

CT State Teachers' Retirement Board

Request For Information # 012014 EGWP Drug Plan

Prepared by Bargained Plans LLC

Table of Contents

Section	Title	Page
1.0	Overview	1
2.0	Scope of Services	3
3.0	Financing Devices	5
4.0	Schedule	5
5.0	Time Table	6
6.0	Current Program	7
7.0	Nature of Underlying Program	9
8.0	Plan Performance	11
9.0	Mail Order and Generic Util. Stat.	14
10.0	State Contract Form	20
	Questionnaire	21

1.0 Overview

The Connecticut State Teachers' Retirement Board (TRB) is a governmental plan with approximately 100,000 members. This includes approximately 35,000 retired members as well as 54,000 active members. Participation in the program is statutory as per the Connecticut General Statutes, Chapter 10-167(a). Membership is limited to certified teachers and administrators and individuals identified under the statute. In addition to the pension program provided to retired teachers and administrators the TRB also offers a Medicare supplement plan to eligible retired members and dependents who have an election to opt in.

The TRB medical program includes a medical coverage provided for in Section 10-183(t). This section provides for an indemnity style benefit under an excess of Medicare program. The prescription drug program (the subject of this Request For Information) is delivered by a Pharmacy Benefit Manager (PBM), the incumbent vendor being Caremark. The TRB pays the costs of the program and then seeks the subsidy from CMS. The TRB also provides a dental program and a vision and hearing program.

The program is funded by a variety of sources including the retiree (by means of cost share), active employees (who contribute 1.25% of their salary) and the State of Connecticut that contributes between 25 and 33 percent of the cost of the plan, less the receipt of the drug subsidy. Current enrollment in the TRB Medicare supplement plan is over 22,000. The enrollment in the program has doubled over the last decade and is growing at a rate of over 1,000 members per year. Table one shows the growth in enrollment over the ten-year period from January 1 of 2004 through January 1 of 2014. The Table shows that over the period the enrollment has increased by just over 1,000 members per year. The increase has however accelerated over the most recent years with almost 1,800 new members in 2013 and 1,400 new members in 2012. This dramatic growth is thought to be the product of three factors: the retirement of teachers hired to teach baby boomers, the continued longevity of the teacher population and the changes in the teaching profession due to the recession.

Table 1	
TRB Prescription Drug Plan Enrollment	
Year January 1 Enrollment	Enrollment Number of Members
2004	11,561
2005	11,930
2006	12,302
2007	12,883
2008	13,710
2009	15,310
2010	16,090
2011	17,430
2012	18,905
2013	20,365
2014	22,103

2.0 Scope of Services

The TRB is the agency authorized by the Connecticut General Statutes to operate retiree medical programs for retired teachers and other statutorily covered individuals. The administrator of the Agency is Ms. Darlene Perez. Ms. Perez reports to a Board of 14 individuals. The Board has members who are elected by the active and retired teachers or appointed by the Governor. Members of the Board are identified as representing active teachers, retired teachers and the public. The TRB operates as an agency of the State of Connecticut and follows the purchasing procedures and regulations of the State. The State of Connecticut is the ultimate purchaser of the goods and services. Besides providing the TRB with an understanding of firms' abilities this process will allow the Agency to evaluate the relative economic difference between the direct provision of pharmacy services and the use of an Employer Group Waiver Program (EGWP) as the basis of the delivery of services.

The TRB is interested in identifying firms that have the ability to provide the prescription drugs services (including specialty drugs) to the members of the TRB plan using an EGWP mechanism. Given the changes in the Federal programs, TRB is trying to evaluate whether to move from a traditional PPO Pharmacy Benefit Plan with the TRB receiving the subsidy to an integrated program with the PBM or insurer coordinating with CMS rather than the TRB performing those tasks.

The TRB is interested in receiving a full set of services from the vendor. This includes: communication with the membership on issues concerning the plan operation (through a communication budget), pricing assistance in setting premiums and assistance with plan designs so that a similar as possible program can be designed within the constraints of Federal rules. As this is a Request For Information (as compared with an Request For Proposals) it is the initial

examination of the abilities of firms' to provide service and not the mechanism used to award a service agreement.

We are interested in receiving information from potential vendors (managed care organizations or PBM's) that will allow the TRB to evaluate 1) Whether to make the change to an EGWP and 2) if the TRB decides to change, to identify the abilities of vendors to perform the necessary tasks.

The rationale of the TRB is that the structure of an EGWP with wrap-around secondary plan provides for two separate but integrated programs. The first is a type of Medicare Part D program offered to the plan members called an EGWP. The second part is a non-Part D plan where benefits are integrated or "wrapped" around the EGWP benefits so that the combined plans benefits reflect something similar to original benefit design prior to the EGWP + Wrap conversion. Because of financial arrangements that are favorable to the plan membership it may be possible to maintain a high quality program without the level of annual cost increases that have plagued TRB just a few years ago.

