ATTACHMENT A-7: Administrative Fees - BAFO #1

Provide the monthly administrative fee per Subscriber (PSPM) broken out by service item. Do not leave the data field blank for any service item line. If there is not a separate allocation for the service item indicate such by inserting "included" in the field. The total PSPM fee should include all administrative fees for all services proposed and for all covered Subscribers. Approximate number of total Plan Non-Medicare Members: **528,648** approximate number of total Plan Subscribers: **333,446**, approximate number of total Plan Medicare Members: 50,177; approximate number of Subscribers: 47,825. Based on June 2022 enrollment (Fees will exclude actual claims payments).

All costs, except actual claim payments for covered Members, must be included below. Unspecified fees and other expenses will not be paid by the Plan.

*Offerors are encouraged to quote additional services not included in the pre-populated list. Additionally, if there are services which if selected by the Plan reduce the monthly administrative fee per Subscriber, list those services and the applicable reduction to the monthly administrative fee. For example, list any savings if electronic EOBs are selected vs. paper EOBs. Include additional documentation for any additional services or discounts as appropriate.

TABLE A-7.1: Monthly TPA Fees

Service Item Per Subscriber Administrative Fee Based on Total Subscribers

	Initial Contract Term			1st Renewal Period	2nd Renewal Period
	01/01/25 -12/31/25	**01/01/26 - 12/31/26**	**01/01/27 - 12/31/27**	**01/01/28 -12/31/28**	**01/01/29 - 12/31/29**
Standard Services PSPM					
Claims Administration	Included	Included	Included	Included	Included
Customer Service	Included	Included	Included	Included	Included
ID Cards	Included	Included	Included	Included	Included
Utilization Review	Included	Included	Included	Included	Included
Medical Management	Included	Included	Included	Included	Included
Network Access	Included	Included	Included	Included	Included
Appeals	Included	Included	Included	Included	Included
Enrollment/EDI Reconciliation	Included	Included	Included	Included	Included
Outbound Data Files	Included	Included	Included	Included	Included
Secure Member Portal	Included	Included	Included	Included	Included
Audits	Included	Included	Included	Included	Included
Standard Reporting	Included	Included	Included	Included	Included
Custom Reporting	Included assuming no programming required	Included assuming no programming required	Included assuming no programming required	Included assuming no programming required	Included assuming no programming required
Ad Hoc Reporting	Included assuming no programming required	Included assuming no programming required	Included assuming no programming required	Included assuming no programming required	Included assuming no programming required
Other (list and describe as needed)					
Standard Services Fees - Subtotal	$ 13.53	$ 14.21	$ 14.92	$ 16.41	$ 18.05

TABLE A-7.1 (continued): Monthly TPA Fees

Service Item Per Subscriber Administrative Fee Based on Total Subscribers

Additional Services PSPM					
Health Savings Accounts (HSA)	$ 1.75	$ 1.75	$ 1.75	$ 1.75	$ 1.75
Health Reimbursement Accounts (HRA)	$ 3.25	$ 3.25	$ 3.25	$ 3.25	$ 3.25
Assume Claims Fiduciary Liability	Included	Included	Included	Included	Included
Exception processing	Included	Included	Included	Included	Included

1095 Reporting	Not included; will provide cost proposal if the Plan chooses this service; total estimated cost, including printing and distribution, ranges from $150,000-$250,000 for the level of service provided for 2020 and 2021 tax years	Not included; will provide cost proposal if the Plan chooses this service; total estimated cost, including printing and distribution, ranges from $150,000-$250,000 for the level of service provided for 2020 and 2021 tax years	Not included; will provide cost proposal if the Plan chooses this service; total estimated cost, including printing and distribution, ranges from $150,000-$250,000 for the level of service provided for 2020 and 2021 tax years	Not included; will provide cost proposal if the Plan chooses this service; total estimated cost, including printing and distribution, ranges from $150,000-$250,000 for the level of service provided for 2020 and 2021 tax years	Not included; will provide cost proposal if the Plan chooses this service; total estimated cost, including printing and distribution, ranges from $150,000-$250,000 for the level of service provided for 2020 and 2021 tax years
Various required filings (including New York and Massachusetts surcharge filing, and Michigan Public Act 142 filing)	Included	Included	Included	Included	Included
Telehealth services	$ 1.00	$ 1.00	$ 1.00	$ 1.00	$ 1.00
Annual OE Plan Vendor testing	Included	Included	Included	Included	Included
Other (list and describe as needed)					
Diagnostic Imaging Management Program	$ 0.55	$ 0.55	$ 0.56	$ 0.58	$ 0.58
Oncology Program (utilization management and treatment pathways)	$ 0.38	$ 0.38	$ 0.39	$ 0.41	$ 0.41
New, Optional Programs Introduced During Contract Term (e.g., new utilization management programs)	Negotiated	Negotiated	Negotiated	Negotiated	Negotiated
Customized Member and Provider Communications (e.g., welcome kits, promotional material, letters, custom EOBs, EOB stuffers, etc.)	$125/hour for customization; any printing and postage costs would be additional pass through expenses	$125/hour for customization; any printing and postage costs would be additional pass through expenses	$125/hour for customization; any printing and postage costs would be additional pass through expenses	$125/hour for customization; any printing and postage costs would be additional pass through expenses	$125/hour for customization; any printing and postage costs would be additional pass through expenses
ID Card Customization (other than Plan logo)	$100/hour for customization	$100/hour for customization	$100/hour for customization	$100/hour for customization	$100/hour for customization
Surveys of HBRs and Members	HBR/Member surveys $30,000. Hourly rate for survey customization $150 per hour. Any printing, mailing, web hosting, or other non-personnel costs would be additional and direct pass through.	HBR/Member surveys $30,000. Hourly rate for survey customization $150 per hour. Any printing, mailing, web hosting, or other non-personnel costs would be additional and direct pass through.	HBR/Member surveys $30,000. Hourly rate for survey customization $150 per hour. Any printing, mailing, web hosting, or other non-personnel costs would be additional and direct pass through.	HBR/Member surveys $30,000. Hourly rate for survey customization $150 per hour. Any printing, mailing, web hosting, or other non-personnel costs would be additional and direct pass through.	HBR/Member surveys $30,000. Hourly rate for survey customization $150 per hour. Any printing, mailing, web hosting, or other non-personnel costs would be additional and direct pass through.
Smart Shopper Tool	$ 0.85	$ 0.85	$ 0.87	$ 0.89	$ 0.89

