

Medical and Prescription Drug
Plan Year Beginning July 1, 2020

Issued by:
Conrad Siegel

Issue Date: March 3, 2020
Proposal Submission Deadline: April 3, 2020

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EXHIBITS *(note some exhibits may be sent through a secure portal)*

Exhibit A – Monthly enrollment and claims experience from July 2016 through December 2019

Exhibit B – High claimant information (plan years 2016-2017, 2017-2018, 2018-2019, 2019-2020 through December)

Exhibit C – Group census

Exhibit D – Current medical and prescription drug plan designs

Exhibit E – 2019-20 Rates

Exhibit F – 2018 and 2019 MedFacts report

Exhibit G – Prescription Drug repricing file

Exhibit H – Top Facility Listing

Exhibit I – Top Provider Listing

Questions regarding this RFP should be addressed to:

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Program Background & Overview

Allentown School District (ASD) has approximately 2,100 benefit eligible active employees. ASD currently has 6 Medical/Rx plan options insured by Highmark that approximately 1,870 employees and their families are enrolled in (4,785 total members) as of December 2019. The remaining benefit eligible employees elect to opt-out of district coverage.

ASD's address is: 31 South Penn Street, Allentown, PA 18105

Information Requested from Interested Bidders:

Plan Specifications – Medical, Prescription Drug, & Stop Loss Program

1. Bidders are requested to provide the following proposals with a **July 1, 2020** effective date:
    a. Self-funded **Reference-Based Pricing** proposals for Medical, Prescription Drug
        i. Prescription drug proposals must include pricing and rebate guarantees, detailed later in this RFP
    b. Stop Loss proposal under the specified parameters detailed later in this RFP

2. Quotes provided must match the current plan designs. If the District's current benefits cannot be matched, please provide a plan design that is as close to their current plan design as possible. If there are benefit areas that you cannot match to the current design, please identify benefits that cannot be matched and propose solutions on how to address these differences.

3. For a self-funded arrangement, the vendor will be required to provide monthly individual claims data.

4. The vendor must produce an SPD/Certificate of Coverage describing benefits coverage to be made available no later than 90 days prior to the effective date.

Financial Response – Medical, Prescription Drug, & Stop Loss

5. **Do not include commissions in any of the rates.** All proposals must be provided net of commissions.

MEDICAL

6. **Reference-Based Pricing (RBP)** arrangement - Provide a comprehensive proposal with a breakdown of ALL applicable administration fees for an RBP proposal effective date of 7/1/2020. This should include all fees associated with plan administration, as well as fees based on savings associated with savings vs. billed charges. Provide up to a 5-year fee guarantee. At a minimum, 3 years of guaranteed fees must be provided.

7. If a carved-out prescription benefit or a non-preferred stop loss vendor would impact the ASO fee, a standalone (medical only) ASO fee must also be provided. Detail any credits or reductions to the administrative fee for carved-in Rx and preferred stop loss vendors.

8. The following rate relativities must be used in determining fully insured rates and ASO budget rates:

Single	1.00
Employee/Child	1.70
Employee/Children	2.63
Employee/Spouse	2.25
Family	2.90

9. If the ASO funding arrangement requires an advance deposit, cash advance, or letter of credit please detail the amount required. If so, are there any payment options that would eliminate or reduce this requirement?

10. Under an ASO funding arrangement, detail any administrative expense for processing run-out claims should there be a desire to move to a fully insured program or switch to another self-funded administrator in the future.

11. For any in-network providers, please provide details on your provider-negotiated contracts. Please provide the basis for your in-network reimbursement levels.

12. Are there any access fees (i.e., network fees) that you pay to access other provider networks? If so, please explain in detail and provide the basis of the fees (percent of savings, PEPM, etc.).

13. Performance Guarantees - Provide performance guarantees tied to plan implementation (1st year only), member satisfaction, reporting/recordkeeping, quality assurance and account management. Complete the chart below to propose your performance measures and amount of fee at-risk. If you would propose other measures, please provide details.

