



## REQUEST FOR PROPOSALS (RFP)

### RFP NO. 2025HCA5

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**PROJECT TITLE:** Fully-Insured Medical Plans

**PROPOSAL DUE DATE:** January 14, 2027, by 4:00pm *Pacific Time*, Olympia, Washington, USA.

Only e-mailed bids will be accepted.

**ESTIMATED TIME PERIOD FOR CONTRACT:** January 1, 2029, to December 31, 2033

The Health Care Authority reserves at its sole discretion the right to extend the contract for up to seven (7) additional one (1)-year periods, dependent on mutual agreement of the contract terms by the parties.

**BIDDER ELIGIBILITY:** This solicitation is open to those Bidders that satisfy the minimum qualifications stated herein and that are available for work in Washington State.

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# 1. INTRODUCTION

## 1.1 DEFINITIONS

**“Affordable Care Act”** or **“ACA”** means the [Patient Protection and Affordable Care Act](#), the comprehensive health care reform law enacted by the 111th Congress of the United States in March 2010.

**“Alternative Payment Model”** or **“APM”** means a plan that places financial responsibility on providers with the goal of improving patient outcomes and decreasing expenditures on low-value care while providing patients with the freedom to select medical service providers. The APM promotes clinical excellence while simultaneously controlling costs. This cost control depends on the APM’s ability to incentivize hospitals, physicians, post-acute care facilities, and other providers to form partnerships and promote better coordination of care delivery. By increasing Care Coordination, the APM’s goal is to reduce low-value medical care and improve health outcomes. For purposes of this RFP, an APM must comply with at least CMS LAN Category 3 B criteria.

**“Annual Open Enrollment”** means an annual event set aside for a period of time by HCA when subscribers may make changes to their health plan enrollment and salary reduction elections for the following plan year. During the annual open enrollment, subscribers may transfer from one (1) health plan to another, enroll or remove Dependents from coverage, enroll in coverage, or waive enrollment. Employees (or School Employees for SEBB) eligible to participate in the salary reduction plan may enroll in or change their election under the dependent care assistance program (DCAP), the flexible spending arrangement (FSA), or limited purpose FSA. They may also enroll in or opt out of the premium payment plan.

**“Annual Premium”** means the total amount of Monthly Premium received by the Contractor for PEBB or SEBB membership during the Plan Year, net of any risk adjustment transfer amount(s) applied for that Plan Year. For example, the Annual Premium amount used to determine a Performance Payment owed to HCA for Measurement Year 2024 includes any premium adjustments applied in calendar year 2025 for Plan Year 2024. Remittance of a Performance Payment to the group policyholder is not a return premium for purposes of [RCW 48.14.020](#) and [48.14.0201](#).

**“Apparent Successful Bidder”** or **“ASB”** means a Bidder selected to perform the anticipated services under this RFP, subject to completion of contract negotiations and execution of a written contract.

**“Appeal”** means a written or oral request for reconsideration of a decision to deny, modify, reduce, or terminate payment, coverage, authorization, or provision of health care services, including the admission to, or continued stay in, a health care facility. Appeal means the same as Request for Review of Adverse Benefit Determination as defined in [RCW 48.43.005](#). The word “Appeal” is used in the Washington State Insurance Code ([Title 48 RCW](#) and [Title 284 WAC](#)) with regard to grandfathered plans (plans which predate and are therefore not subject to the Patient Protection and Affordable Care Act, [Pub. L. No. 111-148, 124 Stat. 119 \(2010\)](#)). “Request for Review of Adverse Benefit Determination” is the term used with regard to non-grandfathered plans (plans subject to the Patient Protection and Affordable Care Act.)

An appeal is different from a grievance or complaint. Grievances or complaints do not request that a carrier change an unfavorable decision.

**“Authorized Representative”** means a person to whom signature authority has been delegated in writing acting within the limits of his/her authority.

**“Benefit Cost Ratio”** means the ratio of claims to premiums.

**“Bid Rate”** means the rate that reflects required revenue, by plan, for a risk standardized population assumed to have the average risk score of the applicable risk pool. Bid Rates for the next plan year are final once presented to and authorized by the PEB and SEB Boards.

**“Bidder”** means individual or company interested in this RFP that submits a proposal to attain a Contract with HCA.

**“Book-of-Business”** means all commercial business of the Bidder, including any and all fully insured and self-insured products within the Bidder’s accounts.

**“Bree Collaborative”** means the statewide public-private consortium established in 2011 by the Washington State Legislature in [chapter 70.250 RCW](#), to provide a mechanism through which public and private health care stakeholders can work together to improve quality, health outcomes, and cost effectiveness of care in Washington State. Annually, the Bree Collaborative identifies up to three (3) areas where there is substantial variation in practice patterns and/or high utilization trends that do not produce better care outcomes. Recommendations from the Bree Collaborative are used by HCA to guide state purchasing for programs such as Medicaid, PEBB and SEBB.

**“Business Day”** means Monday through Friday, 8 a.m. to 5 p.m., Pacific Time, except for holidays observed by the State of Washington, unless otherwise specified within this RFP.

**“Calendar Day”** means Monday through Sunday, beginning at 12:00 a.m., Pacific Time, including holidays.

**“Care Coordination”** means deliberately organizing patient care activities and sharing information among all the participants concerned with a patient’s care to achieve safer and more effective care. This means that the patient’s needs and preferences are known ahead of time and communicated at the right time to the right people, and that this information is used to provide safe, appropriate, and effective care to the patient.

**“Carrier”** means a disability insurance company regulated under chapter [48.20](#) or [48.21](#) RCW, a Health Care Service Contractor as defined in [RCW 48.44.010](#), or a Health Maintenance Organization as defined in [RCW 48.46.020](#).

**“Cascade Care”** means all standardized health plans that are Qualified Health Plans under the Affordable Care Act (ACA) and sold on the Washington Health Benefit Exchange (WAHBE). The Cascade Care program includes Washington’s public option plans (called “Cascade Select”) as well as state premium assistance (called “Cascade Care Savings”).

**“Case Management”** means the collaborative process of assessment, planning, facilitation, Care Coordination, evaluation, and advocacy for options and services to meet an individual’s and family’s comprehensive health needs through communication and available resources to promote quality, cost-effective Outcomes.

**“Centers for Medicare and Medicaid Services”** or **“CMS”** means the federal agency that provides health coverage to more than 160 million through Medicare, Medicaid, the Children's Health Insurance Program, and the Health Insurance Marketplace.

**“Certificate of Coverage”** or **“COC”** means the document that describes in detail a Member's health insurance coverage with their Health Plan. The COC explains the health benefits the Subscriber and their Dependents have under their Health Plan. Details include exclusions, conditions, and limitations. Exclusions are services that are not covered under the Health Plan, and conditions are actions needed to receive benefits. Conditions may include deductibles and copays. Limitations include numbers of visits per benefit.

**“Certified Veteran Owned Business”** means the Bidder is a Certified Veteran-Owned Business as defined in [RCW 43.60A.190](#).

**“Charter School”** has the same meaning as defined in [RCW 28A.710.010](#) which is a public school that is established in accordance with [Chapter 28A.710 RCW](#), governed by a Charter School board, and operated according to the terms of a Charter School contract executed under [chapter 28A.710 RCW](#).

**“Chronic Condition Management”** means the oversight and education activities conducted by health care professionals to help Members with chronic diseases and health conditions such as diabetes, high blood pressure, congestive heart failure, and chronic obstructive pulmonary disease learn to understand their condition and live successfully with it. The work involves motivating Members to persist in necessary therapies and interventions and helping them to achieve an ongoing, reasonable quality of life.

**“Claim”** means the written (including electronic) request on a form acceptable by the Carrier for reimbursement for any health care service or supply pursuant to the terms of the applicable Certificate of Coverage. Under [RCW 41.05.075\(6\)](#), all Claims Data shall be the property of the state.

**“Clinical Data Repository”** or **“CDR”** is a real time database administered by a third-party administrator that consolidates Data from a variety of clinical sources to present a unified view of a single patient. It allows clinicians to retrieve Data for a single patient rather than a population of patients with common characteristics.

**“Clinical Management Services”** means the use of best practice recommendations (such as the Bree Collaborative recommendations) in the provision of Clinical Management to support optimal health Outcomes, in collaboration with HCA's clinical team; proactive identification and management of Members who are at risk for health service utilization; provision of Patient Decision Aids to support appropriate patient self-management; collaboration and integration with providers and delivery systems; reduction of unnecessary variation in clinical practice; and lower healthcare costs.

**“Code of Federal Regulations”** or **“C.F.R.”** means all references in this Contract to [C.F.R.](#) chapters or sections include any successor, amended, or replacement Regulation.

**“Collective Bargaining,”** means the performance of the mutual obligation of the representatives of the employer and the exclusive bargaining representative to meet at reasonable times and to bargain in good faith in an effort to reach agreement with respect to the subjects of bargaining specified under the collective bargaining statute applicable to that

employer. This definition is intended to be materially identical to [RCW 41.56.030\(4\)](#) and [RCW 41.80.005\(2\)](#).

**“Community Advisory Council” or “CAC”** means a group of people from the communities served by the Contractor, especially those from diverse backgrounds. This includes, but is not limited to, individuals of different races, ethnicities, gender identities, sexual orientations, and those with disabilities, as well as people living in rural or underserved areas. The council ensures that the voices and needs of these diverse groups are heard and considered.

**“Complaint”** means an oral or written expression of dissatisfaction submitted by or on behalf of a Member regarding: issues other than denial of or payment for health care services, including dissatisfaction with health care services, delays in obtaining health care services, conflicts with Carrier staff or providers; or dissatisfaction with Health Plan practices or action unrelated to health care services. This definition is materially identical with the definition of Grievance in [RCW 48.43.005](#).

A Complaint or Grievance is not the same as an Appeal or a Request for Review of an Adverse Determination as defined in [RCW 48.43.005\(2\)](#), [WAC 284-43-0160\(1\)](#), and [chapter 284-43 WAC](#), Subchapter E. An Appeal or Request for Review of an Adverse Determination requests that a carrier change an unfavorable decision; a complaint or grievance does not.

**“Confidential Information”** means information that is exempt from disclosure to the public or other unauthorized persons under [chapter 42.56 RCW](#) or other federal or state laws. Confidential Information comprises both Category 3 and Category 4 Data as described in EXHIBIT B – DRAFT CONTRACT, *Attachment 13: Data Sharing Terms, Section 4 Data Classification*, which includes, but is not limited to, Personal Information and Protected Health Information (PHI).

**“Continuation Coverage”** means the temporary continuation of ERB Health Plan coverage available to Subscribers after a qualifying event occurs as administered under Title XXII of the Public Health Service (PHS) Act, [42 U.S.C. Sections 300bb-1 through 300bb-8](#) or the PEB or SEB Boards’ policies.

**“Contract”** means a written agreement, resulting from this procurement, between an ASB and HCA, including all exhibits, schedules, attachments, and other terms or documents referred to, incorporated by reference, or attached hereto. HCA’s draft Contract is included as EXHIBIT B – DRAFT CONTRACT.

**“Contract Year”** means the calendar years beginning from the initial effective date of the Contract. For example, 2029 is expected to be Contract Year one.

**“Contractor”** means an entity performing services under a Contract resulting from this RFP. Contractor includes any firm, provider, organization, individual or other entity performing services under this Contract. It also includes any Subcontractor retained by Contractor as permitted under the terms of this Contract.

**“Data”** means information produced, furnished, acquired, or used by Contractor in meeting requirements under the Contract. Confidential Information, Personal Information, and Protected Health Information are all considered Data for the purposes of the Contract. For EXHIBIT B – DRAFT CONTRACT, *Attachment 13 Data Sharing Terms*, Data specifically refers to the information that is disclosed or exchanged as described in the Attachment.

**“Deliverables”** means all tangible objects, reports, work product, program or tool documentation, designs, formulas, methods, or other documents and materials provided or delivered by Contractor to HCA pursuant to the terms of the Contract. Deliverables will consist of Customized Materials and/or Non-Customized Materials.

**“Dependent”** means an eligible spouse, state-registered domestic partner, and/or child, who meets the PEBB and/or SEBB program eligibility requirements as described in [WAC 182-12-250](#), [WAC 182-12-260](#), and [WAC 182-31-140](#).

**“Diversity, Equity, Inclusion, and Belonging”** or **“DEIB”** means practicing values that respect and create a culture where people are empowered to be their complete, authentic selves, by building and sustaining a high performing workforce, delivering services with cultural humility, and perpetuating a culture of respect, caring, and inclusion.

**“Educational Service District”** or **“ESD”** means a regional education unit in Washington State. There are nine (9) ESDs; each ESD serves multiple school districts. ESDs are established under [RCW 28A.310.020](#) to provide cooperative and information services to local school districts, assist superintendents in the performance of their duties, and provide services to the school districts and the Washington State Center for Childhood Deafness and Hearing Loss and the School for the Blind to assure equal education opportunities.

**“Electronic Protected Health Information”** or **“ePHI”** means Protected Health Information that is transmitted by electronic media or maintained in any medium described in the definition of electronic media at [45 C.F.R. § 160.103](#).

**“Employer Group”** has the same meaning as set forth in [RCW 41.05.011\(9\)](#). An Employer Group is a group that has contracted with HCA to obtain employee benefits through benefit plans developed by the PEBB or SEBB program. Employer Groups eligible to obtain PEBB benefits include counties, municipalities, political subdivisions, the Washington health benefit exchange, tribal governments, and employee organizations representing state civil service employees. Employer Groups eligible to obtain SEBB benefits include employee organizations representing school employees and tribal schools as defined in [RCW 28A.715.010](#)

**“Employer Medical Contribution (EMC)”** means the collectively bargained mechanism used to calculate the employer contribution toward employee medical benefits. The EMC is currently calculated as eighty-five percent (85%) of the single subscriber Bid Rate for the self-insured UMP Classic (PEBB) and UMP Achieve 2 (SEBB). It is the amount subtracted from each plan’s Bid Rate to determine the single subscriber employee contribution amount for each plan. The EMC and the employee’s contribution are both multiplied by one of several pre-determined tier factors if the employee elects to enroll Dependents (self plus spouse/partner, self plus child(ren), or full family).

**“Formulary”** means a list of covered drugs that specifies how prescription drugs are covered by the Contractor, and whether the Contractor has any limitations about how the drug is covered.

**“Grievance”** has the same meaning as “Complaint”

**“Health Care Authority”** or **“HCA”** means the Washington State Health Care Authority, any division, section, office, unit or other entity of HCA, or any of the officers or other officials lawfully representing HCA.

**“Health Care Quality”** means the degree to which health care services for individuals and populations increase the likelihood of desired health Outcomes and are consistent with current professional knowledge.

**“Health Equity”** means the attainment of the highest level of health for all people, where everyone has a fair and just opportunity to attain their optimal health regardless of race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, Preferred Language, or other factors that affect access to care and health Outcomes.

**“Health Plan”** means one of the fully-insured or self-insured medical plans offered by HCA Employee and Retiree Benefits Division (ERB). Each Health Plan includes a Certificate of Coverage for services relating to medical, behavioral health, and pharmacy Claims. If not capitalized, health plan refers to the more general definition of health plan used in statute and rules and by Washington State Office of the Insurance Commissioner (OIC), National Committee for Quality Assurance (NCQA), WHA, and other health insurance industry sources.

**“Health Plan Challenge”** means the Washington Health Alliance’s (WHA) Health Plan Challenge (or similar initiative) which provides a forum for purchasers and health plans to interact and share health plan performance. The WHA invites purchasers and health plans to come together to discuss and answer questions in five topic areas: mental and behavioral health, diversity and equity, advanced primary care, high-cost claims, and innovation and action specific to Washington.

**“Healthcare Effectiveness Data and Information Set”** or **“HEDIS®”** means a widely used tool created by the National Committee for Quality Assurance (NCQA) to measure the performance of health plans in delivering quality care. It's a standardized set of performance measures developed by NCQA to help objectively measure, report, and compare quality across different plans.

**“HIPAA”** means the Health Insurance Portability and Accountability Act of 1996, as amended by the Health Information Technology for Economic and Clinical Health Act of 2009 ([42 U.S.C. 1320d-1329d-9](#)), and its implementing Regulations, including the Standards for Privacy of Individually Identifiable Health Information (45 C.F.R. [Parts 160](#) and [164](#), Subparts A and E), the Security Standards for the Protection of Electronic Protected Health Information (45 C.F.R. [Parts 160](#) and [164](#), Subparts A and C), and Breach Notification for Unsecured Protected Health Information Rules ([45 C.F.R. Part 164, Subpart D](#)).

**“Independent Review Organization”** or **“IRO”** means an organization as defined in [WAC 284-43A-010\(14\)](#).

**“LAN”** or **“HCP-LAN”** means the Health Care Payment Learning and Action Network, a collaborative effort between CMS and its private, public, and non-profit partners to transform the nation’s health system to emphasize value of care over volume.

**“Measurement Period”** means the period of the Contractor’s performance under the Contract for which Performance Results are to be reported. A list of Measurement Periods is outlined in Table 1 “Summary of Performance Standard” below.

**“Measurement Year”** or **“MY”** means the Plan Year in which care occurs and for which performance is used to calculate Performance Results.

**“Member”** means Subscribers and their Dependents who are enrolled in either a PEBB or SEBB program medical plan.

**“Member Portal”** means a web interface requiring sign-up that can act as a central hub to access features such as self-service account management and member services and benefits.

**“Microsite”** means an auxiliary website with independent links and address that is accessed mainly from a larger site. Microsites allow brands to deliver highly targeted content to specific segments of their audience.

**“Monthly Premium”** as used in this RFP, means the total monthly payment made by HCA to Contractor as payment for the insurance coverage and services for the underlying enrolled populations in each program. Monthly Premiums are equal to the plan Payment Rate multiplied by Subscriber enrollment tier factor for all plan enrollees.