Incentives	Paid by the Plan	Paid by the Plan	Paid by the Plan	Paid by the Plan	Paid by the Plan
Value Based Programs	Shared savings and administrative costs paid by the Plan. Financial arrangement to be determined at implementation.	Shared savings and administrative costs paid by the Plan. Financial arrangement to be determined at implementation.	Shared savings and administrative costs paid by the Plan. Financial arrangement to be determined at implementation.	Shared savings and administrative costs paid by the Plan. Financial arrangement to be determined at implementation.	Shared savings and administrative costs paid by the Plan. Financial arrangement to be determined at implementation.
HSA/ HRA Member Account Fees (billed directly to member) for replacement cards, reimbursement checks, returned deposits, stop payments, distribution of excess contribution, account closing, paper account statements)	Varies- List provided upon request	Varies- List provided upon request	Varies- List provided upon request	Varies- List provided upon request	Varies- List provided upon request
Additional Services Fees - Subtotal	$ 7.78	$ 7.78	$ 7.82	$ 7.88	$ 7.88

Credit/Savings					
Electronic EOB Adoption					
Other					
Subtotal Credits/Savings					
Total Cost (PSPM)	$ 21.31	$ 21.99	$ 22.74	$ 24.29	$ 25.93

Monthly Administrative Fees Based on Non-Medicare Lives (Excludes Medicare Primary)

TABLE A-7.1: (continued) Monthly TPA Fees					
Service Item Per Subscriber Administrative Fee Based on Total Non-Medicare Primary Members					
	Initial Contract Term			1st Renewal Period	2nd Renewal Period
	01/01/25 -12/31/25	01/01/26 - 12/31/26	01/01/27 - 12/31/27	01/01/28 -12/31/28	01/01/29 - 12/31/29
Service Item					
Disease Management	Included	Included	Included	Included	Included
Care Coordination	Included	Included	Included	Included	Included
Lifestyle Coaching	Included	Included	Included	Included	Included
Transition of Care	Included	Included	Included	Included	Included
High Utilizer Programs	Included	Included	Included	Included	Included
Complex Case Management	Included	Included	Included	Included	Included
PHM Services via Secure Member Portal	Included	Included	Included	Included	Included
Digital Coaching	Included	Included	Included	Included	Included
Health Risk Assessment	Included	Included	Included	Included	Included
Other (list and describe as needed)					
Total PSPM Additional Services Fee	$ 2.79	$ 2.94	$ 2.94	$ 3.09	$ 3.09

One-time Administration Fees/Credits - TPA Standard Products & Population Health Management

Provide and describe any applicable one-time administrative fees or credits including any applicable conditions, requirements or restrictions related to the charge or credit. Do not leave any data field blank. If there is not a separate one-time charge or credit for the item indicate the fee/credit is not applicable by inserting "N/A" in the field The total should include all onetime administrative fees and credits for all services proposed and for all covered Subscribers/Members.

Specify the expected timing of invoicing for payment of one-time fees and the application of onetime credits, including whether fees will be payable and credits applied in installments .

Offerors may quote additional one-time fees and credits not included in the pre-populated list.

