

ATTACHMENT A-11: NETWORK PRICING GUARANTEES

Vendor:	
Network:	

Vendors are expected to accept all aspects of the Network Pricing Guarantees described within this section and only populate the yellow shaded cells.

Pricing Guarantee for all claims with Medicare Pricing

	Initial Contract Term			1st Renewal Period	2nd Renewal Period
	CY 2028	CY 2029	CY 2030	CY 2031	CY 2032
Indicate Aggregate Percent of Medicare Guarantee (%) ** (e.g., 150% of Medicare)	**%	***%	**%	**%	**%
Total Fees At-Risk/Gain (See schedule below)	\$36,000,000	\$36,000,000	\$36,000,000	\$36,000,000	\$36,000,000

** As the basis for this guarantee, the Medicare allowed amounts will be based on the Medicare fee schedule as of January 1, 2028 for ALL contract years. For example, a proposal that includes the same percent of Medicare guarantee in every year of the contract, indicates that the guarantee is assuming all the risk of increases in the Medicare fee schedule. Again, the Medicare fee schedule in effect on January 1, 2028, will be the Medicare fee schedule used to measure this guarantee for all contract years.

Repricing-to-Guarantee Comparison (CY 2028)

	CY 2028
Based on your claims repricing for Claims with Medicare Pricing, enter the Aggregate Percent of Medicare (%)	**%
Pricing Guarantee for all claims with Medicare Pricing Aggregate Percent of Medicare Guarantee (%) **	**%
Difference	#VALUE!

If the guaranteed Percent of Medicare differs from your claims repricing file, provide a detailed response explaining the difference:

Amount at Risk and to Gain - Total annual amount at risk/gain is \$36 million and the payout amounts are predefined in the chart below.

Achieved % of Medicare Target	Shortfall Paid to Plan	Gain Paid to Vendor
> 6.00% lower	N/A	\$36,000,000
From 4.00% to 6.00% lower	N/A	\$20,000,000
From 2.00% to 4.00% lower	N/A	\$10,000,000
From 0% to 2.00% lower	Risk Free	Risk Free
% of Medicare Target		
From 0% to 2.00% higher	\$18,000,000	N/A
From 2.00% to 4.00% higher		
> 4.00% higher		

Discount Guarantee for only claims w/out Medicare Pricing

	Initial Contract Term			1st Renewal Period	2nd Renewal Period
	CY 2028	CY 2029	CY 2030	CY 2031	CY 2032
Indicate Aggregate Discount Guarantee (%) (e.g., 50% off of Covered Billed Charges)	%	%	%	%	%

Fees At-Risk (Entire amount at risk paid if guarantee is missed)	\$4,000,000	\$4,000,000	\$4,000,000	\$4,000,000	\$4,000,000
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Repricing-to-Guarantee Comparison (CY 2028)

	CY 2028
Based on your claims repricing for Claims without Medicare Pricing, enter the Aggregate Discount (%)	%
Discount Guarantee for all claims w/out Medicare Pricing Aggregate Discount Guarantee (%)	%
Difference	#VALUE!

If the guaranteed discount differs from your claims repricing file, provide a detailed response explaining the difference:

The guarantees will be adjusted (up or down) for any direct contracts negotiated by the State Health Plan. Adjustments will be mutually agreed between the Plan and Vendor.

Percent of Medicare guarantee will be based on the following methodology:

Claims will include all in-network claims (both in and out of state) that can be priced using the Medicare fee schedule.
 The guarantee will apply to all claims that have a Medicare fee (i.e., on the Medicare fee schedule) incurred through all NCSHP medical plans administered by the selected carrier for all non-Medicare participants (active and retiree). Claims for Medicare Primary participants are excluded from this guarantee.
 Claims in excess of \$500,000 will be removed from the calculation. The first \$500,000 for a member will be included in the calculation.
 % of Medicare achieved for 2028 will be calculated as follows: Vendor's total 2028 allowed amount divided by total Medicare allowed amount as of January 1, 2028 for the same claims. The claims used will be 2028 incurred non-Medicare claims that were incurred during the 2028 calendar year and paid during that calendar year and a three month run-out period through March 2029.
 Vendor allowed amounts will include any and all payments associated with the claim, including but not limited to inter-plan network fees, host plan access fees, percent of savings fees, etc.
 Vendor allowed amounts will also include any and all payments made to providers for value-based arrangements, capitations, attribution, provider incentive programs, bonus payments, etc.
 Same methodology (as describe above for 2028) applies for CY 2029, CY 2030, CY 2031, and CY 2032.

Network Discount Guarantee Methodology – for only claims without a Medicare fee (i.e., not on the Medicare fee schedule)

Claims will include all in-network claims (both in and out of state) that cannot be priced using the Medicare fee schedule.
 The guarantee will apply to all NCSHP medical plans administered by the selected carrier for all non-Medicare participants (active and retiree). Claims for Medicare Primary participants are excluded from this guarantee.
 Claims in excess of \$500,000 will be removed from the calculation. The first \$500,000 for a member will be included in the calculation.
 Guarantee will include claims that are incurred during the calendar year and paid during that calendar year and a three month run-out period into the following calendar year.
 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
 Vendor at-risk for \$4,000,000 annually if discount guarantee is not met.
 Cost of Benefits will include any and all payments associated with the claim, including but not limited to inter-plan network fees, host plan access fees, percent of savings fees, etc.
 Cost of Benefits will also include any and all payments made to providers for value-based arrangements, capitations, attribution, provider incentive programs, bonus payments, etc.
 Same methodology (as describe above for 2028) applies for CY 2029, CY 2030, CY 2031, and CY 2032.