**“Multi Factor Authentication”** or **“MFA”** means an electronic authentication method in which a user is granted access to a website or application only after successfully presenting two or more pieces of evidence (or factors) to an authentication mechanism.

**“National Committee for Quality Assurance”** or **“NCQA”** means the private 501(c)(3) not-for-profit organization dedicated to improving Health Care Quality. NCQA is the accrediting body for health plans in the United States. NCQA uses the Healthcare Effectiveness Data and Information Set (HEDIS) to measure health plan performance on important dimensions of care and service.

**“Non-Medicare Retiree(s)”** means a Subscriber who has retired or separated from service, is eligible for PEBB program benefits, and not yet Medicare-eligible.

**“Outcomes”** means changes in Member health, functional status, satisfaction or goal achievement that result from health care and/or supportive services.

**“Participating Provider”** means healthcare institutions and practitioners who have contracted with health insurance companies. They are known as Participating Providers or “in-network” providers.

**“Patient-Centered Medical Home”** or **“PCMH”** means practices that have earned recognition for making a commitment to continuous Quality Improvement and a [patient-centered](#) approach to care.

**“Patient Decision Aid”** means a tool that can help people engage in shared health decisions with their health care provider. Research shows that use of [Patient Decision Aids](#) leads to increased knowledge, more accurate risk perception, and fewer patients remaining passive or undecided about their care.

**“Patient-Reported Outcome Measures”** or **“PROMS”** means tools used to evaluate patients’ perception of their health care Outcomes including symptoms, physical and emotional well-being, and overall quality of life. PROMs are a type of measure that can help clinicians better understand the patient perspective and tailor treatment plans to improve Outcomes over time.

**“Patient Reported Outcome-Based Performance Measures”** or **“PRO-PM”** are a way to aggregate the information from patients into a reliable and valid measure of performance.

**“Payment Rate”** means the Health Plan single Subscriber Bid Rate multiplied by the Contractor’s projected plan Risk Score and is used to calculate Monthly Premiums paid to Contractor.

**“PEBB Employee”** has the same meaning as in [RCW 41.05.011\(6\)\(a\)](#), which includes employees such as employees of state agencies and higher education institutions, superior court and appellate judges, members of the state legislature; and may also include employees of political subdivisions (counties, municipalities, etc.) and employees of employee organizations representing state civil service employees.

**“Performance Metric”** means the specific result the Contractor must achieve on a given Performance Standard to avoid owing a Performance Payment. For example, “Average Answer Time for ninety-five (95%) of all calls into Contractor’s Plan customer service line is thirty (30) seconds or less.”

**“Performance Payment”** means the financial consequence associated with failure to meet the applicable Performance Standard as explained in [RCW 48.30.360](#). Performance Payments can be either a specified dollar amount or calculated as a percentage of Annual Premium. Performance Payments may be paid in the form of premium credits to HCA. Remittance of a Performance Payment to the group policyholder is not a return of premium for purposes of [RCW 48.14.020](#) and [48.14.0201](#).

**“Performance Result”** means the Contractor’s actual result on a given Performance Standard for a given Measurement Period.

**“Performance Standard”** has the same meaning as in [RCW 48.30.360](#): a contractual provision in a group insurance contract that establishes a specific standard for the insurer's or health carrier's performance of an obligation in the contract, and under which the insurer or health carrier is required to remit a penalty payment, based on a percentage of the premium or a set dollar amount, to the group policyholder for the next policy term if the insurer or health carrier fails to comply with the standard. Group policyholders and insurers or health carriers may calculate the amount of the penalty based on a percentage of the overall premium owed to the insurer or health carrier by the policyholder.

**“Performance Standard Verification and Validation”** means the document that sets forth in detail the mechanics of measuring, calculating, and reporting the Contractor’s result under a Performance Standard, including:

- The Performance Standard (which includes the Performance Metric);
- The Measurement Period (e.g., monthly, quarterly, annually);
- Required documentation Contractor must submit to show the Performance Standard has been met;
- How the result will be calculated;
- Any definitions necessary to ensure clarity;
- Performance Penalty;
- Subject Matter Experts;
- Approvals; and
- Any other information deemed necessary by HCA and the Contractor to ensure clarity of expectations.

All Performance Standard Verification and Validations are agreed to between HCA and the Contractor. They become part of the Operations Manual and are incorporated by reference into the Contract.

**“Plan Year”** means the 12-month time period beginning on January 1 of each year and ending December 31 of the same year.

**“Preferred Drug List”** has the same meaning as Formulary.

**“Preferred Language”** has the same meaning as Primary Language.

**“Primary Language”** means the language a Member or potential Member identifies as the language in which they wish to communicate verbally or in writing with HCA.

**“Proposal”** means a formal offer submitted in response to this solicitation. To be responsive, a Proposal must include all items outlined in *section 3 Proposal Contents and Requirements*.

**“Proprietary Information”** refers to any information that has commercial value and is either: (1) technical information, including patent, copyright, trade secret, and other Proprietary Information, techniques, sketches, drawings, models, inventions, know-how, processes, apparatus, equipment, algorithms, software programs, software source documents, and formulae related to the current, future, and proposed products and services; or (2) non-technical information relating to products, including without limitation pricing, margins, merchandising plans and strategies, finances, financial and accounting data and information, suppliers, customers, customer lists, purchasing data, sales and marketing plans, future business plans, and any other information which is proprietary and confidential. Bidder’s Proprietary Information is information owned by Bidder to which Bidder claims a protectable interest under law.

**“Protected Health Information”** or **“PHI”** has the same meaning as defined in [45 C.F.R. § 160.103](#).

**“Public Employee”** has the same meaning as in [RCW 41.05.011\(18\)](#), which includes employees of state agencies and higher education institutions, employees of employer groups with contracts to participate in the PEBB program, and school employees as defined in [RCW 41.05.011\(6\)\(b\)](#).

**“Public Employees Benefits Board”** or **“PEBB”** or **“PEB Board”** means the Public Employees Benefits Board, which is authorized to design benefits and determine the terms and conditions for participation in health insurance benefits for eligible Public Employees and Retirees under [chapter 41.05 RCW](#).

**“Qualified Health Plan”** or **“QHP”** means an insurance plan that’s certified by the Health Insurance Marketplace®, provides essential health benefits, follows established limits on cost-sharing (like deductibles, copayments, and out-of-pocket maximum amounts), and meets other requirements under the ACA. All Qualified Health Plans meet the ACA requirement for having health coverage, known as “minimum essential coverage”.

**“Quality Improvement”** means a systematic and continuous set of actions that lead to measurable improvement in health care services and the health status of targeted patient groups.

**“Quality of Care”** means the degree to which a Bidder increases the likelihood of desired health Outcomes of its Members through its structural and operational characteristics, and through the provision of health services that are consistent with current professional knowledge.

**“Race, Ethnicity, and Language”** – Race refers to the social construction and categorization of people based on perceived shared physical traits that result in the maintenance of a sociopolitical hierarchy. The term is also loosely applied to geographic, cultural, religious, or national groups. Self-reported race frequently varies owing to changing social contexts and an individual’s possible identification with more than one race.

Ethnicity is a characterization of people based on having a shared culture (e.g., language, food, music, dress, values, and beliefs) related to common ancestry and shared history.

Language is the specific communicative system used by a particular group of speakers, with its distinctive vocabulary, grammar, and phonological system.

**“Race, Ethnicity, and Language Data”** means information about demographic factors of an individual or population.

**“Rebates”** means retrospective payments or discounts, including promotional or volume-related refunds, incentives or other credits, however characterized, pre-arranged with pharmaceutical companies on certain prescription drugs, which are paid to or on behalf of a Carrier, and are directly attributable to the utilization of certain drugs by Members, including administrative fees and software or data fees paid by pharmaceutical companies. “Rebate” includes all rebates, discounts, payments or benefits, however characterized, generated by medical drug claims, or derived from any other payment or benefit for the dispensing or administration of prescription drugs or classes or brands of drugs within HCA’s programs or arising out of any relationships the Carrier has with pharmaceutical companies, including but not limited to Rebate sharing, market share allowances, educational allowances, gifts, promotions, or any other form of revenue whatsoever.

**“Reference-based Pricing”** or **“RBP”** is a concept in health care where a standard reimbursement level is established for payment of certain services, such as hospital (inpatient) care. The reference point, or price, is tied to an already defined pricing level, such as Medicare Fee-for-Service (FFS) reimbursement rates.

**“Regulation”** means any federal, state, or local regulation, rule, or ordinance.

**“Request for Proposals”** or **“RFP”** means this formal solicitation document that identifies a service or need but no specific method to achieve it has been chosen.

**“Request for Renewal”** or **“RFR”** is a formal proposal that HCA releases each year for the PEBB and SEBB program health plans. Through the RFR process, the PEB and SEB Boards adjust employee benefits annually because of (a) new requirements under the ACA; (b) changes requested by PEB or SEB Board members, the public, HCA’s Chief Medical Officer, or other internal policy drivers; (c) benefit design strategies promulgated by HCA; and/or (d) legislative mandates and other changes. Both parties may propose possible benefit changes and other potential changes to any of the Health Plans for the following Plan Year. Benefit changes may have cost impacts to the Bid Rate, but benefit changes proposed in the RFR process cannot affect the structure of the Health Plans being offered, the clinical goals and

expectations, or the financial structure of a Contract resulting from this procurement between an ASB and HCA. A secondary purpose of the RFR is to renew the Contract based on annual budget approval by the Legislature, and it is not to be used to re-negotiate any other aspects of the Contract.

**“Revised Code of Washington” or “RCW”** means the laws of the State of Washington, as enacted by the Legislature. Any references to specific titles, chapters, or sections of the [RCW](#) include any substitute, successor, or replacement title, chapter, or section.

**“Risk Score”** means a health status factor calculated by HCA’s contracted actuary via the Milliman Advanced Risk Adjuster (MARA) model and applied as described in EXHIBIT B – DRAFT CONTRACT.

**“School Employee”** has the same meaning as in [RCW 41.05.011\(6\)\(b\)](#), which includes employees of school districts, charter schools, and educational school districts, employees of employee organizations representing school districts, and employees of tribal schools.

**“School Employees Benefits Board” or “SEBB” or “SEB Board”** means the board authorized to design benefits and determine the terms and conditions for participation in health insurance benefits for eligible School Employees under [RCW 41.05.740](#).

**“Service Area”** means the designated geographical area within which a Member must reside or currently work to be eligible for enrollment. This area is comprised of the counties and zip codes listed in any Contract resulting from this RFP.

**“Sexual Orientation and Gender Identity” or “SOGI”** – Sexual orientation is an often-enduring pattern of emotional, romantic, and/or sexual attractions to men, women, or both. It also refers to an individual’s sense of personal and social identity based on those attractions, related behaviors, and membership in a community of others who share those attractions and behaviors.

Gender identity refers to a person’s innermost concept of self as male, female, a blend of both or neither – how individuals perceive themselves and what they call themselves.

These two related, but distinct, characteristics are often discussed together.

**“Shared Decision Making”** means the process that allows Members and their providers to make health care decisions together, considering the best scientific evidence available as well as the patient’s values and preferences.

**“SMART Goals”** means goals which are specific, measurable, achievable, relevant, and time bound.

**“Social Determinants of Health” or “SDOH”** means the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. Examples include housing, education, transportation, access to nutritious food, opportunities for employment, and social support.

**“Statement of Work”** means a detailed description of the work activities the Bidder is required to perform under the terms and conditions of a Contract resulting from this RFP, including the

Deliverables and timeline. See EXHIBIT B: DRAFT CONTRACT, *Attachment 3: Statement of Work*.

**“Subcontract”** means any separate agreement or contract between the Contractor and a person, partnership, or entity not employed or owned by the Bidder (“Subcontractor”) to perform any activities of the Contract under a separate contract with (or on behalf of) the Bidder. Subcontracts may give rise to a business requirement to access the Data that is the subject of the Contract resulting from this RFP.

**“Subcontractor”** means a person, partnership, or entity not employed or owned by the Bidder, who would be performing all or part of the business activities of this RFP under a separate contract with (or on behalf of) the Bidder. The term “Subcontractor” means those who directly or indirectly contract with the Bidder, and includes Healthcare Benefit Managers as defined by [RCW 48.200.020](#).

**“Subscriber”** means the account holder for PEBB or SEBB program benefits.

**“Summary of Benefits and Coverage”** or **“SBC”** means a document, required by law under the ACA, that insurance companies and group health plans provide to consumers comparing benefits and coverage for different plans. The information provided must be concise, use plain language, and be consistent with the health plan’s benefits and coverage information for consumers to easily compare different coverage options to select their health plan.

**“U.S.C.”** means the United States Code. All references in this Contract to [U.S.C.](#) chapters or sections will include any successor, amended, or replacement statute.

**“Uniform Medical Plan”** or **“UMP”** means a collection of the state’s self-insured, preferred provider Health Plans administered by third-party administrators, currently Regence BlueShield and ArrayRx, to PEBB and SEBB program Members. The UMP plans for PEBB program Members include UMP Classic, UMP Select, UMP CDHP, and UMP Classic Medicare with Part D (PDP). The UMP plans for SEBB program Members include UMP Achieve 1, UMP Achieve 2, and UMP High Deductible.

**“Urgent Care”** means a visit for an illness or injury that will not likely cause further disability or death if not treated immediately but could become worse without treatment. Examples include minor lacerations, urinary infections, earaches, migraine headaches and rising fever.

**“Utilization Management”** or **“UM”** means the evaluation of medical necessity appropriateness, and efficient use of health care services, procedures, and facilities under the provisions of the applicable Health Plan. Utilization Management is sometimes called utilization review.

**“Value-Based Payment”** or **“VBP”** is a form of reimbursement that ties payments for care delivery to the Quality of Care provided and rewards providers for both efficiency and effectiveness. HCA defines Value-Based Payments as payment arrangements in the CMS Health Care Learning & Action Network Categories 2c – 4b (See Appendix 1 – CMS Framework for Value-Based Payments or Alternative Payment Models (CMS LAN APM)). VBP refers to arrangements between the Contractor awarded through this RFP and providers.

**“Value-Based Purchasing”** refers to arrangements between HCA and the Contractor and describes a range of health care payment strategies intended to contain costs while improving Outcomes through tying payment to performance expectations. Value-Based Purchasing includes contractual arrangements between a purchaser (e.g., HCA) and its Contractors to meet specified value-based targets which may include quality, cost, access, patient and provider experience, and other value-based metrics.

**“Washington Administrative Code”** or **“WAC”** means the code of regulations (rules) promulgated by agencies of the State of Washington. All references to [WAC](#) chapters or sections will include any substitute, successor, amended, or replacement regulation.

**“Washington All Payer Claims Database”** or **“WA-APCD”** means Washington’s statewide all-payer health care claims database to support transparent public reporting of health care information as described in [RCW 43.371.020](#).

**“Washington Health Alliance”** or **“WHA”** means a nonprofit, nonpartisan organization that reports Data on Health Care Quality and value through the collection and analysis of Claims and clinical Data from providers, health plans, health trusts, and employers. WHA focuses on evidence-based practices and provides information to providers, patients, employers, and union trusts to help them make better decisions about how to reduce waste and cost while focusing on quality.

**“Washington Health Benefit Exchange”** or **“WAHBE”** means Washington’s marketplace for qualified health and dental insurance coverage for individuals and families.

**“Washington Small Business”** means the Bidder is a Washington Small Business as defined in [RCW 39.26.010\(22\)](#).

**“Washington State Common Measure Set”** means a set of quality performance measures for Washington State that provides the foundation for health care accountability and measuring performance. The development and ongoing evolution and implementation of a set of measures is not only mandated by [RCW 41.05.690](#), but necessary to ensuring our ability to measure progress toward achieving healthier Outcomes for all residents in Washington. To learn more go to [Washington State Common Measure Set](#).

**“Washington’s Electronic Business Solution”** or **“WEBS”** means an internet-based bid notification system that HCA uses to post competitive solicitations. Individuals and firms interested in state contracting opportunities with any Washington state agency should register for competitive solicitation notices on WEBS. There is no cost to register on WEBS.

## 1.2 ESTIMATED SCHEDULE OF SOLICITATION ACTIVITIES

|                                                                                                                                                                                                             |                                   |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------|
| Issue Request for Proposals                                                                                                                                                                                 | October 12, 2026                  |
| Pre-Proposal Conference                                                                                                                                                                                     | October 20, 2026                  |
| <b>Microsoft Teams meeting</b><br><b>Join:</b><br><a href="https://teams.microsoft.com/meet/229427348778832?p=Xc2zEyyGrodj6CIIXE">https://teams.microsoft.com/meet/229427348778832?p=Xc2zEyyGrodj6CIIXE</a> | 11:00am – 12:00pm<br>Pacific Time |

|                                                                                                                                                                                                                                                                                                                                                                                              |                                               |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------|
| Meeting ID: 229 427 348 778 832<br>Passcode: Ea6Zs9Li<br><br><a href="#">Need help?</a>   <a href="#">System reference</a><br><b>Dial in by phone</b><br><a href="#">+1 564-999-2000,,284006060#</a> United States, Olympia<br><a href="#">(833) 322-1218,,284006060#</a> United States (Toll-free)<br><a href="#">Find a local number</a><br>Phone conference ID: 284 006 060#<br><br><hr/> |                                               |
| Letter of Intent to Propose Due                                                                                                                                                                                                                                                                                                                                                              | October 23, 2026, at<br><b>4:00pm Pacific</b> |
| Finance Rate Instruction Conference                                                                                                                                                                                                                                                                                                                                                          | October 29, 2026                              |
| Bidder Round 1 Questions Due                                                                                                                                                                                                                                                                                                                                                                 | November 6, 2026                              |
| HCA Answers Posted*                                                                                                                                                                                                                                                                                                                                                                          | November 13, 2026                             |
| Bidder Round 2 Questions Due                                                                                                                                                                                                                                                                                                                                                                 | December 4, 2026                              |
| HCA Answers Posted*                                                                                                                                                                                                                                                                                                                                                                          | December 11, 2026                             |
| Interested Subcontractor Responses Due                                                                                                                                                                                                                                                                                                                                                       | December 15, 2026                             |
| Interested Subcontractor List Posted*                                                                                                                                                                                                                                                                                                                                                        | December 17, 2026                             |
| Complaints Due                                                                                                                                                                                                                                                                                                                                                                               | January 7, 2027                               |
| Bidder Presentations                                                                                                                                                                                                                                                                                                                                                                         | January 2027                                  |
| Proposals Due                                                                                                                                                                                                                                                                                                                                                                                | January 14, 2027, at<br><b>4:00pm Pacific</b> |
| Evaluate Proposals*                                                                                                                                                                                                                                                                                                                                                                          | January 15 – May 27,<br>2027                  |
| Announce “Apparent Successful Bidder(s)” via WEBS*                                                                                                                                                                                                                                                                                                                                           | May 28, 2027                                  |
| Debrief Request Deadline ( <i>3 Business Days after the ASB announcement</i> )                                                                                                                                                                                                                                                                                                               | June 2, 2027, at<br><b>4:00pm Pacific</b>     |
| Negotiate Contract                                                                                                                                                                                                                                                                                                                                                                           | June 2027 – August<br>2027                    |
| Begin Contract Work                                                                                                                                                                                                                                                                                                                                                                          | October 2027                                  |

\*Dates are anticipated and subject to change without an official amendment.