TABLE A-7.2:   Onetime Fees/Credits, TPA Standard Products & Population Health Management

Onetime Fees	Amount		Invoice timing and frequency
Initial TPA Implementation Credit	4,500,000		Payable on invoice 30 days after effective date
Single Sign-on Implementations	13,500,000		Payable monthly during implementaton period beginning January 2024 ($1,125,000 per month)
Termination Fee 18 month claims run-out	Any new SSO implementations $145/hour	Any new SSO implementations $145/hour	One-time, to be determined
New Vendor Data Files	3 months' administrative fees, based on last active month's fee and membership (applies to TPA fees as well as any vendor administrative fees (e.g., HRA, HSA)	3 months' administrative fees, based on last active month's fee and membership (applies to TPA fees as well as any vendor administrative fees (e.g., HRA, HSA)	Monthly, following termination
Web customization to support Plan Programs	$10,000 per new file feed, assuming standard file layout	$10,000 per new file feed, assuming standard file layout	To be determined
Expanded call center hours during OE	Current customization included; changes to customization provided at a rate of $145/hour of development and implementation work	Current customization included; changes to customization provided at a rate of $145/hour of development and implementation work	To be determined
Other (list and describe as needed)	$145/hour per Customer Service Professional during expanded hours	$145/hour per Customer Service Professional during expanded hours	To be determined

Vendor Carve-out Implementation (e.g., PBM, EES)	$10,000 one-time implementation cost for new file feeds (incoming or outgoing), plus $125/hour for additional implementation work	$10,000 one-time implementation cost for new file feeds (incoming or outgoing), plus $125/hour for additional implementation work	To be determined
Customization of Claim Edits	$125/hour per for development and implementation of additional claim edits. If the Plan's requirements would cause Blue Cross to engage a vendor those costs would be a direct pass thru to the Plan	$125/hour per for development and implementation of additional claim edits. If the Plan's requirements would cause Blue Cross to engage a vendor those costs would be a direct pass thru to the Plan	To be determined
New Vendor Integration	$125/ hour for development and time required to implement a new Plan vendor. If additional reports are required applicable costs above apply	$125/ hour for development and time required to implement a new Plan vendor. If additional reports are required applicable costs above apply	To be determined
Customization of Reports, Vendor Files, Transaction Sets or Dashboards	Customization or development to be provided at a rate of $125/hour for development and implementation work	Customization or development to be provided at a rate of $125/hour for development and implementation work	To be determined
Total Onetime Credits/Fees	**18000000**		

TABLE A-7.3: Per Participant Fees, Biometric Screenings

Per Participant Fee for each type of screening performed					
	Initial Contract Term			1st Renewal Period	2nd Renewal Period
	01/01/25 -12/31/25	01/01/26 - 12/31/26	01/01/27 - 12/31/27	01/01/28 -12/31/28	01/01/29 - 12/31/29
Screening Type					

Onsite Biometric Screening 1: Finger Stick, Full Lipid Panel, Blood Glucose or A1c (for diabetics only), Blood Pressure, Height, Weight, BMI Calculation, Waist Circumference, and Counseling	$ 45.00	$ 47.00	$ 52.00	$ 58.00	$ 64.00
Onsite Biometric Screening 2: Finger Stick, Full Lipid Panel, A1c (all), Prediabetes Paper Test (for non-diabetics), Blood Pressure, Height, Weight, BMI Calculation, Body Composition including Waist Circumference or Waist-to-Hip Ratio and other methods, and Counseling	$ 67.00	$ 69.00	$ 77.00	$ 86.00	$ 96.00
Other (list and describe as needed)					
PreDiabetes Paper Test	Not Available	Not Available	Not Available	Not Available	Not Available
Counseling	If the Plan elects counseling with either option above the cost is $17 per hour/telephonic and $125 per hour/onsite	If the Plan elects counseling with either option above the cost is $17 per hour/telephonic and $125 per hour/onsite	If the Plan elects counseling with either option above the cost is $17 per hour/telephonic and $125 per hour/onsite	If the Plan elects counseling with either option above the cost is $17 per hour/telephonic and $125 per hour/onsite	If the Plan elects counseling with either option above the cost is $17 per hour/telephonic and $125 per hour/onsite
Participation Minimum	Each Clinic is quoted with a thirty (30) Recipient minimum, per Clinic. In the event a Clinic does not meet the thirty (30) Recipient minimum entity will bill for additional Recipients to meet the minimum.	Each Clinic is quoted with a thirty (30) Recipient minimum, per Clinic. In the event a Clinic does not meet the thirty (30) Recipient minimum entity will bill for additional Recipients to meet the minimum.	Each Clinic is quoted with a thirty (30) Recipient minimum, per Clinic. In the event a Clinic does not meet the thirty (30) Recipient minimum entity will bill for additional Recipients to meet the minimum.	Each Clinic is quoted with a thirty (30) Recipient minimum, per Clinic. In the event a Clinic does not meet the thirty (30) Recipient minimum entity will bill for additional Recipients to meet the minimum.	Each Clinic is quoted with a thirty (30) Recipient minimum, per Clinic. In the event a Clinic does not meet the thirty (30) Recipient minimum entity will bill for additional Recipients to meet the minimum.