	Vendor's Response
Plan implementation (first year only)	
Performance standard	
Performance guarantees	
Percent of fee at-risk	
Member Satisfaction	
Performance standard	
Performance guarantees	
Percent of fee at-risk	
Reporting/Recordkeeping	
Performance standard	
Performance guarantees	
Percent of fee at-risk	
Quality Assurance	
Performance standard	
Performance guarantees	
Percent of fee at-risk	
Account Management	
Performance standard	
Performance guarantees	
Percent of fee at-risk	

14. Please detail any administrative expense that is not included as part of the claim administration fee/retention. Examples of expenses include ad hoc reports, ID cards, and attendance at open enrollment meetings. Also include any fees associated with Out-of-Network and Out-of-Area claims administration or claims auditing and review processes.

STOP LOSS

16. Please provide quotes for specific and aggregate stop loss coverage for (A) medical only and for (B) medical and prescription drug combined.

    a) Scenario A – Medical Only
        1. Specific Deductibles of $300,000, $400,000 and $500,000 per person
        2. Aggregate Coverage at 125% and 115%
        3. Benefit Period And Lifetime Maximum – Unlimited
        4. Contract Basis 12/12 (PAID) and 12/18 (Incurred)

    b) Scenario B – Medical & Prescription Drug
        1. Specific Deductibles of $300,000, $400,000 and $500,000 per person
        2. Aggregate Coverage at 125% and 115%
        3. Benefit Period And Lifetime Maximum – Unlimited
        4. Contract Basis 12/12 (PAID) and 12/18 (Incurred)

17. List any reinsurers/stop loss carriers with whom you are unable to coordinate. If you have preferred reinsurers, please list. Explain any advantage you see in working with the preferred organizations.

18. Explain in detail the reimbursement process for claims exceeding the stop loss insurance specific attachment point. Would the Fund be required to fund the claim initially and wait for reimbursement, or would the stop loss carrier automatically fund the claims? If the Fund must initially fund the claim, please provide the average wait time for reimbursement.

19. Please confirm the basis of claims expenses that are included as part of the stop loss coverage, including whether any fees associated with % savings are covered, as well as any settlements to providers from disputes associated with the reference-based pricing reimbursement level.

20. What is the earliest date a stop loss renewal can be provided? What is the earliest date that FINAL (not illustrative) stop loss rates will be provided?

21. Please detail disclosure requirements to lock in the initial Stop Loss rates.

PRESCRIPTION DRUG

Pricing Guarantees

21. **Please provide 2 quotes – one assuming an open formulary that matches the current plan design, with no drug exclusions, and a second with a more aggressive formulary and Rx management assumptions**. As other options are available, please include illustrations for limited formularies and other management programs that are not currently part of the District's plans as additional options.

22. Please detail your prescription drug pricing guarantees for the ingredient cost component. Also detail the dispensing fees applicable to each of these categories. Specifically, provide pricing **guarantees** on an AWP-X% basis for: **(Guarantees should be provided for 3 years)**
    a) Retail Claims – up to a 34-day supply
        1. Generic claims
        2. Brand claims
        3. Specialty claims
    b) Retail claims – greater than a 34-day supply to a 90-day supply (If your definition of "Retail 90" varies, please define the specific day supply range that would apply)
        1. Generic claims
        2. Brand claims
        3. Specialty claims
    c) Mail order claims
        1. Generic claims
        2. Brand claims
        3. Specialty claims

23. Please provide the definition of a generic drug used in evaluating whether the pricing guarantees have been met. It is preferred that the definition of generic include all generics, and not reconcile "single-source" or "limited distribution" generics under the brand guarantee. Please provide for both discount and rebate guarantees.

24. Please provide pricing and details relative to any specialty programs. Include a complete list of specialty drugs along with the pricing and dispensing fees of each.

25. Are the pricing guarantees applicable by category, or would a shortfall in one category be offset by a gain in another category?

26. Are Specialty Drugs exclusively available at Retail, Mail Order, or both? Do you require that Specialty Drugs be only filled by an exclusive pharmacy of your choosing?

27. Describe the reconciliation process that occurs to demonstrate to the District that the pricing guarantees have been met. If guarantees have not been met, describe the process to issue the District a "true-up" payment to the minimum contractual discount guarantees.

28. Please provide any additional fees associated with the prescription drug proposal, such as: dispensing fees, rebate management fees, administrative fees, reporting fees, etc.