HCA reserves the right in its sole discretion to revise the above schedule at any time.

### 1.3 PURPOSE AND OBJECTIVES

The Washington State Health Care Authority, hereafter called “HCA,” is initiating this Request for Proposals (RFP) to solicit Proposals from Bidders to provide up to three (3) fully-insured Health Plans each that meet the requirements outlined in EXHIBIT B – DRAFT CONTRACT, *Attachment 3 Statement of Work, section 1. Plan Design for Fully Insured Health Plans*. Identical Health Plan(s) will be offered to non-Medicare Public Employees Benefits Board (PEBB) and School Employees Benefits Board (SEBB) Program Subscribers and their Dependents but will be separately rated for and provided to the PEBB program and the SEBB program because of the differing risk pools of each program. The total number of Health Plans being procured per Bidder is six (6): three (3) for PEBB and three (3) for SEBB. However, the three (3) Health Plans offered to PEBB must be identical in plan design to the three (3) Health Plans offered to SEBB. All Health Plans for the portfolio must be approved by both the PEB Board and the SEB Board and must be open only to PEBB and SEBB Members.

Plans for retirees eligible for Medicare are not covered by this RFP.

Successful Bidder(s) will provide a variety of Health Plan options with access to an adequate provider network in a minimum of two (2) counties in the state of Washington. Preferential scoring will be utilized to incentivize Bidders to submit proposals that cover higher numbers of Washington counties. During the contract period, successful Bidder(s) will be encouraged to grow provider network(s) in additional counties if that is in line with their business goals and any areas of limited PEBB/SEBB health plan availability, thereby expanding PEBB and SEBB Members’ access to providers and services.

Successful Bidder(s) will have demonstrated the ability and capacity to meet HCA’s requirements for fully-insured Health Plan(s), including entering into a binding agreement built on financial and quality performance incentives implementing effective care delivery models, while providing coordinated high-quality care and aligning health system reimbursement and financial incentives. In addition, successful Bidder(s) will demonstrate strong IT infrastructure and interoperability to support the secure, organized exchange of patient data among Participating Providers and other partners.

As soon as ASB(s) are announced, if not before, ASB(s) representatives must begin attending, virtually or in person, all public meetings of the PEB Board and the SEB Board so that:

- A. Board discussions and decisions are heard and understood by ASB(s);
- B. ASB(s) are aware of Board directives regarding plans, including Data reporting, benefit coverage, customer service issues, or other items that may be discussed at Board Meetings;
- C. ASB(s) may answer questions asked directly by the Boards at Board meetings, if the ERB Director or CMO approves; and
- D. ASB(s) establish a partnering relationship with the Boards.
- E. See the [PEB Board Meeting](#) and [SEB Board Meeting](#) websites for more details.

All potential bidders are on notice that the scope of this RFP covers not only Health Plan(s) in the SEBB and PEBB programs but also covers any future programs that may be created and added. It is possible that during the term of any Contract resulting from this RFP that HCA may be required by law or provided the opportunity to manage, operate, or administer

other programs, or that the current PEBB and SEBB programs may merge or be split into additional groups (future programs). It is possible that:

- A. one (1) or more of the existing programs will be replaced with a future program, and/or
- B. some Members will be required to transition from an existing program to a future program, and/or
- C. persons or populations who are not currently Members will become eligible for coverage from a program managed, operated, or administered by HCA.

It is the intent of HCA that the Health Plans described in this RFP and in any resulting Contract may be made available to any eligible Member of any future program without performing an additional procurement. Therefore, all references to PEBB or SEBB include any future program that merges the current two (2) programs or that includes other populations not currently served by the PEBB and SEBB programs.

Although the focus of this RFP is procuring a single portfolio of Health Plan benefits to be offered to both the PEBB and SEBB programs under current, separate financial risk pooling, this RFP is intended to result in Contracts that may be amended and/or renegotiated to add additional populations, including Retirees and/or a consolidated financial risk pool of Members from both the PEBB and SEBB programs during the life of such Contract.

HCA intends to award one (1) or more Contract(s) to provide the services described in this RFP.

## **1.4 BACKGROUND**

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). Functioning as both the state's largest health care purchaser and its behavioral health authority, HCA is a leader in ensuring Washington residents have the opportunity to be as healthy as possible. There are three (3) pillars of our work: Apple Health (Medicaid); the PEBB and SEBB programs; and the Division of Behavioral Health and Recovery. Under these pillars, HCA purchases health care, including behavioral health treatment, for more than 2.7 million Washington residents and provides behavioral health prevention, crisis, and recovery support to all Washington residents.

Under [chapter 41.05 RCW](#), the PEBB program covers eligible Washington State employees and their Dependents from approximately 213 participating state agencies and higher education institutions (state universities, community and technical colleges, etc.). Counties, municipalities, political subdivisions, the WAHBE, employee organizations representing state employees, and tribal governments, known as Employer Groups, can also join PEBB by contract, electing either a complete benefit package including medical, dental, vision, and other benefits or a medical-only medical package for their employees. Further, the PEBB program administers benefits for Medicare eligible retirees from both the PEBB and SEBB programs. These Medicare eligible retirees account for nearly 86,000 of the current roughly 237,500 PEBB Subscribers. In total, the PEBB program provides medical benefits for approximately 419,000 Members.

The SEBB program, which was implemented for the 2020 Plan Year, covers eligible School Employees and their Dependents from approximately 346 school districts and nine (9) ESDs in Washington State. Employee organizations representing School Employees and tribal schools, known as Employer Groups, can join SEBB by contract, electing either a complete

benefit package including medical, dental, vision and other benefits or a medical-only package for their employees. The SEBB program provides medical benefits to nearly 285,000 Members. The SEBB program does not cover retirees (neither non-Medicare nor Medicare).

In creating the SEBB program, the Legislature instructed HCA, as the administrator of the PEBB and SEBB programs, to consider ways to leverage efficient purchasing by coordinating SEBB purchasing with PEBB purchasing. It is pursuant to that instruction that HCA has undertaken this procurement for a single portfolio of fully-insured Health Plans for both populations insured under PEBB and SEBB.

Currently, there are three (3) statutorily authorized health insurance risk pools managed by HCA for employee health plans: the PEBB program non-Medicare risk pool ([RCW 41.05.022\(2\)](#)), the PEBB program Medicare risk pool ([RCW 41.05.080\(3\)](#)), and the SEBB program risk pool ([RCW 41.05.022\(3\)](#)). Please note that the PEBB program non-Medicare risk pool includes retired and disabled School Employees not eligible for Medicare.

In an effort to guarantee the public access to affordable health care, the Legislature passed statute [RCW 41.05.820](#) requiring at least one (1) health carrier within any insurance holding company system that provides a Health Plan to PEBB or SEBB to also offer at least one (1) gold and one (1) silver Qualified Health Plan (QHP) on the Washington Health Benefit Exchange (WAHBE) in the counties covered by the holding company's PEBB or SEBB Health Plan(s). Any health plans offered to maintain compliance with this RCW must be Cascade Care plans, otherwise known as standardized health plans, as defined by [RCW 43.71.095](#).

The outcomes of future legislative actions after the release of this RFP may need to be accounted for in the Bidder's Response to this RFP.

## 1.5 SCOPE OF WORK

ASB(s) will be expected to enter into a Contract with HCA for the provision of fully-insured Health Plans that meet HCA's criteria identified in EXHIBIT B – DRAFT CONTRACT, *Attachment 3: Statement of Work*.

Below is the RFP Scope of Work outline. The RFP Scope of Work correlates with EXHIBIT B – DRAFT CONTRACT, *Attachment 3: Statement of Work*. Bidders must review the complete Statement of Work in EXHIBIT B – DRAFT CONTRACT, *Attachment 3: Statement of Work* for the description of HCA's criteria and requirements for fully-insured Health Plans.

### 1. Plan Design for Fully Insured Health Plans

- 1.1. Health Plan Type
- 1.2. Health Plan Design Requirements
- 1.3. Additions or Reductions to Number of Health Plans

### 2. Plan Administration

- 2.1. Basic Health Plan Operations
- 2.2. Eligibility Files and File Systems
- 2.3. Use of Artificial Intelligence

- 2.4. Enrollment Provisions
- 2.5. Account Management
- 2.6. Certificates of Coverage (COCs)
- 2.7. Claims Services
- 2.8. Member Engagement
- 2.9. Data Reporting and Analytics
- 2.10. Requests for Renewal (RFRs)
- 3. Value-Based Purchasing
- 4. Commitment to Health Care Transformation
  - 4.1. HCA Health Care Transformation Requirements
  - 4.2. Primary Care Transformation Initiative (PCTI) Multi-payer Collaborative (MPC)
- 5. Equity, Social Determinants of Health and Race, Ethnicity, and Language Contract Requirements
  - 5.1. Health Equity Contract Requirements
  - 5.2. Community Advisory Council
  - 5.3. NCQA Health Outcomes Accreditation
  - 5.4. Trauma-Informed Care Education and Training
- 6. Clinical Requirements
  - 6.1. Coordination and Standardization of Care to Improve Outcomes
  - 6.2. Timely Access to Care / Time to Appointment
  - 6.3. Access to Care
  - 6.4. Clinical Programs
  - 6.5. Clinical Management Programs
  - 6.6. Prior Authorization Standards
  - 6.7. Quality Activities
  - 6.8. Reported Measures – Member Experience
  - 6.9. Utilization Management Clinical Services
  - 6.10. Alternative Contracting Arrangements for Clinical Requirements
  - 6.11. Transforming Care: Bree Care Transformation Projects
  - 6.12. Centers of Excellence
  - 6.13. Benefit Enhancements

- 6.14. Innovation in Utilization Management and/or Prior Authorization
- 6.15. Prescription Drug Benefit
- 6.16. Medical Drug Benefit
- 6.17. Transitions and Continuation of Care
- 6.18. Mental Health Parity and Addiction Equity Act (MHPAEA)
- 7. Financial Requirements
  - 7.1. Paid Claims Data
  - 7.2. Hospital Claims Reimbursement Data Reporting for [RCW 41.05.028](#)
  - 7.3. Rate Development
  - 7.4. Rate Adjustment
  - 7.5. Risk Adjustment Data Validation (RADV) Audit
  - 7.6. General
  - 7.7. Compensation
- 8. Implementation
  - 8.1. Implementation Plan

## 1.6 MINIMUM QUALIFICATIONS

Bidder must meet these minimum requirements at the time their proposal is submitted to HCA:

- A. Must have a Unified Business Identifier (UBI) number to operate as a licensed business in Washington State.
- B. Must be a Carrier licensed by the Washington State Office of the Insurance Commissioner (OIC) operating within Washington State with at least 10,000 fully insured lives in their Book-of-Business.
- C. Each separate OIC-licensed carrier must submit a distinct, separate proposal.
- D. All administrative services must be performed within the United States, including clinical decision-making by clinicians licensed in the United States, administrative and clinical claims processing and adjudication, Data storage, customer service, and transfers.
- E. Must currently provide Clinical Management Services, including Utilization Management, complex Case Management, chronic condition management, and consumer support services for Book-of-Business.
- F. Must possess NCQA full health plan accreditation.
- G. Must maintain a provider network throughout the lifetime of the Contract that meets OIC provider network requirements in every Washington county included in Bidder's Service Area proposal or provide a detailed plan for ensuring that it will have such a network in place by January 1, 2029.

- H. Must comply with all applicable state and federal laws, including privacy and security laws, statutes, and Regulations for protecting Member Data, including HIPAA.
- I. Must meet an AM Best financial rating of A- or better at the time of Proposal submission.
- J. Must have at a minimum, the insurance coverages set forth in EXHIBIT B – DRAFT CONTRACT, *section 3.7 Insurance* and Attachment 13, *section 11 Insurance Requirements for Data Breach Response*.
- K. Must operate an integrity program addressing fraud, waste, and abuse, including detection and prevention.

## **1.7 FUNDING**

Any Contract awarded because of this solicitation is contingent upon the availability of funding.

Bidders must be willing to begin a structured Contract implementation plan no later than January 2028, understanding there may be some financial risk if the PEB Board or SEB Board do not authorize the Bidder's proposed rates in Summer 2028. Final funding is determined by the Washington legislature.

## **1.8 PERIOD OF PERFORMANCE**

Implementation activities for any Contract resulting from this RFP will begin no later than January 2028 so the ASB(s) will be prepared for Annual Open Enrollment beginning in October 2028 and for coverage to begin January 1, 2029. The period of performance of any Contract resulting from this RFP is scheduled to begin on or about January 1, 2029, and to end on December 31, 2033. Amendments extending the period of performance, if any, will be initiated at the discretion of HCA.

HCA reserves the right to extend the contract for seven (7) more years on a year-to-year basis.

Benefit coverage and operational services will not begin until January 1, 2029, at which time, Monthly Premium payments will begin. HCA will not be obligated to make any payment to Contractor(s) prior to January 1, 2029.

## **1.9 ADA**

HCA complies with the Americans with Disabilities Act (ADA). Bidders may contact the RFP Coordinator to receive written information in another format (e.g., large print, audio, accessible electronic formats, and other formats).

## 2. GENERAL INFORMATION FOR BIDDERS

### 2.1 RFP COORDINATOR

The RFP Coordinator is the sole point of contact in HCA for this solicitation. All communication between the Bidder and HCA upon release of this RFP must be with the RFP Coordinator, as follows:

|                |                                                                            |
|----------------|----------------------------------------------------------------------------|
| Name           | Sean Gregory                                                               |
| E-Mail Address | <a href="mailto:HCAProcurements@hca.wa.gov">HCAProcurements@hca.wa.gov</a> |

Any other communication will be considered unofficial and non-binding on HCA. Bidders are to rely on written statements issued by the RFP Coordinator.

**Communication directed to parties other than the RFP Coordinator may result in disqualification of the Bidder.**

### 2.2 PRE-PROPOSAL CONFERENCE

A pre-proposal conference is scheduled to be held on October 20, 2026, at 11:00 a.m., Pacific Time, via a video-conferencing tool at HCA's discretion. All prospective Bidders should attend; however, attendance is not mandatory. An agenda containing meeting details is contained in ATTACHMENT 12 – PRE-PROPOSAL CONFERENCE AGENDA of this solicitation.

HCA will be bound only to HCA written answers to questions. Questions arising at the pre-proposal conference or in subsequent communication with the RFP Coordinator will be documented and answered in written form. A copy of the questions and answers will be posted on WEBS as an Amendment to this RFP.

### 2.3 FINANCE RATE INSTRUCTION CONFERENCE

A Finance Rate Instruction Conference is scheduled to be held on October 29, 2026 at 9:30 a.m., Pacific Time, via a video-conferencing tool at HCA's discretion.

All prospective Bidders that have submitted an LOI will receive an invite to the conference. Bidders intending to submit a proposal are **required** to attend.

HCA will be bound only to HCA written answers to questions. Questions arising at the Finance Rate Instruction conference or in subsequent communication with the RFP Coordinator will be documented and answered in written form. A copy of the questions and answers will be posted on WEBS as an Amendment to this RFP.

### 2.4 LETTER OF INTENT TO PROPOSE

To be eligible to submit a Proposal, a Bidder must submit a Letter of Intent to Propose. The Letter of Intent to Propose must be emailed to the RFP Coordinator, listed in *section 2.1 RFP Coordinator*, and must be received by the RFP Coordinator no later than the date and time stated in *section 1.2 Estimated Schedule of Solicitation Activities*. The subject line of the email must include the following: **RFP #2025HCA5 Letter of Intent to Propose - [Your entity's name]**.

Once a Bidder submits a Letter of Intent to Propose, Exhibit D1 and D2 (PEBB and SEBB COST PROPOSAL) and all supplementary rating materials (as detailed in *section 3.6 Exhibit D1 and D2 –Cost Proposals*) will be provided to Bidder via Managed File Transfer (MFT). Login credentials will be provided by the RFP Coordinator for Bidders to retrieve files. Only Bidders who submit a Letter of Intent to Propose by the required date and time stated in the Solicitation Schedule will be provided these materials.

*The data products delivered to bidders are intended for the use of the State of Washington (HCA) in support of the procurement for fully insured carriers in the PEBB and SEBB programs. The provided data report may not be distributed to other third parties without the prior consent of HCA and HCA's contracted actuary. 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, and it should be used only for the purposes of responding to this RFP.*

The Letter of Intent to Propose may be attached to the email as a separate document, in Word or PDF, or the information may be contained in the body of the email.