Calculation of Minimum	Entity will be billed for 80% of the projected minimum per Clinic, or actual participation, or thirty (30) Recipient minimum, whichever is greater. The projected minimum is used to calculate the number of staff required for a clinic. This number must be furnished by noon EST ten (10) business days prior to all Clinics, excluding Federal Holidays. The rate used to calculate additional screenings to meet the projected minimum will be the lesser of the fasting or non-fasting screening rates for the Clinic.	Entity will be billed for 80% of the projected minimum per Clinic, or actual participation, or thirty (30) Recipient minimum, whichever is greater. The projected minimum is used to calculate the number of staff required for a clinic. This number must be furnished by noon EST ten (10) business days prior to all Clinics, excluding Federal Holidays. The rate used to calculate additional screenings to meet the projected minimum will be the lesser of the fasting or non-fasting screening rates for the Clinic.	Entity will be billed for 80% of the projected minimum per Clinic, or actual participation, or thirty (30) Recipient minimum, whichever is greater. The projected minimum is used to calculate the number of staff required for a clinic. This number must be furnished by noon EST ten (10) business days prior to all Clinics, excluding Federal Holidays. The rate used to calculate additional screenings to meet the projected minimum will be the lesser of the fasting or non-fasting screening rates for the Clinic.	Entity will be billed for 80% of the projected minimum per Clinic, or actual participation, or thirty (30) Recipient minimum, whichever is greater. The projected minimum is used to calculate the number of staff required for a clinic. This number must be furnished by noon EST ten (10) business days prior to all Clinics, excluding Federal Holidays. The rate used to calculate additional screenings to meet the projected minimum will be the lesser of the fasting or non-fasting screening rates for the Clinic.	Entity will be billed for 80% of the projected minimum per Clinic, or actual participation, or thirty (30) Recipient minimum, whichever is greater. The projected minimum is used to calculate the number of staff required for a clinic. This number must be furnished by noon EST ten (10) business days prior to all Clinics, excluding Federal Holidays. The rate used to calculate additional screenings to meet the projected minimum will be the lesser of the fasting or non-fasting screening rates for the Clinic.
Biometric Screenings Fees - Total	As shown above	As shown above	As shown above	As shown above	As shown above

Is Contractor willing to offer a multi-year fee rate cap for TPA Services?

Yes, we are willing to provide a multi-year rate cap for TPA services.

If yes, provide cap and explain.

Our proposed fees are represented above.

ATTACHMENT A-8: NETWORK PRICING GUARANTEES - BAFO #1

Indicate the expected improvement on provider reimbursement arrangements by completing the exhibits on the "Guarantees (In State)" and "Guarantees (Out of State)" tabs.

The State Health Plan seeks the most favorable pricing from providers in the selected network and **seeks a contractor that is confident enough in its ability to secure discounts to assume the full risk for any shortfall in the contracted pricing guarantees**. From each bidder, the Plan is seeking (1) discount guarantees, (2) guarantees not to exceed a percentage of the fees charged by Medicare, and (3) guarantees to stay below an overall PMPM trend level. Bidders must provide the guarantee levels requested below and indicate whether they are willing to be at-risk for the full impact of any missed guarantees or a percentage of the full impact (with a minimum of 10% of the amount by which the guarantee was missed). Bidders will be scored on the guarantee levels and the amount placed at-risk. Guarantees can improve from one year to the next but should not become less favorable over time.

At the completion of each plan year, the Contractor shall provide an analysis of its performance against the guarantees. Guarantees will be calculated using claims from active employees and non-Medicare retirees; claims from Medicare retirees are excluded from the calculations.

Network Pricing Guarantees Impact on Projected Costs

Bidders should consider the following when providing their expected improvement in contracted discounts:

- Discount improvements will only be reflected in projected costs to the extent the Vendor is willing to provide shortfall guarantees on a dollar-for-dollar basis. **Discount improvements without guarantees will not be reflected in the projected cost analysis and guarantees not on a dollar-for-dollar basis will only be reflected up to the dollar amount at-risk.**
- The State's expectation is that the following methodology will be used to calculate the average discount for the purposes of the dollar-for-dollar discount guarantee in each of the three contract years. Deviations from this methodology that diminish the value of the guarantee may result in no credit.

Network Discount Guarantee Methodology – for ALL In-Network Claims

- Large claims over $250,000 can be removed from the measurement. While bidders are requested to include all claims regardless of amount in their claims repricing and contracted future discounts, removing large claims over $250,000 will be permitted in the discount guarantee calculation to offset the risk of unforeseen large claims.
- Covered Billed Charges = Total of all facility and professional provider submitted charges minus non-covered charges, ineligible amounts, COB (Coordination of Benefits) and Medicare savings
- Network Savings = Covered Billed Charges minus Cost of Benefits (prior to plan design)
- Achieved Discount % Savings = Network Savings divided by Covered Billed Charges

ATTACHMENT A-8: NETWORK PRICING GUARANTEES (In State) - BAFO #1

Proposer:	Blue Cross Blue Shield of North Carolina
Network:	Broad Network (PPO)

The State Health Plan seeks the most favorable pricing from providers in the selected network and seeks a contractor that is confident enough in its ability to secure discounts to assume the full risk for any shortfall in the contracted pricing guarantees. From each bidder, the Plan is seeking (1) discount guarantees, (2) guarantees not to exceed a percentage of the fees charged by Medicare, and (3) guarantees to stay below an overall PMPM trend level. Bidders must provide the guarantee levels requested below and indicate whether they are willing to be at-risk for the full impact of any missed guarantees or a percentage of the full impact (with a minimum of 10% of the amount by which the guarantee was missed). Bidders will be scored on the guarantee levels and the amount placed at-risk. Guarantees can improve from one year to the next but should not become less favorable over time.