The Plan intends to have typical cost management programs in place; however, the Plan maintains control of managing the health plan as indicated in the technical section.

Indicate any additional proposed requirements for the network pricing guarantees. (The valuation of your proposal will diminish with any caveats that materially reduce the value of the network pricing guarantees.)

ATTACHMENT A-11: TREND GUARANTEES

Vendor:	0
Network:	0

Vendors are required to accept all aspects of the medical trend guarantee described within this section and only populate the yellow shaded cells.

Please confirm acceptance of the required medical trend guarantee as described within this section.	Select one of the two responses here
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Trend Guarantee will apply to Year 1 of the contract and all subsequent years of the contract.

Claims Trend Guarantee - The combined active and non-Medicare retiree plans claims trend that your organization expected to achieve for each year of the contract is < 4.00%. This is based on the Plan's budgeted increases.

Amount at Risk and to Gain - Total annual amount at risk/gain is \$25 million and the payout amounts are predefined in the chart below.

Achieved Trend	Shortfall Paid to Plan	Gain Paid to Vendor
0.00% of lower	N/A	\$25,000,000
From 0.00% to 0.99%	N/A	\$20,000,000
From 1.00% to 1.99%	N/A	\$15,000,000
From 2.00% to 2.99%	N/A	\$10,000,000
From 3.00% to 3.49%	N/A	\$5,000,000
From 3.50% to 3.99%	Risk Free	Risk Free
Target 4%		
From 4.00% to 4.49%		
From 4.50% to 4.99%	\$10,000,000	N/A
From 5.00% to 5.99%	\$15,000,000	N/A
From 6.00% to 6.99%	\$20,000,000	N/A
7.00% or greater	\$25,000,000	N/A

The trend guarantee will be adjusted (up or down) for any direct contracts negotiated by the State Health Plan. Adjustments will be mutually agreed between the Plan and Vendor.

Trend guarantee will be based on the following methodology:

The trend guarantee will apply to all claims incurred through all medical plans administered by the selected carrier for all non-Medicare participants (active and retiree).

Claims in excess of \$500,000 will be removed from the calculation. The first \$500,000 for a member will be included in the calculation.

The actual 2028 incurred claims number will be measured using all non-Medicare claims that were incurred during the 2028 calendar year and paid during that calendar year and a three-month run-out period through March 2029. This total will be divided by the actual enrollment during the contract year.

The actual 2027 incurred claims number will be measured using all non-Medicare claims that were incurred during the 2027 calendar year and paid during that calendar year and a three-month run-out period through March 2028. This total will be divided by the actual enrollment during the contract year. All the necessary supporting claims and enrollment data for the 2027 calendar year will be obtained by the Plan from its current medical administrator and provided to the Vendor.

Same methodology (as describe above for 2027 and 2028) applies for CY 2029, CY 2030 and CY 2031.

The actual 2028 trend will be calculated by dividing the adjusted 2028 incurred claims per member per month (calculated as described above) by the adjusted 2027 incurred claims per member per month (calculated as described above) less 1. (Same methodology applies for CY 2029 over 2028, for CY 2030 over CY 2029, for CY 2031 over 2030, and for CY 2032 over 2031.)

Claims will include in-network and out-of-network claims as well as in and out of state.

Claims will include the amounts that are the responsibility of both the member and the Plan to mitigate distortions created by plan design changes.

Claims will include any and all payments associated with the claim, including but not limited to inter-plan network fees, host plan access fees, percent of savings fees, etc.

Claims will also include any and all payments made to providers for value-based arrangements, capitations, attribution, provider incentive programs, bonus payments, etc.

Due to the size and stability of this population, risk and other demographic adjustments will not be included in this calculation.

A member continuously enrolled 12 months would count as 12 member months.

Trend guarantee final reconciliation:

As noted above, the initial trend guarantee calculations will be conducted after the three-month run-out period. The initial financial settlements will also apply at this time.

Final reconciliation of the trend guarantees will be conducted, during the following year's initial calculation, to capture the full 15 months of claims run-out. If applicable with the results varying from the initial calculation, financial settlements will be adjusted at this time.

For example, the final reconciliation of the 2028 trend guarantee will be conducted in calendar year 2030 during the initial calculation of the 2029 guarantee. The 2028 final reconciliation will include claims that were incurred during the 2028 calendar year and paid during that calendar year and the 15-month run-out period through March 2030. These 2028 claims will be measured against 2027 claims that will include claims paid during that calendar year and the 15-month run-out period through March 2029.

The Plan intends to have typical cost management programs in place; however, the Plan maintains control of managing the health plan as indicated in the technical section.