Information in the Letter of Intent to Propose should be placed in the following order:

- A. Bidder's Organization Name;
- B. Bidder's Authorized Representative for this RFP (who must be named the Authorized Representative identified in the Bidder's Proposal);
- C. Title of Authorized Representative;
- D. Address, telephone number, and email address;
- E. Statement of intent to propose;
- F. A statement of how the Bidder meets ALL the minimum requirements specified in *section 1.6 Minimum Qualifications*; and
- G. Signature of Bidder's Authorized Representative.

HCA may use the Letters of Intent to Propose as a pre-screening to determine whether minimum qualifications are met.

## **2.5 INTERESTED SUBCONTRACTOR LIST**

HCA supports and encourages contracts and subcontracts with Washington Small, diverse, and Certified Veteran Owned Businesses. To support participation in this process, the RFP Coordinator will add a list of interested Subcontractors to the RFP. The RFP Coordinator will prepare the list based on the timely and complete submission of specific information requested in this section. The purpose of the list is to communicate to prime Bidders the capabilities of interested Subcontractors who can perform components of this RFP's Scope of Work.

- A. Interested Subcontractor Instructions
  - i. Failure to follow the instructions in this section may prevent your information from being included in the list.
  - ii. An interested party must complete the table below to submit their firm name, contact information, and the summary of their capabilities as they relate to

this RFP's Scope of Work (*Section 1.5 Scope of Work*). Submissions are limited to what is requested in the table below and capability summaries must be two (2) paragraphs or less.

- iii. The RFP Coordinator will only include the information requested below. Do not submit marketing materials.
- iv. Submissions must be emailed to the RFP Coordinator, with the subject line **"RFP #2025HCA5 Interested Subcontractor List - [Interested Subcontractor Name]"** by the date specified in *section 1.2 Estimated Schedule of Solicitation Activities*.
- v. All material submitted for the interested Subcontractor list becomes a public record.

| Interested Subcontractor Name | Contact Name | Contact Address, Phone Number, and Email Address | Summary of your capabilities as it relates to the Scope of Work |
|-------------------------------|--------------|--------------------------------------------------|-----------------------------------------------------------------|
|                               |              |                                                  |                                                                 |

#### B. Posting Date

Complete and timely submissions will be compiled and posted in alphabetical order by interested Subcontractor name. HCA anticipates the list will be posted as an RFP amendment on the *Interested Subcontractor List Posted* date identified in *section 1.2 Estimated Schedule of Solicitation Activities*. Late submissions will not be posted.

#### C. Information Provided As-Is

The list of interested Subcontractors is provided as an opportunity to support participation in this RFP. HCA provides this information as a courtesy with no warranties or representations as to any party and no guarantee of a Subcontract. The list of interested Subcontractors shall not be construed as an endorsement by the state of Washington or HCA. The interested party is responsible for the completeness and accuracy of their submission.

## 2.6 BIDDER QUESTION PERIODS

Bidders are provided with two (2) opportunities to ask questions during the bidder question periods, which start on the date of the RFP posting and conclude on the *Bidder Round 2 Questions Due* date specified in *section 1.2 Estimated Schedule of Solicitation Activities*.

- A. Questions regarding the RFP will only be accepted in writing, sent by email to the RFP Coordinator. The Bidder must use the following email subject line when submitting questions: **"RFP #2025HCA5 Question(s) - [Bidder Legal Name]"** to ensure timely receipt.
- B. HCA anticipates it will post answers to the questions in WEBS as an RFP amendment on the *Answers Posted* date specified in *section 1.2 Estimated Schedule of Solicitation Activities*.
- C. HCA is under no obligation to respond to any questions received after the *Questions Due date* but may do so at its' discretion.

## 2.7 SUBMISSION OF PROPOSALS

Proposals must be received by the RFP Coordinator no later than the *Proposal Due* deadline in *section 1.2 Estimated Schedule of Solicitation Activities*. Complete Proposals containing all required documentation identified in *section 3 Proposal Contents and Requirements* must be submitted or the Proposal will be rejected. Proposals must be submitted electronically as an attachment to an e-mail to the RFP Coordinator at the e-mail address listed in *section 2.1 RFP Coordinator*, and meet the following requirements:

- A. Attachments to e-mail must be in Microsoft Word or Excel format or PDF.
- B. Must use the following email subject line:
  - a. **RFP #2025HCA5 Submission - [Bidder Legal Name]**
- C. Each exhibit must be submitted as a separate attachment.
- D. Zipped files cannot be used for submission of Proposals.
- E. Password protected files cannot be used for submission of Proposals.
- F. The forms and certifications that require authorized signature (as designated in *section 3.3 Exhibit A: Bidder Forms and Certifications*) must have a signature of the individual within the organization authorized to bind the Bidder to the offer.
- G. HCA does not assume responsibility for problems with Bidder's e-mail. If HCA e-mail is not working, appropriate allowances will be made.

Bidders should allow sufficient time to ensure timely receipt of the Proposal by the RFP Coordinator. Late Proposals will not be accepted and will be automatically disqualified from further consideration, unless HCA e-mail is found to be at fault or HCA deems a grace period is in the best interest of the State. All Proposals and any accompanying documentation become the property of HCA and will not be returned.

## 2.8 PROPRIETARY INFORMATION / PUBLIC DISCLOSURE

Proposals submitted in response to this RFP will become the property of HCA. All Proposals received will remain confidential until the ASB is announced; thereafter, the Proposals will be deemed public records as defined in [chapter 42.56 RCW](#).

Any information in the Proposal that the Bidder desires to claim as proprietary and exempt from disclosure under [chapter 42.56 RCW](#), or other state or federal law that provides for the nondisclosure of a document, must be clearly designated. Each page claimed to be exempt must:

- A. Identify the specific exemption relied upon, or
- B. Include a statement explaining why the information is exempt.

General markings such as "confidential" or "proprietary" applied to an entire Proposal will not be honored. Each exemption claim must be specific to the page and the type of information withheld.

If a public records request is made for information the Bidder has designated as exempt, HCA will notify the Bidder. The Bidder will then have the responsibility to obtain a court order enjoining disclosure. If the Bidder fails to obtain such an order, HCA will release the information as required by law.

No fee will be charged for inspection of contract files, but 24 hours' notice to the RFP Coordinator is required. All requests for information should be directed to the RFP Coordinator.

The submission of any public records request to HCA pertaining in any way to this RFP will not affect the solicitation schedule, as outlined in *section 1.2 Estimated Schedule of Solicitation Activities*, unless HCA, in its sole discretion, determines that altering the schedule would be in HCA's best interests.

## **2.9 REVISIONS TO THE RFP**

If HCA determines in its sole discretion that it is necessary to revise any part of this RFP, then HCA will publish addenda on WEBS. For this purpose, the published questions and answers and any other pertinent information will be provided as an addendum to the RFP and will be published on WEBS.

HCA also reserves the right to cancel or to reissue the RFP in whole or in part, at any time prior to the execution of a contract.

## **2.10 COMPLAINT PROCESS**

The complaint process allows potential Bidders to focus on the solicitation requirements and evaluation process and raise issues early enough in the process to allow HCA to correct a problem before Proposals are submitted. The complaint period starts on the date of the RFP posting and concludes on the *Complaints Due* date identified in *section 1.2 Estimated Schedule of Solicitation Activities*.

A. Potential Bidders may submit a complaint to HCA based on any of the following:

- i. The RFP unnecessarily restricts competition;
- ii. The RFP evaluation or scoring process is unfair or unclear; or
- iii. The RFP requirements are inadequate or insufficient to prepare a response.

B. For a complaint to be considered, it must be received by HCA by 5:00 pm PT on the *Complaints Due* date identified in *section 1.2 Estimated Schedule of Solicitation Activities*. The complaint must:

- i. Be in writing;
- ii. Be sent to the RFP Coordinator at the e-mail address listed in *section 2.1 RFP Coordinator*;
- iii. Must use the following email subject line:
  - a. **RFP #2025HCA5 Complaint - [Bidder Legal Name]**
- iv. Clearly articulate the basis for the complaint; and

- v. Include a proposed remedy.

C. HCA will address any complaint as follows:

- i. The RFP Coordinator or designee will respond to the complaint in writing;
- ii. The response to the complaint and any changes to the RFP will be posted on WEBS;
- iii. The Director of HCA will be notified of all complaints and will be provided a copy of HCA's response.

Complaints may not be raised again during a protest and HCA's action or inaction in response to a complaint will be final. There is no appeal process.

## **2.11 RESPONSIVENESS**

The RFP Coordinator will review all Proposals to determine compliance with administrative requirements and instructions specified in this RFP. A Bidder's failure to comply with any part of the RFP may result in rejection of the Proposal as non-responsive.

HCA also reserves the right at its sole discretion to waive minor administrative irregularities.

## **2.12 MOST FAVORABLE TERMS**

HCA reserves the right to make an award without further discussion of the Proposal submitted. Therefore, the Proposal should be submitted initially on the most favorable terms which the Bidder can propose. HCA reserves the right to contact a Bidder for clarification of its Proposal.

The ASB(s) should be prepared to accept this RFP for incorporation into a contract resulting from this RFP. The Contract resulting from this RFP will incorporate some, or all, of the Bidder's Proposal. The Proposal will become a part of the official solicitation file on this matter without obligation to HCA.

## **2.13 RECEIPT OF INSUFFICIENT NUMBER OF PROPOSALS**

If HCA receives only one (1) responsive Proposal as a result of this RFP, HCA reserves the right to either: 1) directly negotiate and contract with the Bidder; or 2) not award any contract at all. HCA may continue to have the Bidder complete the entire RFP. HCA is under no obligation to tell the Bidder if it is the only Bidder.

## **2.14 NO OBLIGATION TO CONTRACT**

This RFP does not obligate HCA to enter into any contract for services specified herein.

## **2.15 REJECTION OF PROPOSALS**

HCA reserves the right, at its sole discretion, to reject any and all Proposals received without penalty and not to issue any contract as a result of this RFP.

### 3. PROPOSAL CONTENTS AND REQUIREMENTS

#### 3.1 PROPOSAL SUBMITTAL CHECKLIST

Proposals must be submitted per the instructions in *section 2.6 Submission of Proposals*. Bidders are provided two (2) opportunities to ask questions during the bidder question periods which start on the date of the RFP posting and conclude on the *Bidder Round 2 Questions Due* date specified in *section 1.2 Estimated Schedule of Solicitation Activities*.

- ☐ EXHIBIT A – BIDDER FORMS AND CERTIFICATIONS\* (*section 3.3*)
- ☐ EXHIBIT B – DRAFT CONTRACT (*section 3.4*)
- ☐ EXHIBIT C1.1 – MANDATORY ATTESTATIONS (*section 3.5*)
- ☐ EXHIBIT C1.2 – WRITTEN PROPOSAL PHASE 1 (*section 3.5*)
- ☐ EXHIBIT C2 – WRITTEN PROPOSAL PHASE 2 (*section 3.5*)
- ☐ EXHIBIT D1 - PEBB COST PROPOSAL (*section 3.6*)
- ☐ EXHIBIT D2 – SEBB COST PROPOSAL (*section 3.6*)
- ☐ EXHIBIT E –SERVICE AREA (*section 3.7*)
- ☐ EXHIBIT G – PLAN DESIGN OUTLINE (*section 3.9*)
- ☐ EXHIBIT H – BREE COLLABORATIVE FOR COMPLEX DISCHARGES AND SDOH (*section 3.10*)
- ☐ EXHIBIT I – BIDDER SUBCONTRACTOR LIST (*section 3.11*)

**\*Authorized signature required**

#### 3.2 PROPOSAL REQUIREMENTS AND GUIDELINES

Proposals must comply with the requirements or restrictions listed below. Failure to do so may result in the disqualification of the Bidder's Proposal:

- A. State the Bidder's full legal name on the first or cover page of the Proposal.
- B. Proposals must provide information in the same order as presented in this RFP and with the same headings. Title and number each item in the same way it appears in the RFP. Each question must be restated prior to the Bidder's response.
- C. **All items listed in *section 3.1 Proposal Submittal Checklist* must be included as part of the Proposal for the Proposal to be considered responsive**; however, only the items identified in *section 4.3 Phase 1 Evaluation* and *section 4.4 Phase 2 Evaluation* will be scored during the evaluation process.

- D. Page limits stated in this RFP are determined by counting single sides of the response. HCA has no obligation to read, consider, or score any material exceeding the stated page limits. There will be no grounds for protest if critical information is on the pages exceeding the specified page limit that is not reviewed.
- E. Margins are to be 1" and minimum font size is 11.
- F. Bidders are liable for all errors or omissions contained in their Proposals. Bidders will not be allowed to alter Proposal documents after the deadline for Proposal submission. HCA is not liable for any errors in Proposals.
- G. HCA has no obligation to consider any supplemental materials submitted that were not requested.

### **3.3 EXHIBIT A: BIDDER FORMS AND CERTIFICATIONS**

- A. EXHIBIT A – BIDDER FORMS AND CERTIFICATIONS, *section A, Bidder Profile & Submittal Form* must be completed in its entirety and signed and dated by a person authorized to legally bind the Bidder to a contractual relationship (e.g., the President or Executive Director if a corporation, the managing partner if a partnership, or the proprietor if a sole proprietorship).
- B. EXHIBIT A – BIDDER FORMS AND CERTIFICATIONS, *section B, Diverse Business Inclusion Plan* must be completed in its entirety. In accordance with legislative findings and policies set forth in [RCW 39.19](#) the state of Washington encourages participation in all contracts by firms certified by the Office of Minority and Women's Business Enterprises (OMWBE), set forth in [RCW 43.60A.200](#) for firms certified by the Washington State Department of Veterans Affairs, and set forth in [RCW 39.26.005](#) for firms that are Washington Small Businesses. Participation may be either on a direct basis or on a Subcontractor basis. However, no preference on the basis of participation is included in the evaluation of Diverse Business Inclusion Plans submitted, and no minimum level of minority- and women-owned business enterprise, Washington Small Business, or Washington State Certified Veteran Owned Business participation is required as a condition for receiving an award. Any affirmative action requirements set forth in any federal government Regulations included or referenced in the contract documents will apply.
- C. EXHIBIT A – BIDDER FORMS AND CERTIFICATIONS, *section C Executive Order 18-03 – Worker's Rights*: Bidder must complete and respond as to whether Bidder requires its employees, as a condition of employment, to sign or agree to mandatory individual arbitration clauses and class or collective action waivers.

### **3.4 EXHIBIT B: DRAFT CONTRACT**

The ASB will be expected to enter into a contract that is substantially the same as the draft Contract, including its general terms and conditions and all attachments, attached as EXHIBIT B – DRAFT CONTRACT. HCA will not accept any draft Contracts prepared by any Bidder. The Bidder must be prepared to agree to all terms of the attached EXHIBIT B – DRAFT CONTRACT, as presented, or the Proposal may be rejected.

If Bidder has exceptions to the terms and conditions, they must include with their Proposal a copy of the draft Contract with tracked changes edits/comments documenting the changes they propose to

be made if selected as ASB. Bidder's exceptions must propose a compromise that is reasonable in light of the commitment being sought by HCA.

If the Bidder fails to identify an objection to any particular term or condition, the term or condition will be deemed agreed to by the Bidder.

**Please be advised:** The Contract(s) to be awarded are the result of a competitive solicitation developed pursuant to Washington's Procurement Code for Goods/Services that is designed to meet governmental needs for eligible purchasers. HCA endeavors to develop commercially reasonable Contracts that incentivize performance and equitably allocate risk and return based on input from stakeholders, subject matter experts, procurement professionals, and others.

Accordingly:

- A. Bidder tracked changes edits/comments to EXHIBIT B – DRAFT CONTRACT will be evaluated during Phase 2, described in *section 4.4, Phase 2 Evaluation*.
- B. Standard Bidder Contracts will not be reviewed. Do not provide a copy of Bidder's (or a third party's) standard contract or contract section. It will not be reviewed.
- C. No Substantial Changes. Bidders are cautioned that this is a competitive solicitation for a public contract and **HCA cannot and will not accept a Proposal or enter into a Contract that substantially changes the material terms and conditions set forth in this RFP and draft Contract**. Bidders who respond with substantial changes to EXHIBIT B – DRAFT CONTRACT, *Attachment 4 Performance Standards and Performance Payments* will lose points in the evaluation. If, after Phase 2 evaluation noted in 3.4.A above, any Proposals are found to be contingent upon HCA making substantial changes to material terms and conditions set forth in the RFP or Draft Contract, such Proposals may be rejected pursuant to section 2.14 REJECTION OF PROPOSALS. HCA will consider the number and nature of the items shown in edits or comments on the bidders' Draft Contract response.

If, after the announcement of the ASB(s), and after a reasonable period of time, any particular ASB and HCA cannot reach agreement on acceptable terms for the Contract, HCA may cancel the selection and award Contract(s) to the other ASBs or to other qualified Bidders not initially selected as ASBs.

### 3.5 EXHIBITS C1.1; C1.2; AND C2

#### A. EXHIBIT C1.1 – MANDATORY ATTESTATIONS

- i. Bidders must complete and submit EXHIBIT C1.1 – MANDATORY ATTESTATIONS for Proposal responsiveness evaluation.

#### B. EXHIBIT C1.2 – WRITTEN PROPOSAL PHASE 1

- i. Bidder must answer all questions in EXHIBIT C1.2 – WRITTEN PROPOSAL PHASE 1. The Exhibit must be completed in its entirety in accordance with the page limits identified within the Exhibit (see *section 3.2.D*). Bidder should respond using EXHIBIT C1.2 – WRITTEN PROPOSAL PHASE 1 as its template, to ensure compliance with the formatting requirements outlined in *sections 3.2.B* and *3.2.E*.
- ii. Questions in EXHIBIT C1.2 – WRITTEN PROPOSAL PHASE 1 are tied directly to specific sections of EXHIBIT B – DRAFT CONTRACT, *Attachment 3: Statement of*

*Work.* Those Statement of Work sections are restated in EXHIBIT C1.2 – WRITTEN PROPOSAL PHASE 1 for Bidder reference.