At the completion of each plan year, the Contractor shall provide an analysis of its performance against the guarantees. Guarantees will be calculated using claims from active employees and non-Medicare retirees; claims from Medicare retirees are excluded from the calculations.

	Initial Contract Term			1st Renewal Period	2nd Renewal Period
	01/01/25 -12/31/25	01/01/26 - 12/31/26	01/01/27 - 12/31/27	01/01/28 -12/31/28	01/01/29 - 12/31/29
Discount Guarantees					
Inpatient Facility Discount (%) (e.g., 50% discount)	54.3%	54.8%	55.3%	55.8%	56.3%
Fees At-Risk (select from dropdown list)	% of shortfall	% of shortfall	% of shortfall	% of shortfall	% of shortfall
Percentage of Shortfall (if selected from dropdown) **MINIMUM 10%**	10%	10%	10%	10%	10%
Additional Info/Explanation of Calculation of Fees At-Risk	Payout = 10% of each dollar miss as measured by impact to paid inpatient claims; subject to maximum payout ("cap") of 5% of that year's total administrative fee attributable to in-state members, exclusive of fund administration fees and optional services fees. illustrative example: if actual measured inpatient discount is 50.6% in CY2025 based on total billed inpatient charges of $1B and a paid to allowed claims ratio of 80%, payout is lesser of 10% of impact of discount miss (10% x ([1-0.506] x $1B - [1-0.516] x $1B) x 80%) = $0.8M or 5% of total administrative fee for in-state members				
Outpatient Facility Discount (%) (e.g., 50% discount)	59.5%	60.0%	60.6%	61.1%	61.6%
Fees At-Risk (select from dropdown list)	% of shortfall	% of shortfall	% of shortfall	% of shortfall	% of shortfall
Percentage of Shortfall (if selected from dropdown) **MINIMUM 10%**	10%	10%	10%	10%	10%
Additional Info/Explanation of Calculation of Fees At-Risk	Payout = 10% of each dollar miss as measured by impact to paid outpatient claims; subject to maximum payout ("cap") of 5% of that year's total administrative fee attributable to in-state members, exclusive of fund administration fees and optional services fees. Calculation same as that described above for inpatient.				
Professional Fees Discount (%) (e.g., 50% discount)	50.5%	50.8%	51.0%	51.3%	51.5%
Fees At-Risk (select from dropdown list)	% of shortfall	% of shortfall	% of shortfall	% of shortfall	% of shortfall
Percentage of Shortfall (if selected from dropdown) **MINIMUM 10%**	10%	10%	10%	10%	10%
Additional Info/Explanation of Calculation of Fees At-Risk	Payout = 10% of each dollar miss as measured by impact to paid outpatient claims; subject to maximum payout ("cap") of 5% of that year's total administrative fee attributable to in-state members, exclusive of fund administration fees and optional services fees. Calculation same as that described above for inpatient.				
Percent of Medicare Guarantees					
Inpatient Facility Costs (%) (e.g., 135% of Medicare)	179%	178%	177%	176%	175%
Fees At-Risk	% of overage	% of overage	% of overage	% of overage	% of overage
Percentage of Overage (if selected from dropdown) **MINIMUM 10%**	10%	10%	10%	10%	10%
Additional Info/Explanation of Calculation of Fees At-Risk	Payout = 10% of each dollar miss as measured by impact to paid inpatient claims; subject to maximum payout ("cap") of 5% of that year's total administrative fee attributable to in-state members, exclusive of fund administration fees and optional services fees. illustrative example: if actual result is 185% of Medicare in CY2025 based on total inpatient paid claims of $500M, payout is lesser of 10% of impact of discount miss (10% x ($500M - [179% / 185%] x $500M) = ~$1.6M or 5% of total administrative fee for in-state members				
Outpatient Facility Costs (%) (e.g., 135% of Medicare)	308%	307%	306%	305%	304%
Fees At-Risk	% of overage	% of overage	% of overage	% of overage	% of overage
Percentage of Overage (if selected from dropdown) **MINIMUM 10%**	10%	10%	10%	10%	10%
Additional Info/Explanation of Calculation of Fees At-Risk	Payout = 10% of each dollar miss as measured by impact to paid outpatient claims; subject to maximum payout ("cap") of 5% of that year's total administrative fee attributable to in-state members, exclusive of fund administration fees and optional services fees. Calculation same as that described above for inpatient.				
Professional Costs (%) (e.g., 135% of Medicare)	182%	181%	180%	179%	178%
Fees At-Risk	% of overage	% of overage	% of overage	% of overage	% of overage
Percentage of Overage (if selected from dropdown) **MINIMUM 10%**	10%	10%	10%	10%	10%
Additional Info/Explanation of Calculation of Fees At-Risk	Payout = 10% of each dollar miss as measured by impact to paid professional claims; subject to maximum payout ("cap") of 5% of that year's total administrative fee attributable to in-state members, exclusive of fund administration fees and optional services fees. Calculation same as that described above for inpatient.				
Trend Guarantee					