29. Describe any cost-saving opportunities available with limiting the prescription drug network (i.e. enhanced discount guarantees achieved by excluding certain pharmacies).

30. Please provide minimum rebate guarantees for retail, mail order and specialty claims **assuming both an open formulary and a closed formulary**.

31. Specify whether the rebates are per claim, per brand claim, or per "rebateable" claim. Note that "100% of the rebates" is not a guarantee – please provide a specific guarantee so the District can assess how your organization's rebates compare to competing proposals.

32. Please confirm the District receive 100% of the rebates as a full pass-through arrangement?

33. What is the timeframe for distribution of rebates?

34. Exhibit G contains individual claims data for the current prescription drug program. Please conduct a re-pricing of the claims for the period 1/1/2019 through 12/31/2019. The template has been provided and all fields in "blue" must be completed. If a claim cannot be re-priced, please provide the reason

35. Please describe the District's audit rights associated with verifying appropriate pricing/payment to providers as well as meeting discount guarantees. Also please verify that reporting will be made available in order to independently verify discount guarantees are met.

Technical Response – Medical and Prescription Drug

GENERAL

36. State your ability to totally comply with the plan design specifications outlined in the Plan Specifications section and detailed in Exhibit D. Note any variations from the program specifications in your proposal, explain the variation, provide the reason you are not able to comply with the specification, and provide ideas on how you could address these differences.

IMPLEMENTATION

37. Assuming an April 15th notification of being awarded the contract, provide an implementation timeline identifying each task and target completion date for a July 1, 2020, effective date. On the timeline, indicate the District's involvement in each phase of implementation.

38. Provide copies of communication materials that you distribute to employees to announce the District's plan of benefits. Include a sample letter to employees announcing that your organization will be responsible for program administration effective July 1.

39. Indicate if you would be willing to conduct open enrollment meetings at all District sites.

ACCESS AND DISRUPTION

42. Provide a GeoAccess study using the standards defined below and the employee residence zip code data provided on the census (Exhibit C).

- Two primary care physicians within 10 miles of an employee's zip code.
- Two specialty physicians within 10 miles of an employee's zip code. Include all specialties. Include a list of the types of specialties.
- One hospital within 15 miles of an employee's zip code.

43. Complete a network disruption analysis using the data contained in the facility and provider listings (Exhibits H and I).

44. Please least any known providers in the service area that will not participate in your RBP pricing process. Describe the process that an employee must go through when a provider will not agree to provide services due to the lack of specific contractual relationship.

SERVICE

47. Describe in detail your claims and appeal processes including the names of the companies you contract with to conduct the external review.

48. Complete the chart below to provide information on your organization's customer service.

Customer Service Area	Vendor's Response
Average hold time in seconds and average abandonment rate for calls in 2018 and 2019	
Hours of operation of customer service unit	
Will there be a dedicated toll-free customer service unit for District employees?	
Average length of service of the customer service representatives	
Customer service employee turnover rate for 2018 and 2019	
Member satisfaction rating in most recent member satisfaction survey	

49. Is your organization willing to establish a dedicated customer service unit?

50. Will your organization provide a dedicated account representative for the District's Human Recourses Department? In addition, will your organization provide direct access to this individual's supervisor in the event they cannot access or are having issues with their dedicated account representative?

PROGRAM ADMINISTRATION

55. Are any of your claims administration functions outsourced? If yes, please list.

56. Describe your claim payment turnaround time.

57. In addition to your standard reporting, are ad hoc reports available to the District? If yes, are there charges for these reports?

58. Please confirm your willingness to provide a comprehensive ASO reporting package including individual claims data and enrollment on a monthly basis.

PROGRAM MANAGEMENT

63. Provide information on how benefits are administered and claim costs determined for employees who are out-of-area/out-of-state.

64. Describe your organization's prior authorization process including who initiates, time frames, communications to employees, etc. If denied, what is the appeal process and how long does it take?

65. Do you require pre-certification for any procedures or diagnostic services? If yes, list criteria and procedures and describe the pre-certification process.

66. List other utilization management efforts and results. Is an integrated prescription drug benefit program critical for successful utilization management? If so, please describe the impact on utilization/claim management a carved-out prescription benefit would have.