#### C. EXHIBIT C2 – WRITTEN PROPOSAL PHASE 2

- i. Bidder must answer all questions / submit all documentation requested in EXHIBIT C2 – WRITTEN PROPOSAL PHASE 2. The exhibit must be completed in its entirety in accordance with the page limits identified within the exhibit (see *section 3.2.D*). Bidder should respond using EXHIBIT C2 – WRITTEN PROPOSAL PHASE 2 as its template, to ensure compliance with the formatting requirements outlined in *sections 3.2.B* and *3.2.E*.

### 3.6 EXHIBIT D1 AND D2: COST PROPOSALS

Once a Bidder submits a Letter of Intent to Propose, Exhibit D1 and D2 (PEBB and SEBB COST PROPOSAL) and all supplementary rating materials (as detailed in *section 3.6 Exhibit D1 and D2 – Cost Proposals*) will be provided to Bidder via Managed File Transfer (MFT). Login credentials will be provided by the RFP Coordinator for Bidders to retrieve files. Only Bidders who submit a Letter of Intent to Propose by the required date and time stated in the Solicitation Schedule will be provided these materials.

Bidders must complete Excel workbooks EXHIBIT D1 – PEBB COST PROPOSAL and EXHIBIT D2 – SEBB COST PROPOSAL, providing separate submissions for the PEBB and SEBB program Bid Rates, using the instructions provided in the spreadsheet.

#### **Attachments provided for Bidders to complete Cost Proposal:**

- A. Exhibit D1 and D2 - Individual PEBB and SEBB Bid Rate forms; bidders are required to include inputs on each of the following tabs within the excel workbook and submit separate bid submissions for the PEBB and SEBB program offerings. Please reference the Bid Form Instructions in each Exhibit for more information on how to fill out the forms correctly:
  - a. General Inputs;
  - b. WS1a – Base Rate Development Acute Care;
  - c. WS1b – Base Rate Development Special Hospitals;
  - d. WS1c – Base Rate Development Non-Capped Hospitals;
  - e. WS1d – Base Rate Development Professional;
  - f. WS1e – Base Rate Development Pharmacy (Rx)
  - g. WS2 – Plan Rate Development
  - h. All other tabs provide supplemental information, instructions, or summary details and do not require Bidder inputs.
- B. Additional supplemental attachments, detailed below, provide supporting data and detail to aid Bidders in development of inputs for Exhibit D1 and D2:
  - a. HCA PEBB and SEBB Proposal census data
  - b. HCA PEBB Proposal Summary Rx (pharmacy) data

- c. HCA SEBB Proposal Summary Rx (pharmacy) data
- C. AV Calculator – With each rate submission, HCA requires that the Bidder provide a completed Actuarial Value (AV) Calculator for each alternative plan proposed. Bidders will be required to use the 2027 AV Calculator provided by HCA and provide a PDF version of the completed AV Calculator for each plan. HCA requests that the AV Calculator be completed with the desired metal tier of Platinum. Given that all plan designs proposed must be identical for the PEBB and SEBB programs, only one AV calculation is required for each proposed plan. That is, if a Bidder is proposing two (2) alternative plans for each program, only two (2) AV calculations are required.
  - a. Final-2027-AV-Calculator
- D. Rate Development Transparency – Submission of Actuarial Memorandum: With each rate submission, HCA requests the following detailed information supporting the Bidder's rate submissions for additional transparency into the rate development process. Each Bidder will submit one (1) actuarial memorandum for PEBB and one (1) actuarial memorandum for SEBB. Please include any back-up calculations and descriptions of assumptions used to develop the rates in an actuarial memorandum. In addition, please ensure detailed supporting documentation includes the following:
  - a. A summary written description of Bidder's actual rating methodology at a conceptual (not mathematical) level.
  - b. Bidder's new business rate development documentation for the PEBB and SEBB programs demonstrating numerical calculations in the development of your rates.
  - c. Summary information for the past three years' experience gains or losses separately in aggregate by line of business.
  - d. On a per adult unit per month (PAUPM) basis, the amount Bidders have included for administration costs. Show all subcategories used in Bidder's internal modeling, including but not limited to the following:
    - i. Administrative Costs
    - ii. Taxes or Fees
    - iii. Standard Margin
    - iv. Projection Margin
    - v. Other Retention

## **Background and Expectations**

HCA anticipates the rate development process associated with this procurement to occur in three (3) parts, all dates are subject to change at the discretion of the HCA:

- A. Rate Submission 1: Submission of scored initial Bid Rates by Bidders as part of the RFP response, January 2027
  - i. Bidders will be provided with all relevant attachments, as detailed above, for initial Bid Rate development. Individual submissions are required for PEBB program proposals and SEBB program proposals. Initial Bid Rate development will include a complete base period of historical experience, Bidders will be required to develop

projected rates in accordance with the instructions provided within EXHIBIT D1 and D2 – COST PROPOSAL TEMPLATE.

- ii. Bidders will be scored only according to the final risk normalized PAUPM (Bid Rate) for only the standardized plan bid (Plan A). The standardized plan bid is a plan design modeled off of UMP Classic (PEBB) and UMP Achieve 2 (SEBB) plan designs. Bidders should use all identified WS1 tabs for rate build up; other than the allowed input values for 'Retention' amounts, bidders are not permitted to adjust plan specific inputs provided on WS2, column D. The dollar amount populated in column D, row 59 (Risk normalized per adult unit per month (PAUPM), Bid Rate) will be used to score Bidder's cost proposal submissions.
- iii. Alternative plan designs submitted for consideration, and accompanying rates, will not be scored but will be considered as potential plan options to be presented to the Board for final authorization (Paragraph C Board Authorization of Premiums). Bidders are only permitted to submit up to three (3) plan options (Plan A, Plan B, and Plan C) for HCA's consideration, each of which must be identical for the PEBB and SEBB programs. If adopted by the PEB and SEB Boards, each plan design must be offered to both the PEBB and SEBB programs (potentially resulting in a total of six (6) plans per Bidder).
- iv. Due to the Procurement timeline, and relevant periods of historical base period experience required to develop rates, ASBs will be required to submit revised bids using a more recent period of experience in a future phase of the rate development process.

**B. Rate Submission 2: Rate refinement following announcement of ASB(s), Fall/Winter 2027**

- i. Following announcement of ASB(s), HCA will engage in discussions with the PEB and SEB Boards regarding proposed plan designs submitted by Bidders in Submission 1. Once the Board authorizes final plan designs, HCA will request ASB(s) to refine initial rate submissions using a more recent period of base claims experience. Bidders will be provided updated rate materials to assist in rating only the plan designs approved by the PEB and SEB Boards.
- ii. To ensure consistency with the methodologies and original assumptions, and to hold Bidders accountable to initial rate submissions in Submission 1, HCA will require Submission 2 Bid Rates increase by no more than:
  - a. 5 percent, or the increase observed in the UMP Classic/Achieve 2 Submission 2 Bid Rate, whichever is greater.
- iii. Plan offerings, and underlying rates, are not considered final until authorized by the PEB and SEB Boards during the 2028 board season. Therefore, HCA will include placeholder rates as an Exhibit in any negotiated contracts to be signed at the end of 2027, pending PEB and SEB Board authorization.

**C. Board Authorization of Premiums: PEB and SEB Board Authorization of employee premiums, Summer 2028**

- i. HCA will present final rates, as submitted by ASB(s) in Submission 2, to the PEB and SEB Boards during the 2028 board season. Once rates are authorized by the PEB and SEB Boards, any signed contracts will be amended to include authorized rates for the 2029 plan year and applicable Payment Rates to be paid to carriers as Monthly Premiums.

## ***Employer Medical Contribution***

The total cost of the Bid Rate is split between the employer and the employee. The employer's portion for an employee with no Dependents is known as the "Employer Medical Contribution (EMC)" and is collectively bargained ([RCW 41.56.030\(4\)](#) and [RCW 41.80.005\(2\)](#)) to be 85 percent of the Bid Rate for the self-insured UMP Classic (PEBB)/Achieve 2(SEBB). The employee contribution for an employee with no Dependents will be the difference between a plan's final Bid Rate and the EMC. The EMC will be applied uniformly across all medical plan offerings within the portfolio, and both the EMC and employee's share are multiplied by the tier ratios shown in Table 1 –Tier Factor Ratios. The minimum employee premium contribution across all plans and all tiers is collectively bargained to be set at no less than two percent of the EMC.

## ***Risk Pools***

There are three (3) statutorily authorized health insurance risk pools managed by HCA: the PEBB program non-Medicare risk pool ([RCW 41.05.022\(2\)](#)), the PEBB program Medicare risk pool ([RCW 41.05.080\(3\)](#)), and the SEBB program risk pool ([RCW 41.05.022\(3\)](#)). Please note that the PEBB program non-Medicare risk pool includes retired and disabled School Employees not eligible for Medicare. Each bidder will complete one (1) Bid Rate form for the PEBB program non-Medicare risk pool which is comprised of state and other employees, state and other non-Medicare retirees and school non-Medicare retirees, and one (1) Bid Rate form for the SEBB program risk pool which includes School Employees.

## ***Tier Factors***

Bid Rates should be developed only for the PEBB program non-Medicare risk pool and the SEBB program risk pool. The tier structure is shown below for the PEBB and SEBB programs in Table 1.

Table 1 – Tier Factor Ratios

| <b>Tier Factor</b>                  | <b>PEBB</b> | <b>SEBB</b> |
|-------------------------------------|-------------|-------------|
| Employee Only                       | 1.0         | 1.0         |
| Employee + Spouse/SRDP              | 2.0         | 2.0         |
| Employee + Child(ren)               | 1.75        | 1.75        |
| Employee, Spouse/SRDP, + Child(ren) | 2.75        | 3.0         |

## **Rate Adjustment Process (Risk Adjustment)**

Rate adjustments will include the application of Risk Scores to the final Bid Rates as described in EXHIBIT B – DRAFT CONTRACT, *Attachment 3: Scope of Work*.

For additional information, Bidders should review ATTACHMENT 8 – FINANCIAL DETAILS and ATTACHMENT 9 – REQUIRED CLAIMS FIELD DATA.

### **3.7 EXHIBIT E: SERVICE AREA**

Bidder must submit a completed EXHIBIT E – SERVICE AREA to identify its intended list of Washington State counties that will be covered by Bidder's proposed Health Plan(s).

ASB(s) will not be permitted to reduce the geographic Service Area set forth in its Proposal without written approval from HCA.

### **3.8 PERFORMANCE STANDARDS AND PERFORMANCE PAYMENTS**

Bidder must review the Performance Standards stated in EXHIBIT B – DRAFT CONTRACT, *Attachment 4 Performance Standards and Performance Payments* and answer EXHIBIT C1.2 – WRITTEN PROPOSAL PHASE 1 *Question 7.1: Performance Standards and Performance Payments*.

Exhibit C1.2 Question 7.1 will be scored separately from all other questions in Exhibit C1.2 as noted in the evaluation summary in section 4.1 EVALUATION PROCEDURE subsection E.

Redlines to EXHIBIT B – DRAFT CONTRACT, *Attachment 4 Performance Standards and Performance Payments* will result in the loss of 500 points.

HCA will not negotiate separate Performance Standards with each Bidder.

### **3.9 EXHIBIT G: PLAN DESIGN OUTLINE**

Bidder must submit a completed EXHIBIT G – PLAN DESIGN OUTLINE.

### **3.10 EXHIBIT H: BREE COLLABORATIVE FOR COMPLEX DISCHARGE AND HEALTH EQUITY/SDOH**

Bidder must submit a completed EXHIBIT H – BREE COLLABORATIVE FOR COMPLEX DISCHARGES AND SDOH.

### **3.11 EXHIBIT I: BIDDER SUBCONTRACTOR LIST**

Bidder must submit a completed EXHIBIT I – BIDDER SUBCONTRACTOR LIST

## 4. EVALUATION AND CONTRACT AWARD

### 4.1 EVALUATION PROCEDURE

Responsive Proposals will be evaluated strictly in accordance with the requirements stated in this RFP and any addenda issued. The evaluation of Proposals will be accomplished by an evaluation team, to be designated by HCA, which will determine the ranking of the Proposals. Evaluation teams could be comprised of internal (HCA) and external individuals. Evaluations will be based only upon information provided in the Bidder's Proposal.

- A. HCA reserves the right to determine a Bidder's compliance with the requirements specified in this RFP, request clarification, and to waive minor administrative irregularities.
- B. Only responsive Proposals that meet the requirements will be evaluated by the evaluation team. Any Bidder who does not meet the stated qualifications or any Proposal that does not contain all the required information will be rejected as non-responsive.
- C. Responsive Proposals will be reviewed and scored in two phases as identified in *sections 4.3 Phase 1 Evaluation* and *4.4 Phase 2 Evaluation*.
- D. HCA reserves the right to award a Contract to the Bidder(s) whose Proposal is deemed to be in the best interest of HCA and the state of Washington.
- E. HCA will use the following process and evaluation criteria to determine ASB(s):

| EVALUATION SCORING AND CRITERIA                    |                                                                                                                                                                            |           |
|----------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------|
| Step                                               | Administrative Review                                                                                                                                                      | Points    |
| 1                                                  | Proposal Responsiveness                                                                                                                                                    | Pass/Fail |
| 2                                                  | Exhibit C1.1 Mandatory Attestations                                                                                                                                        | Pass/Fail |
| Phase 1 Proposal Evaluation                        |                                                                                                                                                                            |           |
| 3                                                  | Executive Order 18-03                                                                                                                                                      | 150       |
| 4                                                  | Exhibit C1.2 – Written Proposal Phase 1 (Excluding Q7.1)                                                                                                                   | 1000      |
| 5a                                                 | Exhibit D1 – PEBB Cost Proposal                                                                                                                                            | 650       |
| 5b                                                 | Exhibit D2 – SEBB Cost Proposal                                                                                                                                            | 650       |
| 6                                                  | Exhibit E – Service Area                                                                                                                                                   | 380       |
| 7                                                  | Exhibit C1.2 Question 7.1: <i>Performance Standards and Performance Payments</i> .<br><br>Question 7.1 will be scored separately from all other questions in Exhibit C1.2. | 500       |
| Top-Scored Bidder(s) Advance to Phase 2 Evaluation |                                                                                                                                                                            |           |
| Phase 2 Proposal Evaluation                        |                                                                                                                                                                            |           |
| 8                                                  | Exhibit C2 – Written Proposal Phase 2 (Includes Exhibit H, Bree Collaborative)                                                                                             |           |
| 9                                                  | Exhibit B – Draft Contract                                                                                                                                                 |           |
| 10                                                 | Bidder presentation                                                                                                                                                        |           |

## 4.2 ADMINISTRATIVE REVIEW

- A. **BIDDER RESPONSIVENESS (Step 1).** HCA will review Proposals on a pass/fail basis to determine whether the bid is responsive to this RFP. This includes reviewing each Proposal to determine whether the Proposal is complete – i.e., does the Proposal include each of the required Proposal submittals, are the submittals complete, signed, legible. HCA reserves the right – in its sole discretion – to determine whether a Proposal is responsive – i.e., to determine a Bidder's compliance with the requirements specified in this RFP.
- B. **EXHIBIT C1.1 – MANDATORY ATTESTATIONS (Step 2).** Bidder must respond to each requirement. Each row is a mandatory attestation. **Any Bidder that does not respond “yes” to all mandatory attestations will have their Proposal rejected as non-responsive.**

## 4.3 PHASE 1 EVALUATION

- A. **Executive Order 18-03 (Step 3).** Pursuant to [RCW 39.26.160\(3\)](#) and consistent with Executive Order 18-03 – Supporting Workers' Rights to Effectively Address Workplace Violations (dated June 12, 2018), HCA will evaluate proposals for best value and provide a preference in the amount of 150 points to any Bidder who certifies, pursuant to the certification included in EXHIBIT A – BIDDER FORMS AND CERTIFICATIONS, *section C Executive Order 18-03 Worker's Rights*, that their firm does NOT require its employees, as a condition of employment, to sign or agree to mandatory individual arbitration clauses or class or collective action waiver. Bidders that do require their employees, as a condition of employment, to sign or agree to mandatory individual arbitration clauses or class or collective action waiver will not be disqualified from evaluation of this RFP, however they will receive 0 out of 150 points for this section.
- B. **EXHIBIT C1.2 – WRITTEN PROPOSAL PHASE 1 (Step 4).** Each question has been assigned a point value. Bidder points will be assigned to each question based upon the average of all evaluation team members scores for the question (0-10) multiplied by the question's weight. Individual question scores will then be combined to result in the Bidder's total weighted score. Any point calculations that result in decimal points will be rounded to the nearest whole number.

| Scoring Rubric |                          |                                                                                                                                                                                              |
|----------------|--------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Score          | Description              | Scoring Criteria                                                                                                                                                                             |
| 10             | Far Exceeds Requirements | The Bidder has provided an innovative, detailed, and thorough response to the requirement, and clearly demonstrates a high level of experience with, or understanding of the requirement.    |
| 7              | Exceeds Requirements     | The Bidder has demonstrated an above-average capability, approach, or solution and has provided a complete description of the capability, approach, or solution.                             |
| 5              | Meets Requirements       | The Bidder has an acceptable capability of solution to meet this criterion and has described its approach in sufficient detail to be considered “as substantially meeting the requirements”. |
| 3              | Below Requirements       | The Bidder has established some capability to perform the requirement but descriptions regarding their approach are not sufficient to                                                        |

|   |                                  |                                                                                                                                                          |
|---|----------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|
|   |                                  | demonstrate the Bidder will be fully able to meet the requirements.                                                                                      |
| 1 | Substantially Below Requirements | The Bidder has not established the capability to perform the requirement, has marginally described its approach, or has simply restated the requirement. |
| 0 | Unresponsive                     | The Bidder does not address any component of the requirement, or no information was provided.                                                            |

- C. **EXHIBIT D – COST PROPOSAL (Step 5).** Bidders are required to submit all required attachments, as described in *section 3.6 Exhibit D1 and D2: PEBB and SEBB Cost Proposal*. HCA intends to reward Bidders who provide a competitive bid, in relation to the self-insured UMP plan offering. Therefore, Bidder Cost Proposals will be evaluated based on the assessment of the risk normalized PAUPM (Bid Rate, WS2 row 59) for only the standardized Plan A option in relation to the UMP Classic/UMP Achieve 2 Bid Rate. All UMP projections are considered estimates to help inform Bidders in the rating process and are subject to change in Phase 2.