Annual PMPM Incurred Medical Cost Trend (%) (e.g., 6%)	Trend guarantee begins in Year 2. Guarantee is percent increase over prior year.	6.0%	6.0%	6.0%	6.0%
Fees At-Risk		% of overage	% of overage	% of overage	% of overage
Percentage of Overage (if selected from dropdown)		10%	10%	10%	10%
Additional Info/Explanation of Calculation of Fees At-Risk		Payout = 10% of each dollar miss as measured by impact to paid total medical claims up to a 10% trend; subject to cap of 5% of that year's total administrative fee attributable to in-state members (exclusive of fund administration fees and optional services fees). If actual trends exceed 10%, Blue Cross NC will automatically pay out 5% of administrative fee attributable to in-state members even if cap has not been reached. Guarantee subject to exclusions/caveats listed below.			
Other Guarantees (Encouraged but not Required)					
Explain:					
Fees At-Risk					
Additional Info/Explanation of Calculation of Fees At-Risk					

Describe your proposed formula for determining the actual performance against expected or quoted pricing guarantees?

These guarantees are offered on total fee-for-service claims (Inpatient, Outpatient and Professional/Other costs), excluding Prescription Drug costs, Claims incurred outside of the United States, Denied Claims, Pending Claims, Orphan Claims, Care Management Fees, and Network Access Fees, if any. Claims incurred by providers who signed up for the Clear Pricing Program both prior to and during the measurement year will be excluded from these guarantees. Payouts will be based on proportional impact to paid claims as described above.

Discount Guarantee:

Discount percent will be calculated as follows for each measurement year:
1. Total savings equals billed charges less allowed charges
2. Both billed and allowed charges exclude claims incurred by out-of-network providers
3. Claims where Medicare, Medicaid, or another insurer is primary will be exluded from the discount calculation
4. Discount percent = [total savings] / (billed charges less non-eligible charges)

Percent of Medicare Guarantee:

Percent of Medicare = [Actual Fee-for-Service Allowed Charges during Measurement Year] / [Medicare Reimbursement Levels for identical services]
Exclusions may apply for services unable to be "repriced" as percent of Medicare

Trend Guarantee:

Trend percent will be calculated as follows:
1. Measurement year (i.e. 2026) medical allowed claims (per member per month)
2. Base year (i.e. 2025) medical allowed claims (per member per month)
3. ([Measurement year PMPM] / [Prior Year PMPM]) - 1 = Trend percent

The first measurement year target claims will be calculated using allowed charges incurred from 1/1/2026 to 12/31/2026 and paid through 4/30/2027. The first base year claims will be calculated using Allowed charges incurred from 1/1/2025 to 12/31/2025 and paid through 4/30/2026.

Exclusions from total incurred claims for both the measurement and base years:
- All claims for those individuals with claims in excess of $250,000 in a calendar year
- Claims related to new services or benefits added at the discretion of the Plan during the term of this contract

Events that trigger revisiting structure of all financial guarantees based on mutually agreeable terms between the Plan and Blue Cross NC:
- Blue Cross NC may revisit the structure or conditions of any guarantees if total enrollment changes by more than 10% in any given year versus the prior years or if any events materially change the geographic distribution of State Health Plan employees
- Changes to the Plan benefits or the administration of the Plan initiated by the SHP that results in a substanital change in the services to be performed by Blue Cross NC
- Changes required by Federal, State or Local government laws or regulations related to changes in mandates, taxes, surcharges or premium taxes, fees, etc. The effective date of the change will be that required by the imposing Agency, even if retro-active.
- Material changes in the identity or mix of providers whose claims/payments will be included or excluded in the analysis of any of the above Guarantees

The actual paid annual administrative fee based upon actual enrollment within the measurement year will be used to determine guarantee payouts, if any.

Describe the management information that you will provide SHP to support the year-end performance results.

Discount guarantee:

Blue Cross NC will continue to provide the following metrics to support year-end evaluation of the discount guarantee for a given measurement period: total billed charges, total non-eligible charges, total allowed charges, and "total savings" (as defined above) for each type of service (Inpatient, Outpatient, Professional/Other) based on services incurred during the measurement period. Paid claims will be required to determine the amounts of payouts, if any.

Percent of Medicare guarantee:

Blue Cross NC will provide results of a claims-level "repricing" of services incurred during the measurement period by type of service aggregated at the type of service level relative to Medicare reimbursement levels for the same time period, with disclosures summarizing any exclusions, and actuarial certification of any results (this may be rendered by an outside Third Party acting as a representative for Blue Cross NC). Additional details may be provided to support reviews of this analysis upon request.

Trend guarantee:

Measurement year and base year allowed charges and enrollment counts and the calculated trend percent will be provided each year. Settlement will occur by September 30th of the following year after the measurement year.

Provide samples of existing agreements, if any, that your network has used with other large plan sponsors to meet network discount targets or other network pricing guarantees.

The discount and trend guarantee structure outlined above is generally identical to others offered to large plan sponsors with the exception that we generally do not guarantee "dollar for dollar" payouts in the event of a miss. However, we believe we have structured an arrangement here that uniquely addresses the needs of the Plan that is mutually acceptable to Blue Cross NC.

Would you consider a gain-sharing arrangement off a negotiated PMPM claims cost? Perhaps, similar to the PMPM developed in the **Self-Funded Claims Projection - Attachment A-9?** If so, please elaborate and propose a recommended methodology.

We would be open to discussions with the Plan around gain-sharing arrangements. These arrangements would likely be between large integrated provider systems and the Plan, with Blue Cross NC playing the role of the administrator to measure provider performance and provide "shared savings" payments to providers for demonstration of performance (i.e. lower cost of care relative to targets such as those shown in Attachment A-9 and/or quality outcomes).

ATTACHMENT A-8: NETWORK PRICING GUARANTEES (Out of State) - BAFO #1

Proposer:	Blue Cross Blue Shield of North Carolina
Network:	Broad Network (PPO)

The State Health Plan seeks the most favorable pricing from providers in the selected network and seeks a contractor that is confident enough in its ability to secure discounts to assume the full risk for any shortfall in the contracted pricing guarantees. From each bidder, the Plan is seeking (1) discount guarantees, (2) guarantees not to exceed a percentage of the fees charged by Medicare, and (3) guarantees to stay below an overall PMPM trend level. Bidders must provide the guarantee levels requested below and indicate whether they are willing to be at-risk for the full impact of any missed guarantees or a percentage of the full impact (with a minimum of 10% of the amount by which the guarantee was missed). Bidders will be scored on the guarantee levels and the amount placed at-risk. Guarantees can improve from one year to the next but should not become less favorable over time.

At the completion of each plan year, the Contractor shall provide an analysis of its performance against the guarantees. Guarantees will be calculated using claims from active employees and non-Medicare retirees; claims from Medicare retirees are excluded from the calculations.

	Initial Contract Term			1st Renewal Period	2nd Renewal Period
	01/01/25 -12/31/25	01/01/26 - 12/31/26	01/01/27 - 12/31/27	01/01/28 -12/31/28	01/01/29 - 12/31/29
Discount Guarantees					
Inpatient Facility Discount (%) (e.g., 50% discount)	57.9%	58.4%	58.8%	59.2%	59.7%
Fees At-Risk (select from dropdown list)	% of shortfall	% of shortfall	% of shortfall	% of shortfall	% of shortfall
Percentage of Shortfall (if selected from dropdown) **MINIMUM 10%**	10%	10%	10%	10%	10%
Additional Info/Explanation of Calculation of Fees At-Risk	Payout = 10% of each dollar miss as measured by impact to paid inpatient claims; subject to maximum payout ("cap") of 5% of that year's total administrative fee attributable to out-of-state members, exclusive of fund administration fees and optional services fees. illustrative example: if actual measured inpatient discount is 54.5% in CY2025 based on total billed inpatient charges of $1B and a paid to allowed claims ratio of 80%, payout is lesser of 10% of impact of discount miss (10% x ([1-0.545] x $1B - [1-0.555] x $1B) x 80%) = $0.8M or 5% of total administrative fee for out-of-state members				
Outpatient Facility Discount (%) (e.g., 50% discount)	64.2%	64.6%	65.1%	65.5%	65.9%
Fees At-Risk (select from dropdown list)	% of shortfall	% of shortfall	% of shortfall	% of shortfall	% of shortfall
Percentage of Shortfall (if selected from dropdown) **MINIMUM 10%**	10%	10%	10%	10%	10%
Additional Info/Explanation of Calculation of Fees At-Risk	Payout = 10% of each dollar miss as measured by impact to paid outpatient claims; subject to maximum payout ("cap") of 5% of that year's total administrative fee attributable to out-of-state members, exclusive of fund administration fees and optional services fees. Calculation same as that described above for inpatient.				
Professional Fees Discount (%) (e.g., 50% discount)	55.1%	55.3%	55.5%	55.7%	55.9%
Fees At-Risk (select from dropdown list)	% of shortfall	% of shortfall	% of shortfall	% of shortfall	% of shortfall
Percentage of Shortfall (if selected from dropdown) **MINIMUM 10%**	10%	10%	10%	10%	10%
Additional Info/Explanation of Calculation of Fees At-Risk	Payout = 10% of each dollar miss as measured by impact to paid outpatient claims; subject to maximum payout ("cap") of 5% of that year's total administrative fee attributable to out-of-state members, exclusive of fund administration fees and optional services fees. Calculation same as that described above for inpatient.				
Percent of Medicare Guarantees					
Inpatient Facility Costs (%) (e.g., 135% of Medicare)	179%	178%	177%	176%	175%
Fees At-Risk	% of overage	% of overage	% of overage	% of overage	% of overage
Percentage of Overage (if selected from dropdown) **MINIMUM 10%**	10%	10%	10%	10%	10%
Additional Info/Explanation of Calculation of Fees At-Risk	Payout = 10% of each dollar miss as measured by impact to paid inpatient claims; subject to maximum payout ("cap") of 5% of that year's total administrative fee attributable to out-of-state members, exclusive of fund administration fees and optional services fees. illustrative example: if actual result is 185% of Medicare in CY2025 based on total inpatient paid claims of $500M, payout is lesser of 10% of impact of discount miss (10% x ($500M - [179% / 185%] x $500M) = ~$1.6M or 5% of total administrative fee for out-of-state members				
Outpatient Facility Costs (%) (e.g., 135% of Medicare)	308%	307%	306%	305%	304%
Fees At-Risk	% of overage	% of overage	% of overage	% of overage	% of overage
Percentage of Overage (if selected from dropdown) **MINIMUM 10%**	10%	10%	10%	10%	10%
Additional Info/Explanation of Calculation of Fees At-Risk	Payout = 10% of each dollar miss as measured by impact to paid outpatient claims; subject to maximum payout ("cap") of 5% of that year's total administrative fee attributable to out-of-state members, exclusive of fund administration fees and optional services fees. Calculation same as that described above for inpatient.				
Professional Costs (%) (e.g., 135% of Medicare)	182%	181%	180%	179%	178%
Fees At-Risk	% of overage	% of overage	% of overage	% of overage	% of overage
Percentage of Overage (if selected from dropdown) **MINIMUM 10%**	10%	10%	10%	10%	10%
Additional Info/Explanation of Calculation of Fees At-Risk	Payout = 10% of each dollar miss as measured by impact to paid professional claims; subject to maximum payout ("cap") of 5% of that year's total administrative fee attributable to out-of-state members, exclusive of fund administration fees and optional services fees. Calculation same as that described above for inpatient.				
Trend Guarantee					
Annual PMPM Incurred Medical Cost Trend (%) (e.g., 6%)		6.0%	6.0%	6.0%	6.0%