While bidders are permitted to submit three (3) Health Plan designs for HCA's consideration, only the Standardized Plan option will be scored in Phase 1. Bidders will be provided illustrative employee contributions for all Health Plans included in the cost proposal; this information is intended to inform bidders on Health Plan premium position in relation to the self-insured UMP Health Plan offering and is not used for any other purpose. As detailed in *section 3.6 Exhibit D: Cost Proposal*, HCA will present final rates and employee premium contributions, as submitted by ASB(s) in Submission 2, to the PEB and SEB Boards during the 2028 board season.

Individual PEBB and SEBB cost proposals (Exhibits D1 and D2) will be scored using the following methodology:

| When the Bidder's Scored Plan A Bid Rate is:                      | Percent of Total Points Available | Points Allotted |
|-------------------------------------------------------------------|-----------------------------------|-----------------|
| Less than or equal to the Best Estimate UMP Bid Rate              | 100%                              | 650             |
| Exceeds the UMP Best Estimated Bid Rate by no more than 2 percent | 75%                               | 488             |
| Exceeds the UMP Best Estimate Bid Rate by no more than 3 percent  | 50%                               | 325             |
| Exceeds the UMP Best Estimate Bid Rate by no more than 4 percent  | 25%                               | 163             |
| Exceeds the UMP Best Estimate Bid Rate by more than 4 percent     | 10%                               | 65              |

- i. As noted in *section 3.6 Exhibit D1 and D2: Cost Proposals*, following announcement of ASB(s), HCA will engage in discussions with the PEB and SEB Boards regarding proposed Health Plan designs submitted by Bidders in Submission 1. Once the Board authorizes final Health Plan designs, HCA will request ASB(s) to refine initial rate submissions using a more recent period of base claims experience. Bidders will be provided updated rate materials to assist in rating only the Health Plan designs approved by the PEB and SEB Boards. Bid Rates increase by no more than 5 percent (5%), or the increase observed in the UMP Classic/Achieve 2 Submission 2 Bid Rate, whichever is greater.

- D. **EXHIBIT E: SERVICE AREA (Step 6)** is an automatic scoring Excel spreadsheet. Bidder will receive the points associated with each county their Health Plan(s) will be offered in.

ASB(s) will not be permitted to reduce the geographic service area set forth in its Proposal without written approval from HCA.

- E. **PERFORMANCE STANDARDS AND PERFORMANCE PAYMENTS** Bidder must review the Performance Standards stated in EXHIBIT B – DRAFT CONTRACT, Attachment 4 Performance Standards and Performance Payments and answer EXHIBIT C1.2 – WRITTEN PROPOSAL PHASE 1 Question 7.1: Performance Standards and Performance Payments.

Bidders that attest “yes”, agreeing to the Performance Standards as written, will receive full points for Phase 1 Performance Standards identified by question 7.1.

Bidders that attest “no” and therefore do not agree to the Performance Standards as written will receive 0 points for question 7.1

HCA will not negotiate separate Performance Standards with each Bidder.

- F. Total Score

| Evaluation Table – All Scored Items Phase 1 |                                                                                                             |                |
|---------------------------------------------|-------------------------------------------------------------------------------------------------------------|----------------|
|                                             | Title                                                                                                       | Maximum Points |
|                                             | Executive Order 18-03                                                                                       | 150            |
|                                             | Exhibit C1.2 Written Proposal Phase 1 (excluding Q7.1)                                                      | 1000           |
|                                             | Exhibit D1 – PEBB Cost Proposal                                                                             | 650            |
|                                             | Exhibit D2 – SEBB Cost Proposal                                                                             | 650            |
|                                             | Exhibit E – Service Area                                                                                    | 380            |
|                                             | EXHIBIT C1.2 – WRITTEN PROPOSAL PHASE 1 <i>Question 7.1: Performance Standards and Performance Payments</i> | 500            |
| Total Maximum Points Phase 1                |                                                                                                             | 3330           |

- G. Phase 1 Evaluation Outcome and Next Steps

- i. After the evaluation of Phase 1, HCA will select the Bidder(s) who scored the highest in Phase 1 (finalists) to move forward to Phase 2. The number of highest-scoring Bidders selected will be at HCA’s sole discretion.
- ii. The Phase 1 scores **will not** carry forward to Phase 2.

#### 4.4 PHASE 2 EVALUATION

- A. **OVERVIEW.** Phase 2 includes evaluation of finalist Bidders’ complete Proposals, including, but not limited to:

1. **EXHIBIT C2 – WRITTEN PROPOSAL PHASE 2 (Step 8);**
2. **EXHIBIT B – DRAFT CONTRACT (Step 9); and**
3. **BIDDER PRESENTATION (Step 10).**

HCA, at its sole discretion, can elect to evaluate or not evaluate any component of Bidder’s Proposal in Phase 2.

Scores from Phase 1 **will not** carry forward to the scoring of Phase 2. The evaluation team will unanimously assign one (1) score to each Bidder in Phase 2. The evaluation team will determine the Bidders’ ranks via a consensus-based evaluation based on the Strengths, Weaknesses, Opportunities, and Risks (SWOR) analysis described in this section. Phase 2 scores will determine the ASB(s).

**B. EXHIBIT C2 – WRITTEN PROPOSAL PHASE 2; EXHIBIT H – BREE COLLABORATIVE FOR COMPLEX DISCHARGES AND SDOH (Step 8)**

The evaluation team will review all responses provided in EXHIBIT C2 – WRITTEN PROPOSAL PHASE 2, and EXHIBIT H – BREE COLLABORATIVE FOR COMPLEX DISCHARGES AND SDOH and factor them into the SWOR analysis.

**C. EXHIBIT B – DRAFT CONTRACT (Step 9)**

The evaluation team will review all redlines, edits, and comments provided in EXHIBIT B – DRAFT CONTRACT and factor them into the SWOR analysis.

**D. BIDDER PRESENTATION (Step 10)**

1. The RFP Coordinator will contact Bidders who advance to Phase 2 to provide further details and schedule the presentation.
2. The presentation will be held via HCA's preferred video conferencing tool.
3. Bidder presentations will be part of at least one 2-4 hour discussion meeting, timing to be determined by HCA after bids are received. Topics of the presentation will be provided in advance of this meeting and will be based upon HCA's review of the initial proposal.
4. Bidders will answer questions developed by the evaluation team to clarify their Proposals. Bidder will ensure that appropriate subject matter experts are present at the meeting to address those questions.
5. Commitments made by Bidders during the presentation will be considered binding.

**E. PHASE 2 SCORING**

Bidders that are selected to move to Phase 2 as described above will be evaluated based on a consensus-based Strengths-Weaknesses-Opportunities-Risks (SWOR) analysis. The Phase 2 evaluation will be accomplished by an evaluation team, to be designated by HCA.

Each Bidder's SWOR analysis will be captured in the table below.

| SWOR Analysis Table   |            |
|-----------------------|------------|
| Internal              |            |
| Strengths             | Weaknesses |
|                       |            |
| External              |            |
| Opportunities         | Risk       |
|                       |            |
| SWOR Analysis Summary |            |

The Evaluation Team will use the SWOR analysis to determine the Bidders' ranks via a consensus-based evaluation. The Bidder's rank will result in points as described below:

| SWOR Analysis<br>Ranking Scores Table |       |
|---------------------------------------|-------|
| Rank                                  | Score |
| 1                                     | 100   |
| 2                                     | 90    |
| 3                                     | 80    |
| 4                                     | 70    |
| 5                                     | 60    |
| 6                                     | 50    |
| 7                                     | 40    |
| 8                                     | 30    |
| 9                                     | 20    |
| 10                                    | 10    |

The score awarded in Phase 2 will be the Bidder's final score.

#### **4.5 ANNOUNCEMENT OF APPARENT SUCCESSFUL BIDDER(S)**

HCA will determine the Apparent Successful Bidder(s) (ASB(s)). The ASB(s) will be the responsive and responsible Bidder(s) that best meet the RFP requirements and presents the best total value, including price, and other factors as set forth in this RFP.

There is no limit to the number of ASB(s) that HCA may select. HCA may enter Contract negotiations with one (1) or more of the ASB(s). If, after a reasonable period of time, HCA, in its sole judgement, cannot reach agreement on acceptable Contract terms with any particular ASB, HCA may cancel the negotiation and award Contracts to the other ASB(s) or to other qualified Bidders not initially selected as an ASB.

As soon as ASB(s) are announced, if not before, ASB(s) representatives must begin attending, virtually or in person, all public meetings of the PEB Board and the SEB Board so that

- A. Board(s) discussions and decisions are heard and understood by ASB(s);
- B. ASB(s) are aware of Board(s) directives regarding plans, including Data reporting, benefit coverage, customer service issues, or other items that may be discussed at Board Meetings;
- C. ASB(s) may answer questions directly from the Board(s), if and when the ERB Director or CMO approve; and
- D. ASB(s) establish a partnering relationship with the Boards.

See the [PEB Board Meeting](#) and [SEB Board Meeting](#) websites for more details.

#### 4.6 BEST AND FINAL OFFER (BAFO)

HCA reserves the right to use a Best and Final Offer (BAFO) before awarding any contract to further assist in determining the ASB(s).

#### 4.7 NOTIFICATION TO BIDDERS

HCA will announce the ASB(s) to all Bidders via the WEBS notification system.

#### 4.8 DEBRIEFING OF UNSUCCESSFUL BIDDERS

Any Bidder who has submitted a Proposal and been notified it was not selected for contract award may request a debriefing conference. The request must be emailed to the RFP Coordinator with the subject line “**RFP #2025HCA5 Debriefing Conference - [Bidder Legal Name]**” and must be received by the RFP Coordinator no later than 5:00 p.m., Pacific Time, within three (3) Business Days after the Unsuccessful Bidder Notification is emailed to the Bidder. The debriefing will be held within three (3) Business Days of the request, or as schedules allow.

Discussion at the debriefing conference will be limited to the following:

- A. Evaluation and scoring of the Bidder’s Proposal;
- B. Critique of the Proposal based on the evaluation; and
- C. Review of the Bidder’s final score in comparison with other final scores without identifying the other Bidders.

Topics a Bidder could have raised as part of the *section 2.9 Complaint Process* cannot be discussed as part of the debriefing conference, even if the Bidder did not submit a complaint.

Comparisons between Proposals, or evaluations of the other Proposals, will not be allowed. Debriefing conferences will be conducted by telephone/video call and will be scheduled for a maximum of thirty (30) minutes.

#### 4.9 PROTEST PROCEDURE

A protest may be made only by Bidders who submitted a response to this RFP and who have participated in a debriefing conference. Upon completing the debriefing conference, the Bidder is allowed five (5) Business Days to file a protest. Protests must be received by the Contracts Administrator no later than 4:30 p.m., Pacific Time, on the fifth (5<sup>th</sup>) Business Day following the Bidder’s debriefing. Protests must be submitted by e-mail to ensure timely receipt.

Consistent with [RCW 39.26.030](#), Proposal submissions and Proposal evaluations will be available for public inspection following the announcement of ASB(s). If requested by a Bidder who received a debriefing pursuant to *section 4.8 Debriefing of Unsuccessful Bidders*, the protest period will not conclude before the requestor has been provided with the applicable Proposal submissions and Proposal evaluations and provided five (5) Business Days to review the same. Bidder is responsible for notifying the RFP Coordinator of any such public disclosure requests so the timeline can be adjusted accordingly.

Bidders protesting this RFP must follow the procedures described below. Protests that do not follow these procedures will not be considered. This protest procedure constitutes the sole administrative remedy available to Bidders under this RFP.

- A. All protests must be in writing, addressed to the Contracts Administrator, and signed by the protesting party or an authorized agent. The protest must state (1) the RFP number, (2) the grounds for the protest with specific facts, (3) complete statements of the action(s) being protested, and (4) the relief or corrective action being requested. Protests must be emailed to [contracts@hca.wa.gov](mailto:contracts@hca.wa.gov) with the following subject line: **"RFP #2025HA5 Protest – [Bidder Name]"**
- B. Only protests alleging an issue of fact concerning the following subjects will be considered:
  - i. A matter of bias, discrimination, or conflict of interest on the part of an evaluator;
  - ii. Errors in computing the score; or
  - iii. Non-compliance with procedures described in the RFP, HCA's protest process, or Department of Enterprise Services (DES) policy requirements (POL-DES-170-00).

Protests based on anything other than those items listed above will not be considered. Protests will be rejected as without merit to the extent they address issues such as: 1) an evaluator's professional judgment on the quality of a Proposal; or 2) HCA's assessment of its own needs or requirements.

- C. Upon receipt of a protest, HCA will undertake a protest review. HCA's Director, or an HCA employee delegated by the HCA Director who is a neutral party with no involvement in the evaluation and award process (Protest Officer), will review and respond to the protest. If the HCA Director delegates the protest review to an HCA employee, the Director nonetheless reserves the right to make the final agency decision on the protest. The Protest Officer will have the right to seek additional information regarding the solicitation from sources they deem appropriate to fully consider the protest.
- D. If HCA determines in its sole discretion that a protest from one (1) Bidder may affect the interests of another Bidder, then HCA may invite such Bidder to submit its' views and any relevant information on the protest to the Protest Officer. In such a situation, the protest materials submitted by each Bidder will be made available to all other Bidders upon request.
- E. The Protest Officer will issue a written protest response no more than ten (10) Business Days after receipt of the protest, unless additional time is needed, in which case HCA will notify the protesting Bidder in writing. The Protest Officer's decision is final unless the HCA Director elects to make the final agency decision on the protest. There will be no appeal process.
- F. The final determination of the protest will:
  - i. Find the protest lacking in merit and uphold HCA's action; or
  - ii. Find only technical or harmless errors in HCA's acquisition process and determine HCA to be in substantial compliance and reject the protest; or
  - iii. Find merit in the protest and provide options to the HCA Director, which may include:
    - a. Correct the errors and re-evaluate all proposals; or
    - b. Issue a new solicitation document and begin a new process; or

c. Make other findings and determine other courses of action as appropriate.

If the protest is not successful, HCA will enter into a contract with the ASB(s), assuming the parties reach agreement on the contract's terms.

## **5. RFP EXHIBITS**

EXHIBIT A – BIDDER FORMS AND CERTIFICATIONS

EXHIBIT B – DRAFT CONTRACT

EXHIBIT C1.1 – MANDATORY ATTESTATIONS

EXHIBIT C1.2 – WRITTEN PROPOSAL PHASE 1

EXHIBIT C2 – WRITTEN PROPOSAL PHASE 2

EXHIBIT D1 – PEBB COST PROPOSAL TEMPLATE

EXHIBIT D2 - SEBB COST PROPOSAL TEMPLATE

EXHIBIT E – SERVICE AREA

EXHIBIT F - INTENTIONALLY BLANK

EXHIBIT G – PLAN DESIGN OUTLINE

EXHIBIT H – BREE COLLABORATIVE FOR COMPLEX DISCHARGES AND SDOH

EXHIBIT I – BIDDER SUBCONTRACTOR LIST

ATTACHMENT 1 – APM FRAMEWORK

ATTACHMENT 2 - INTENTIONALLY BLANK

ATTACHMENT 3 – MFT USER GUIDE

ATTACHMENT 4 – 834 COMPANION GUIDE

ATTACHMENT 5 – BUSINESS IMPACT ANALYSIS

ATTACHMENT 6- INTENTIONALLY BLANK

ATTACHMENT 7 – DISASTER RECOVERY PLAN TEMPLATE

ATTACHMENT 8 – FINANCIAL DETAILS

ATTACHMENT 9 – REQUIRED CLAIMS FIELD DATA

ATTACHMENT 10 – ASB TECHNICAL REQUIREMENTS

ATTACHMENT 11 – WATECH IT SECURITY CHAPTER

ATTACHMENT 12 – PRE-PROPOSAL CONFERENCE AGENDA

## **EXHIBIT A – BIDDER FORMS AND CERTIFICATIONS**

Exhibit A is included as a separate document.

## **EXHIBIT B – DRAFT CONTRACT**

Exhibit B is included as a separate document.

## **EXHIBIT C1.1 – MANDATORY ATTESTATIONS**

Exhibit C1.1 is included as a separate document.

## **EXHIBIT C1.2 – WRITTEN PROPOSAL PHASE 1**

Exhibit C1.2 is included as a separate document.

## **EXHIBIT C2 – WRITTEN PROPOSAL PHASE 2**

Exhibit C2 is included as a separate document.

## **EXHIBIT D1 AND D2 – PEBB AND SEBB COST PROPOSAL TEMPLATE**

Exhibit D is included as a separate document.

## **EXHIBIT E – SERVICE AREA**

Exhibit E is included as a separate document.

## **EXHIBIT F – INTENTIONALLY BLANK**

Exhibit F intentionally left blank.