Fees At-Risk	Trend guarantee begins in Year 2. Guarantee is percent increase over prior year.	% of overage	% of overage	% of overage	% of overage
Percentage of Overage (if selected from dropdown)		10%	10%	10%	10%
Additional Info/Explanation of Calculation of Fees At-Risk		Payout = 10% of each dollar miss as measured by impact to paid total medical claims up to a 10% trend; subject to cap of 5% of that year's total administrative fee attributable to out-of-state members (exclusive of fund administration fees and optional services fees). If actual trends exceed 10%, Blue Cross NC will automatically pay out 5% of administrative fee attributable to in-state members even if cap has not been reached. Guarantee subject to exclusions/caveats listed below.			
Other Guarantees (Encouraged but not Required)					
Explain:					
Fees At-Risk					
Additional Info/Explanation of Calculation of Fees At-Risk					

Describe your proposed formula for determining the actual performance against expected or quoted pricing guarantees?

These guarantees are offered on total fee-for-service claims (Inpatient, Outpatient and Professional/Other costs), excluding Prescription Drug costs, Claims incurred outside of the United States, Denied Claims, Pending Claims, Orphan Claims, Care Management Fees, and Network Access Fees, if any. Claims incurred by providers who signed up for the Clear Pricing Program both prior to and during the measurement year will be excluded from these guarantees. Payouts will be based on proportional impact to paid claims as described above.

Discount Guarantee:

Discount percent will be calculated as follows for each measurement year:
1. Total savings equals billed charges less allowed charges
2. Both billed and allowed charges exclude claims incurred by out-of-network providers
3. Claims where Medicare, Medicaid, or another insurer is primary will be exluded from the discount calculation
4. Discount percent = [total savings] / (billed charges less non-eligible charges)

Percent of Medicare Guarantee:

Percent of Medicare = [Actual Fee-for-Service Allowed Charges during Measurement Year] / [Medicare Reimbursement Levels for identical services]
Exclusions may apply for services unable to be "repriced" as percent of Medicare

Trend Guarantee:

Trend percent will be calculated as follows:
1. Measurement year (i.e. 2026) medical allowed claims (per member per month)
2. Base year (i.e. 2025) medical allowed claims (per member per month)
3. ([Measurement year PMPM] / [Prior Year PMPM]) - 1 = Trend percent

The first measurement year target claims will be calculated using allowed charges incurred from 1/1/2026 to 12/31/2026 and paid through 4/30/2027. The first base year claims will be calculated using Allowed charges incurred from 1/1/2025 to 12/31/2025 and paid through 4/30/2026.

Exclusions from total incurred claims for both the measurement and base years:
- All claims for those individuals with claims in excess of $250,000 in a calendar year
- Claims related to new services or benefits added at the discretion of the Plan during the term of this contract

Events that trigger revisiting structure of all financial guarantees based on mutually agreeable terms between the Plan and Blue Cross NC:
- Blue Cross NC may revisit the structure or conditions of any guarantees if total enrollment changes by more than 10% in any given year versus the prior years or if any events materially change the geographic distribution of State Health Plan employees
- Changes to the Plan benefits or the administration of the Plan initiated by the SHP that results in a substanital change in the services to be performed by Blue Cross NC
- Changes required by Federal, State or Local government laws or regulations related to changes in mandates, taxes, surcharges or premium taxes, fees, etc. The effective date of the change will be that required by the imposing Agency, even if retro-active.
- Material changes in the identity or mix of providers whose claims/payments will be included or excluded in the analysis of any of the above Guarantees

The actual paid annual administrative fee based upon actual enrollment within the measurement year will be used to determine guarantee payouts, if any.

Describe the management information that you will provide SHP to support the year-end performance results.

Discount guarantee:

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