## **EXHIBIT G – PLAN DESIGN OUTLINE**

Exhibit G included as separate document.

## **EXHIBIT H – BREE COLLABORATIVE FOR COMPLEX DISCHARGE AND SDOH**

Exhibit H included as separate document.

## **EXHIBIT I – BIDDER SUBCONTRACTOR LIST**

Exhibit I included as separate document.

## **ATTACHMENT 1 – APM FRAMEWORK**

Attachment 1 is included as a separate document.

## **ATTACHMENT 2 – INTENTIONALLY BLANK**

Attachment 2 intentionally left blank.

## **ATTACHMENT 3 – MFT USER GUIDE**

Attachment 3 included as a separate document.

## **ATTACHMENT 4 – 834 COMPANION GUIDE**

Attachment 4 is included as a separate document.

## ATTACHMENT 5 – HCA BUSINESS IMPACT ANALYSIS TEMPLATE

### 1. Overview

This Business Impact Analysis (BIA) is developed by HCA as part of the contingency planning process for the {system name}{system acronym}. It was prepared on {insert BIA completion date}.

#### 1.1 Purpose

The purpose of the BIA is to identify and prioritize system components by correlating them to the mission/business process(es) the system supports and using this information to characterize the impact on the process(es) if the system were unavailable.

The BIA is composed of the following three steps:

1. **Determine mission/business processes and recovery criticality.** Mission/Business processes supported by the system are identified and the impact of a system disruption to those processes is determined along with outage impacts and estimated downtime. The downtime should reflect the Maximum Tolerable Downtime (MTD) the agency can tolerate while still maintaining the mission. The criticality of the system or data within the system is used to determine the Recovery Point Objective (RPO).
2. **Identify resource requirements.** Realistic recovery efforts require a thorough evaluation of the resources required to resume mission/business processes and related interdependencies as quickly as possible. Examples of resources that should be identified include facilities, personnel, equipment, software, licensing, data files, system components, and vital records.
3. **Identify recovery priorities for system resources.** Based upon the results from the previous activities, system resources can be linked more clearly to critical mission/business processes and functions. Priority levels can be established for sequencing recovery activities and resources and Recovery Time Objective (RTO) assigned. To successfully meet the agency's mission, the RTO should never exceed the MTD.

This document is used to build the {system name} Disaster Recovery Plan (DRP) and is included as a key component. It also may be used to support the development of other contingency plans associated with the system, including, but not limited to the Continuity of Operations Plan (COOP).

### 2. System Description

***Provide a general description of system architecture and functionality. Indicate the operating environment, physical location, general location of users, and partnerships with external organizations/systems. Include information regarding any other technical considerations that are important for recovery purposes, such as backup procedures. Provide a diagram of the architecture, including inputs and outputs and telecommunications connections.***

### 3. BIA Data Collection

Data collection can be accomplished through individual/group interviews, workshops, email, questionnaires, or any combination of these.

#### 3.1 Determine Process and System Criticality

**Step one of the BIA process** - Working with input from users, managers, mission/business process owners, and other internal or external points of contact (POC), identify the specific mission/business processes that depend on or support the information system.

| Mission/Business Process | Description                                                                                |
|--------------------------|--------------------------------------------------------------------------------------------|
| Pay vendor invoice       | Process of obligating funds, issuing check or electronic payment and acknowledging receipt |
|                          |                                                                                            |
|                          |                                                                                            |
|                          |                                                                                            |

If criticality of mission/business processes has not been determined outside of the BIA, the following subsections will help to determine criticality of mission/business processes that depend on or support the information system.

##### 3.1.1 Identify Outage Impacts and Estimated Downtime

This section identifies and characterizes the types of impact categories that a system disruption is likely to create in addition to those identified by the FIPS 199 impact level (attached below), as well as the estimated Maximum Tolerable Downtime (MTD) for a given process. Impact categories should be created and values assigned to these categories in order to measure the level or type of impact a disruption may cause. An example of cost as an impact category is provided. Organizations could consider other categories like: Agency Mission; Legal, Regulatory and Contractual; People Welfare; Financial; Reputational

##### Outage Impacts

Impact categories and values should be created in order to characterize levels of severity to the organization that would result for that particular impact category if the mission/business process could not be performed. These impact categories and values are samples and should be revised to reflect the system or service targeted by the BIA.

The following impact categories represent important areas for consideration in the event of a disruption or impact.

Impact category: {insert category name}

Impact values for assessing category impact:

- Severe = {insert value}
- Moderate = {insert value}
- Minimal = {insert value}

##### **Example impact category = Cost**

- **Severe** - temp staffing, overtime, fees are greater than \$1 million
- **Moderate** – fines, penalties, liabilities potential \$550k
- **Minimal** – new contracts,

The table below summarizes the impact on each mission/business process if {system name} were unavailable, based on the following criteria:

| Mission/Business Process | Impact Category |          |          |          |        |
|--------------------------|-----------------|----------|----------|----------|--------|
|                          | {insert}        | {insert} | {insert} | {insert} | Impact |
| Pay vendor invoice       |                 |          |          |          |        |
|                          |                 |          |          |          |        |
|                          |                 |          |          |          |        |
|                          |                 |          |          |          |        |

### Estimated Downtime

Working directly with mission/business process owners, departmental staff, managers, and other stakeholders, estimate the downtime factors for consideration as a result of a disruptive event.

- Maximum Tolerable Downtime (MTD).** The MTD represents the total amount of time leaders/managers are willing to accept for a mission/business process outage or disruption and includes all impact considerations. Determining MTD is important because it could leave the agency with imprecise direction on (1) selection of an appropriate recovery strategy, and (2) the depth of detail which will be required when developing recovery procedures, including their scope and content.
- Recovery Time Objective (RTO).** RTO defines the maximum amount of time that a system resource can remain unavailable before there is an unacceptable impact on other system resources, supported mission/business processes, and the MTD. Determining the information system resource RTO is important for selecting appropriate technologies that are best suited for meeting the MTD. To successfully meet the agency's mission, the RTO should never exceed the MTD.
- Recovery Point Objective (RPO).** The RPO represents the point in time, prior to a disruption or system outage, to which mission/business process data must be recovered (given the most recent backup copy of the data) after an outage.

The table below identifies the MTD, RTO, and RPO (as applicable) for the agency mission/business processes that rely on *{system name}*. *Values for MTDs and RPOs are expected to be specific time frames, identified in hourly increments (i.e., 8 hours, 36 hours, 97 hours, etc.).*

| Mission/Business Process | MTD      | RTO      | RPO                    |
|--------------------------|----------|----------|------------------------|
| Pay vendor invoice       | 72 hours | 48 hours | 12 hours (last backup) |
|                          |          |          |                        |
|                          |          |          |                        |
|                          |          |          |                        |

*Include a description of the drivers for the MTD, RTO, and RPOs listed in the table above (e.g., mandate, workload, performance measure, etc.).*

*Include a description of any alternate means (secondary processing or manual work-around) for recovering the mission/business process(es) that rely on the system. If none exist, so state.*

### 3.2 Identify Resource Requirements

The following table identifies the resources that compose *{system name}* including hardware, software, and other resources such as data files.

| System Resource/Component | Platform/OS/Version<br>(as applicable) | Description          |
|---------------------------|----------------------------------------|----------------------|
| <i>Web Server 1</i>       | <i>AWS EC2 Medium</i>                  | <i>Web Site Host</i> |
|                           |                                        |                      |
|                           |                                        |                      |
|                           |                                        |                      |

It is assumed that all identified resources support the mission/business processes identified in *section 3.1 Determine Process and System Criticality* unless otherwise stated.

### 3.3 Identify Recovery Strategies for System Resources

The table below lists the order of recovery for *{system name}* resources. The table also identifies the expected time for recovering the resource following a “worst case” (complete rebuild/repair or replacement) disruption.

- **Recovery Time Objective (RTO)** - RTO defines the maximum amount of time that a system resource can remain unavailable before there is an unacceptable impact on other system resources, supported mission/business processes, and the MTD. Determining the information system resource RTO is important for selecting appropriate technologies that are best suited for meeting the MTD.

| Priority            | System Resource/Component | Recovery Time Objective               |
|---------------------|---------------------------|---------------------------------------|
| <i>Web Server 1</i> | <i>AWS EC3 Medium</i>     | <i>24 hours to rebuild or replace</i> |
|                     |                           |                                       |
|                     |                           |                                       |

*A system resource can be software, data files, servers, or other hardware and should be identified individually or as a logical group.*

*Identify any alternate strategies in place to meet expected RTOs. This includes backup or spare equipment and vendor support contracts.*

[FIPS 199](#), Standards for Security Categorization of Federal Information and Information Systems

## **ATTACHMENT 6 – INTENTIONALLY BLANK**

Attachment 6 intentionally left blank

## **ATTACHMENT 7 – DISASTER RECOVERY PLAN TEMPLATE**

Attachment 7 Disaster Recovery Plan Template included as a separate document. The Disaster Recovery Plan Template will be required of HCA's Contractor(s) during the EXHIBIT B – DRAFT CONTRACT, *Attachment 3: Statement of Work* implementation.

## **ATTACHMENT 8 – FINANCIAL DETAILS**

### **Background**

The Washington Health Care Authority (HCA) continues to transform the way it pays for medical care for Members. HCA aims to improve health care by reducing the cost of health care, encouraging cost containment, and holding providers and networks accountable for financial and population health through procurement and contracts with fully insured health maintenance (HMO) or preferred provider organization (PPO). Through this procurement and ongoing analytical efforts, HCA intends to have a more targeted, actionable, and data-driven approach to health care management by incorporating a patient classification system overtop other management tools relating to risk adjustment and unit cost evaluation.

HCA has a fiduciary duty to effectively purchase and manage high quality, accessible, and affordable health insurance for Public Employees as defined by [RCW 41.05.011](#) and their eligible Dependents. In support of this obligation, HCA's goals for this procurement include:

- Ensuring access to appropriate health care services and promoting continuity of care for all Members.
- Tracking and incentivizing improvements in Members' health Outcomes over time.
- Improving and protecting the affordability of health insurance coverage for Members and for the State of Washington.

HCA intends to achieve these goals by requiring application of advanced population analytics, establishing a cost efficiency and Quality Improvement Performance Standard, and implementing price and cost growth restrictions enforced through the rate development process.

### **Annual Rate Development Methodology & Cost Controls**

#### **1. Rate Adjustment**

- A. Contractor will be required to participate in HCA's rate adjustment process for both the PEBB and SEBB programs, as detailed below. HCA will determine any risk adjustment software applied in the rate adjustment for both PEBB and SEBB programs.
- B. Rate adjustments will include the application of Risk Scores, as calculated by HCA's designated actuary for each individual population, to the final Bid Rates for the respective plan year. Rate adjustment(s) will be revenue neutral across all individual program medical plans and will be calculated and shared with the Contractor pursuant to the schedule below.
- C. All medical and pharmacy claims/encounter Data supplied by the Contractor to HCA's designated actuary, as defined in ATTACHMENT 8: FINANCIAL DETAILS, will be used in the rate adjustment process. To calculate procurement Payment Rates, interim Payment Rates, and final Payment Rates, Risk Scores will be applied to Contractor's final Bid Rates after application of a ten percent (10%) exclusion adjustment for administrative expenses.
- D. For the initial Contract Year, HCA assumes historical data for populations enrolled in Health Plans will not be available. Therefore, the Contractors Payment Rate will equal the Bid Rate for year 1 of the contract; that is, the Monthly Premiums paid to Health Plans during the first year of these new

contracts will equal the Final Bid Rates for that year. For all Contract Years following the initial year, monthly premiums will be equal to the Payment Rate.

E. The rate adjustment process will follow the general structure detailed below:

i. Step 1: Renewal Risk Score

- a. The Contractor's renewal Risk Scores include prospective risk score values provided each year during the annual RFR, with a concurrent risk score estimate for the previous plan year's future rate adjustment settlement and will be calculated and provided to the Contractor pursuant to the schedule below. The renewal risk scores used during the annual RFR will be used to calculate the initial Payment Rate, which will serve as the Monthly Premium until the final risk adjustment transfer amount is applied, as detailed in step 3 below. The Contractor's renewal Payment Rate will be calculated by applying the prospective renewal Risk Score, with any applied adjustments made by the Contractor during rate development, to only the non-administrative portion of the Contractor's final Bid Rate, as represented by the following example.

|                        |                                                  |         |
|------------------------|--------------------------------------------------|---------|
| <i>A</i>               | Final Bid Rate                                   | \$1,000 |
| <i>B</i>               | Administrative exclusion adjustment              | 10%     |
| $C = A \times B$       | Administrative portion of the final Bid Rate     | \$100   |
| $D = A - C$            | Non-administrative portion of the final Bid Rate | \$900   |
| <i>E</i>               | Renewal Risk Score                               | 1.20    |
| $F = C + (D \times E)$ | Renewal Payment Rate                             | \$1,180 |

ii. Step 2: Interim Risk Adjustment Estimate

- a. The interim Risk Score will be calculated and provided to the Contractor, pursuant to the schedule below. The interim Risk Score is a concurrent estimate based on a partial year of claims experience, and the resulting deliverable is for informational purposes only and does not reflect any final risk adjustment transfer amount or adjustments to Monthly Premiums.
- b. All medical and pharmacy Claims/encounter Data provided by the Contractor to HCA's designated actuary, as defined in Attachment 8: FINANCIAL DETAILS, will be used to calculate concurrent Risk Scores for the period described below. The Contractor's interim Payment Rate will be calculated by applying concurrent Risk Scores, calculated based on the period of Data summarized below, to the Contractor's final Bid Rates after a ten percent (10%) exclusion adjustment for administrative expenses, as described in the example above. The illustrative interim risk transfer estimate is based on the difference between the renewal Payment Rates and the interim Payment Rates, recognizing the enrolled membership through the period indicated below.

iii. Step 3: Final Risk Adjustment Settlement Transfer

- a. The final Risk Score will be calculated and provided to Contractor pursuant to the schedule below. The final Risk Score is a concurrent score based on the full twelve months of the applicable plan year, with three months of run out, and will be used to calculate the final risk adjustment transfer amount. All medical and pharmacy Claims/encounter Data, and any supplemental Data files provided by the Contractor to HCA's designated actuary, as defined in Attachment 8: FINANCIAL DETAILS, will be used to calculate concurrent Risk Scores for the period described below.
  - b. The Contractor's final risk adjustment transfer amount will be calculated by applying the concurrent final Risk Scores to the Contractor's final Bid Rates after a ten percent (10%) exclusion adjustment for administrative expenses, as described in the example in Step 1 above. The final risk adjustment transfer amount is based on the difference between the renewal Payment Rates and the final Payment Rates, recognizing the enrolled membership through December of the applicable Plan Year.
  - c. HCA will notify Contractor of the final risk adjustment transfer amount for the applicable Plan Year no later than the last calendar day of August of the next calendar year. Once the Contractor is notified of the final risk adjustment transfer amount, the Contractor, HCA, or HCA's contracted actuary will have no more than thirty (30) Business Days from the date of notification to request any adjustments to the final risk adjustment transfer amount.
  - d. Following receipt and review of any request for adjustment from any party mentioned above, HCA will notify the Contractor of any resolutions to the final risk adjustment transfer amount no later than sixty (60) Business Days from the date of request for adjustment. No further adjustments will be made to the final risk adjustment transfer amount paid to or owed by the Contractor after that date.
  - e. HCA will adjust Monthly Premiums paid to the Contractor by the final risk adjustment transfer amount during the calendar year in which the Contractor is notified of the final risk adjustment transfer amount. For example, the Contractor will be notified of the final risk adjustment transfer for Plan Year 2029 in August of calendar year 2030, and the adjustment amount will be reflected in adjustments to Monthly Premiums paid to Contractor for the remainder of calendar year 2030.
- F. Based on the information provided above, the following table illustrates the intended cadence of rate adjustment, and RFR Deliverables related to rate adjustment, for the first four (4) years of this Contract. Dates are subject to change:

|           | Plan Year 2029                        | Plan Year 2030                        | Plan Year 2031                        | Plan Year 2032                        |
|-----------|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|
| January   |                                       |                                       |                                       |                                       |
| February  |                                       |                                       |                                       |                                       |
| March     |                                       |                                       |                                       |                                       |
| April     | Renewal risk score for Plan Year 2030 | Renewal risk score for Plan Year 2031 | Renewal risk score for Plan Year 2032 | Renewal risk score for Plan Year 2033 |
| May       |                                       |                                       |                                       |                                       |
| June      |                                       |                                       |                                       |                                       |
| July      |                                       |                                       |                                       |                                       |
| August    |                                       | Plan Year 2029 final risk score       | Plan Year 2030 final risk score       | Plan Year 2031 final risk score       |
| September |                                       |                                       |                                       |                                       |
| October   |                                       |                                       |                                       |                                       |
| November  |                                       |                                       |                                       |                                       |
| December  | Plan year 2029 interim risk score     | Plan year 2030 interim risk score     | Plan year 2031 interim risk score     | Plan year 2032 interim risk score     |

G. The following schedules detail the applicable periods of claims incurred periods, run out periods, enrollment periods and due dates for data delivery to HCA's contracted actuary for the first four rate adjustment Deliverables provided in the table above: the renewal risk score for Plan Year 2030, the Plan Year 2029 interim risk score, the renewal risk score for Plan year 2031 and the Plan Year 2029 final risk score. Details for future risk score Deliverables will be updated in future contract amendments during the annual RFR cycle, and all dates are subject to change at HCA's discretion:

| Renewal Risk Scores for Plan Years 20230 and 2031                |                                                                                                                       |                                     |
|------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------|-------------------------------------|
| <i>Prospective and concurrent risk score estimates</i>           | Plan Year 2030                                                                                                        | Plan Year 2031                      |
| <b>Claims incurred period</b>                                    | January 1, 2028 - December 31, 2028 (claims from previous period applied to populations enrolled with new Contractor) | January 1, 2029 - December 31, 2029 |
| <b>Claims paid through period</b>                                | February 2029                                                                                                         | February 2030                       |
| <b>Enrollment through period</b>                                 | February 2029 (applies results of 2029 Annual Open Enrollment for carrier specific risk scores)                       | February 2030                       |
| <b>Data required to be delivered to HCA's contracted actuary</b> | N/A; HCA will provide enrollment file                                                                                 | March 30, 2030                      |
| <b>HCA delivery of risk scores to Contractor</b>                 | April 2029                                                                                                            | April 2030                          |

| <b>Interim Risk Score for Plan Year 2029</b>                     |                                   |
|------------------------------------------------------------------|-----------------------------------|
| <i>Concurrent risk score estimates</i>                           |                                   |
| <b>Claims incurred period</b>                                    | January 1, 2029 - August 31, 2029 |
| <b>Claims paid through period</b>                                | August 31, 2029                   |
| <b>Enrollment through period</b>                                 | August 2029                       |
| <b>Data required to be delivered to HCA's contracted actuary</b> | October 31, 2029                  |
| <b>HCA delivery of risk scores to Contractor</b>                 | December 2029                     |

| <b>Final Risk Score for Plan Year 2029</b>                       |                                     |
|------------------------------------------------------------------|-------------------------------------|
| <i>Concurrent risk score for final settlement</i>                |                                     |
| <b>Claims incurred period</b>                                    | January 1, 2029 - December 31, 2029 |
| <b>Claims paid through period</b>                                | March 31, 2030                      |
| <b>Enrollment through period</b>                                 | December 2030                       |
| <b>Data required to be delivered to HCA's contracted actuary</b> | April 30, 2030                      |
| <b>HCA delivery of risk scores to Contractor</b>                 | August 2030                         |

### **HCA's approach to population health analytics**

HCA believes effective healthcare purchasing is predicated on the ability of Health Plans to improve the health of members through innovative and efficient care strategies. Successful Bidder(s) will have the ability to (1) deliver high-quality care, (2) have knowledge, experience, and capacity to clinically integrate care, (3) be accountable financially and clinically for a defined population and, (4) produce measurable improved population health Outcomes.

A core tenet of this fully insured Health Plan procurement, and the resulting contractual arrangements, will be seeking to encourage further focus on clinical management of the PEBB and SEBB enrolled populations through a patient classification methodology. The PEBB and SEBB populations will be clinically stratified into four distinct patient classification subgroups and HCA will use a Benefit Cost Ratio (BCR) calculation to evaluate Health Plan efficiency of care. It is HCA's intention to engage in reporting and collaborative discussions regarding patient classification and BCR frameworks throughout the contract period, using this information to inform rate negotiation discussions, rate development, and plan performance.

To provide a transparent and powerful analytical foundation of accountability, HCA will use two key software solutions to measure whether carriers are meeting expectations for delivering cost effective value-based care to enrolled members:

- Solventum/3M™ Clinical Risk Group (CRG) software to classify all individuals into clinical risk groups and,
- Milliman Advanced Risk Adjuster (MARA) risk adjustment software to better assess required clinical resources at the individual and population levels.

HCA will not require a Successful Bidder to license the software, but both CRG and MARA software solutions may be used in additional PEBB and SEBB program methodologies, including but not limited to: rate development calculations, annual risk adjustment payments, population health-based analysis, and provider outcomes/efficiency reports. Any Successful Bidder(s) or eventual contractor can elect to license both tools to apply in parallel analytics to their respective populations.

### **3M's Clinical Risk Grouper (CRG) Software, Milliman Advanced Risk Adjuster (MARA), and Population Classification**

The CRG grouper software allows HCA and any Successful Bidder clear, concise, and clinically relevant definitions when analyzing an underlying or applying risk-based methodologies. The grouper software uses claims data to group members into mutually exclusive clinical risk groups using medical claims, pharmacy claims, diagnosis codes, and procedure code(s). Every Member receives a CRG assignment, and details can be scaled from Member specific insights up to population averages and summaries.

The grouper's logic assigns a numerical ranked value for "health status" ranging from 0 (non-utilizer) to 9 (catastrophic condition(s)) defined in Table 8.1. The health status is a hierarchical value and provides indication of the types of condition categories for a member, where health status 1 (healthy) does not indicate significant health conditions, where health status 9 (catastrophic condition(s)) includes' long-term dependency on medical or pharmaceutical health intervention/technology or exhibit life-depending conditions requiring frequent medical care.

The grouper logic also assigns a value for severity of the illness (SOI), or how complex a patient's disease state might be given underlying claims data. The severity of illness is a ranked value from 00 (non-user) to 06 (high degree of severity). The grouper ultimately assigns every Member a mutually exclusive CRG that is intended to encapsulate a metric for health status and the severity of illness for all of a Member's underlying condition categories. To learn more about the entire grouper software, visit the website [here](#).

**Table 8.1. 3M CRG Patient Classification Health Status Summary Table\***

| Group Identifier | Group Status                                    | Summary Description                                                                                                                                                  |
|------------------|-------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 0                | Non-User                                        | Active Member without medical or pharmaceutical claims within the Health Plan year.                                                                                  |
| 1                | Healthy                                         | Active Member with at least one (1) medical and/or pharmacy claim. Claims denote absence of any significant acute disease occurring within the Health Plan year.     |
| 2                | History of Significant Acute Disease            | Active Member with at least one (1) medical and/or pharmacy claim. Claims denote a history of an acute condition.**<br>e.g. Pneumonia, Premature Newborns            |
| 3                | Single Minor Chronic Disease                    | Active Member with at least one (1) medical and/or pharmacy claim. Claims denote a single (1) minor chronic condition/disease.<br>e.g. Migraine                      |
| 4                | Minor Chronic Disease in Multiple Organ Systems | Active Member with at least one (1) medical and/or pharmacy claim. Claims denote two (2) or more minor chronic condition/disease.<br>e.g. Migraine + Thyroid disease |

|   |                                                         |                                                                                                                                                                                                                                                                                                                                                                  |
|---|---------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 5 | Single Dominant or Moderate Chronic Disease             | Active Member with at least one (1) medical and/or pharmacy claim. Claims denote a single (1) dominant or moderate chronic condition/disease.<br><br>e.g. Diabetes                                                                                                                                                                                               |
| 6 | Significant Chronic Disease in Multiple Organ Systems   | Active Member with at least one (1) medical and/or pharmacy claim. Claims denote two (2) or more dominant or moderate chronic condition/disease.<br><br>e.g. Congestive Heart Failure (CHF) + Diabetes                                                                                                                                                           |
| 7 | Dominant Chronic Disease in Three or More Organ Systems | Active Member with at least one (1) medical and/or pharmacy claim. Claims denote three (3) or more dominant condition/disease. One (1) condition may be a moderate chronic condition/disease.<br><br>e.g. CHF + Diabetes + Chronic obstructive pulmonary disease (COPD)                                                                                          |
| 8 | Malignancy, Under Active Treatment                      | Active Member with at least one (1) medical and/or pharmacy claim. Claims denote a malignancy and Member is undergoing active treatment.<br><br>e.g. Lung malignancy + chemotherapy                                                                                                                                                                              |
| 9 | Catastrophic Condition                                  | Active Member with at least one (1) medical and/or pharmacy claim. Claims denote long-term dependency on medical supplies, medical technology, and life-defining chronic disease/condition dominating medical care required.<br><br>e.g. history of major organ transplant, acquired quadriplegia, cystic fibrosis, use of dialysis, use of parenteral nutrition |

\* Examples of conditions/diagnoses are not in totality or exclusive. These are examples used by Solventum Medical in webinars for overview of 3M CRG assignment process.

\*\* Pregnancy may override Status 2 and identify individual in Status 3-6 depending on medical services needed or diagnoses/health status changes during pregnancy.

HCA intends to structure future reporting, plan performance measurement, rate negotiation discussions and population health analytics using a patient classification methodology; CRG health status and severity of illness serve as the foundation for organization and classification of Members into four (4) clinically relevant population subgroups.

**Figure 8.2. HCA's Population Classification Matrix**

| Patient Classification CRG Matrix                      |                                                  |
|--------------------------------------------------------|--------------------------------------------------|
| Health Status                                          | Severity of Illness                              |
|                                                        | 01 02 03 04 05 06                                |
| 0 Non-utilizer                                         | Subgroup 1<br>Healthy                            |
| 1 Healthy                                              |                                                  |
| 2 Significant acute disease                            | Subgroup 2a<br>Minor acute/chronic conditions    |
| 3 Single minor chronic                                 |                                                  |
| 4 Minor chronic in multiple organ systems              | Subgroup 2b<br>Moderate acute/chronic conditions |
| 5 Single dominant or moderate chronic disease          |                                                  |
| 6 Significant chronic disease multiple organ systems   | Subgroup 3<br>Catastrophic conditions            |
| 7 Dominant chronic disease three or more organ systems |                                                  |
| 8 Malignancy                                           |                                                  |
| 9 Catastrophic conditions                              |                                                  |

The key objective of stratifying PEBB and SEBB populations into population subgroups is to encourage a Successful Bidder to focus management efforts on segments of the population that require additional care management or Care Coordination. Through utilization of the CRG software, HCA hopes a clinically relevant grouping logic will help hold providers, provider

networks, and any Successful Bidder more accountable to the care provided to members, resulting in improved member Outcomes.

In combination with population classification, HCA will utilize the Milliman Advanced Risk Adjusters (MARA) software (or an alternative grouping/risk adjustment software as selected by HCA) to assist in measuring the clinical resource intensity required to treat all of a member's underlying condition categories. MARA is currently used as the singular risk adjustment tool in the PEBB and SEBB programs. Risk Scores are calculated using the same claims detail inputs as the CRG software (medical procedure codes, diagnosis codes and pharmacy data gleaned from detailed claims) and are applied to each member in a population to assist in establishing both a projected (prospective) and actual (concurrent) cost of care for an underlying population. The Successful Bidder is expected to submit data to HCA's third-party actuary on a regular cadence, as defined in *ATTACHMENT 9 REQUIRED CLAIMS FIELD DATA*.

## **ATTACHMENT 9 – REQUIRED CLAIMS DATA FIELDS**

Attachment 9 Required Claims Data Fields included as a separate document.

## ATTACHMENT 10 – ASB TECHNICAL REQUIREMENTS

| Timeline Category | Number | Requirement                                                                                                                                                                                                                     | Start Date | End Date | Internal Notes                                                                                                                                                                                                                                                                                                              |
|-------------------|--------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------|----------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| MFT Test          | 1.0    | ASB is required to establish an account with the Managed File Transfer(MFT) testing site. If a service account is being set up, HCA will require a current SSH key. ASB may need to send HCA a list of approved senders.        |            |          | Attachment 3 Statement of Work Section 8 Implementation 8.1.C.iii.<br>By March 31, 2028, Contractor must establish an account with the Managed File Transfer (MFT) testing site. If a service account is being set up, HCA will require a current SSH key. Contractor may need to send HCA a whitelist of approved senders. |
| MFT Test          | 1.1    | ASB is required to successfully send and/or receive files in the MFT test environment prior to and during testing.                                                                                                              |            |          | Attachment 3 Statement of Work Section 8 Implementation<br>8.1.C.iv. During April 2028, ASB must successfully send and/or receive files in the MFT test environment prior to and during testing.                                                                                                                            |
| Requirements      | 2.0    | ASB is required to designate a technical lead for all testing activities.                                                                                                                                                       |            |          | Attachment 3 Statement of Work Section 8 Implementation - Bidder must support HCA's designated Annual Open Enrollment activities each fall, including, but not limited to, develop and deliver communications, attend benefit fairs, process eligibility files, etc.                                                        |
| Requirements      | 2.1    | HCA will prepare internal business requirements for Fully Insured Implementation. ASB is required to review with HCA to ensure HCA considers any particular business requirements from the ASB that may be needed on their end. |            |          |                                                                                                                                                                                                                                                                                                                             |
| Requirements      | 2.2    | ASB is required to follow the most current 834 Companion Guide. See ATTACHMENT 18 – 834 COMPANION GUIDE. If the ASB has concerns or questions about any aspect of the guide,                                                    |            |          | Attachment 3 Statement of Work 2.2 Eligibility Files and File Systems B<br>Accept and ingest daily HIPAA Compliant 834 Eligibility                                                                                                                                                                                          |

|                   |     |                                                                                                                                              |  |  |                                                                                                                                                                                                                                                            |
|-------------------|-----|----------------------------------------------------------------------------------------------------------------------------------------------|--|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                   |     | the ASB will contact HCA for guidance.                                                                                                       |  |  | Files according to the process outlined in ATTACHMENT 13: DATA SHARING TERMS in the format detailed in ATTACHMENT 18 834 COMPANION GUIDE.                                                                                                                  |
| Requirements      | 2.3 | ASB is required to be able to correctly process all new enrollment, enrollment change, and enrollment termination scenarios provided by HCA. |  |  |                                                                                                                                                                                                                                                            |
| Analysis & Design | 3.0 | ASB is required to analyze and design their system in preparation for Fully Insured Implementation testing.                                  |  |  |                                                                                                                                                                                                                                                            |
| Analysis & Design | 3.1 | ASB is required to report any issues or delays in system analysis and design to HCA in a timely manner.                                      |  |  |                                                                                                                                                                                                                                                            |
| Testing           | 4.0 | ASB is required to participate in all Fully Insured Implementation testing activities.                                                       |  |  | Attachment 3<br>Statement of Work 2.2<br>Eligibility Files and File Systems I. Eligibility<br>Participate in file-mapping and file testing processes during implementation of Health Plans and at any necessary occasion during the life of this Contract. |
| Testing           | 4.1 | ASB is required to do any necessary volume testing related to Fully Insured Implementation.                                                  |  |  | Attachment 3<br>Statement of Work 8<br>Implementation<br>8.1.C.xii: Between July 26, 2028, and August 20, 2028, participate in volume testing of HIPAA Compliant 834 Eligibility Files and Contractor file systems.                                        |
| Testing           | 4.2 | ASB is required to report any issues to the designated HCA ticketing system to ensure accurate tracking of any reported issues.              |  |  |                                                                                                                                                                                                                                                            |
| Testing           | 4.3 | At the conclusion of the testing period the ASB is required to confirm with HCA in writing that the testing was successful.                  |  |  |                                                                                                                                                                                                                                                            |
| Stabilization     | 5.0 | ASB is required to work with HCA during the stabilization period and report any issues.                                                      |  |  |                                                                                                                                                                                                                                                            |

|                               |     |                                                                                                                                        |  |  |                                                                                                                                                                                                                                                                                     |
|-------------------------------|-----|----------------------------------------------------------------------------------------------------------------------------------------|--|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Post Open Enrollment (Annual) | 6.0 | ASB is required to successfully ingest the Annual Open Enrollment file at the conclusion of each year's Annual Open Enrollment period. |  |  | Attachment 3 Statement of Work 2.3<br>Enrollment Provisions C Enrollment Bidder must support HCA's designated Annual Open Enrollment activities each fall, including, but not limited to, develop and deliver communications, attend benefit fairs, process eligibility files, etc. |
|-------------------------------|-----|----------------------------------------------------------------------------------------------------------------------------------------|--|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

## **ATTACHMENT 11 – WATECH IT SECURITY CHAPTER**

[WaTech Security Chapter policies](#) are included by reference.

## ATTACHMENT 12 – PRE-PROPOSAL CONFERENCE AGENDA

|                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                    |
|----------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------|
| <b>Date</b>                            | <b>October 20, 2026</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                    |
| <b>Time</b>                            | 11:00AM – 12:00PM PT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                    |
| <b>Microsoft Teams Meeting Details</b> | <p>The Pre-Proposal Conference will be hosted virtually on the Microsoft Teams platform. HCA requests that interested participants internally test their access to Teams prior to the scheduled meeting time.</p> <p><b>Microsoft Teams meeting</b></p> <p><b>Join:</b><br/> <a href="https://teams.microsoft.com/join/229427348778832?p=Xc2zEyvGrodj6CilXE">https://teams.microsoft.com/join/229427348778832?p=Xc2zEyvGrodj6CilXE</a><br/>           Meeting ID: 229 427 348 778 832<br/>           Passcode: Ea6Zs9Li</p> |                    |
|                                        | <p><a href="#">Need help?</a>   <a href="#">System reference</a></p> <p><b>Dial in by phone</b><br/> <a href="#">+1 564-999-2000,,284006060#</a> United States, Olympia<br/> <a href="#">(833) 322-1218,,284006060#</a> United States (Toll-free)<br/> <a href="#">Find a local number</a><br/>           Phone conference ID: 284 006 060#</p>                                                                                                                                                                             |                    |
|                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                    |
|                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                    |
| <b>Topic</b>                           | <b>Time/Duration</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | <b>Facilitator</b> |
| <b>Welcome and Introductions</b>       | 11:00 a.m. – 11:05 a.m.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Sean Gregory       |
| <b>Solicitation Schedule</b>           | 11:05 a.m. – 11:10 a.m.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Sean Gregory       |
| <b>Evaluation Overview</b>             | 11:10 a.m. – 11:25 a.m.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Sean Gregory       |
| <b>Program Overview</b>                | 11:25 a.m. – 11:40 a.m.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Beth Heston        |
| <b>Financial Overview</b>              | 11:40 a.m. – 11:55 a.m.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Sara Whitley       |
| <b>Questions/Discussion</b>            | 11:55 a.m. – 12:00 p.m.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | All                |

HCA will be bound only by written answers to questions provided by the RFP Coordinator. Questions arising during the pre-proposal conference will be documented and answered in written form as an amendment to the solicitation.

### HCA Key Personnel

- Beth Heston, HCA Contract Manager
- Sara Whitley, ERB Finance Unit Manager
- Sean Gregory, RFP Coordinator