CMS asserts that the 50% Discount Program under PPACA applies to EGWPs as well as traditional Part D plans. Under PPACA, starting in 2011, 50% of the cost of brand name drugs incurred in the Part D donut hole will be paid for by participating drug manufacturers. CMS said that the discount would be applied before any additional coverage provided under a non-Part D plan, this gives rise to significant potential for savings under which any brand name prescription drug coverage in the Part D donut hole is provided by a secondary, non-Part D plan.

A lesser source of savings comes from the CMS opinion, which provides for amounts paid under the Discount Program to count as if paid by the participant, for purposes of meeting the Out-of-Pocket threshold for catastrophic coverage under Part D. This will result in more members qualifying for catastrophic coverage under Part D, which is primarily funded by reinsurance dollars from CMS.

While there are certain positive attributes that have encouraged the TRB to examine the use of the EGWP concept there are certain concerns that the Board has identified. An EGWP arrangement has potential pitfalls. For instance, EGWP + Wrap plans are more complex to administer. While the drug benefit vendor handles most of the burden, there will be additional fees for administering these plans. However, the cost savings from converting to an EGWP + Wrap will likely be larger than these additional costs. Another consideration is the increased level of retiree communications required on the EGWP plan, which when combined with additional communications explaining the secondary plan and overall impact on benefits may confuse older retirees. Any plan proposed would have to overcome these hurdles. Potential vendors will be encouraged to comment on these issues in the questionnaire.

3.0 Financing Devices

The TRB is interested in receiving information on potential plan costs both on a self-funded and insured basis. The premise here is that there are expected savings associated with plan design and by better using federal subsidies. Given these cost reductions the Board may be interested in some certainty during the initial period of such an arrangement. Therefore the Board is seeking information on both types of plans and welcomes RFI responses that respond on a both or either basis.

4.0 Schedule

The TRB schedule is identified below. Upon receiving the RFI we request that companies that are interested indicate that they would like to participate. This is done so that we can provide answers to questions to all participants. Questions about the TRB and its needs may be sent to Ms. Perez between January 21 and February 5. Any question asked by a respondent will be sent to all interested firms. There is no requirement that a potential vendor identify themselves prior to the due date for responses. It may however be useful for the vendor to have copies of the

questions. Thus we suggest, but do not require that responders notify us of their intent to participate so that we can share any updates or responses to questions.

5.0 Time Table

January 21, 2014	Release of RFI
February 10, 2014	Indication of interest
January 21- February 5	Question period
February 11, 2014	Responses Due No Later Than Noon
February 18, 2014	Health Insurance Sub Committee Meeting The TRB may request presentations for this date
March 12, 2014	Board Meeting – Direction From Board
January 1, 2015	Potential change in Program

Expressions of interest and questions may be sent by email to Ms. Darlene Perez at Darlene.Perez@ct.gov

Five copies of submissions are to be delivered by noon on February 11 to the attention of Ms. Perez at the TRB office:

Ms Darlene Perez
Administrator
CT Teachers' Retirement Board
765 Asylum Avenue
Hartford, CT 06105-2822

6.0 Current Program

The current program is a three-tier PPO based Rx model. There is an annual calendar year deductible of \$250 Per member (again members are each individual as there is no family coverage under the plan). Thus a retired couple would have a \$500 deductible for the two individual members. The tiers are set at percentage copays rather than the typical dollar based copays. Following is a description of the plan cost shares required of members.

6.1 Member Costs

Deductible \$250 (per member calendar year)

Coinsurance levels Retail Pharmacy

Non-Maintenance Medications:

For Generic drugs	5%
For Preferred drugs	20%
For Non-Preferred drugs	30%

For individuals who select to use retail pharmacies to fill their maintenance drug needs there is a penalty equal to 5% of the cost of the drug. Thus the cost share increases to:

For Generic drugs	10%
For Preferred drugs	25%
For Non-Preferred drugs	35%

This penalty coinsurance only applies after the first fill for the drug (or new dosage) has been completed at the lower copay level. Clearly the member has the option to

use mail order for new scripts. Given the potential for immediate need for the drug the first script is not required to be done by mail and that is acknowledged by the cost share structure.

For maintenance drugs purchased at mail order the cost shares are:

For Generic drugs	5%
For Preferred drugs	10%
For Non-Preferred drugs	20%

The maximum out of pocket per member per calendar year from deductible and coinsurance is limited to \$1,000. Again the out of pocket is per member so a couple will have a combined out of pocket of \$2,000 with each being responsible for \$1,000 (including the deductible) during the calendar year.

A very high percentage of the drugs used are filled by mail order. This occurs because of the nature of the population (all over age 65 retirees) and the nature of the drugs used. This sets up an important administrative issue for any potential vendor. Members who use an unusually high percentage of mail order drugs where the copays that are based upon a percentage of drug cost need to know what the cost of the drug will be. real time pricing has to be available at both retail and especially at mail order point of service.

The goal here is to produce an EGWP plan that as closely as possible reflects the current benefit in a manner as similar to the current plan as possible while taking advantage of the favorable economics of PPACA. The questionnaire highlights this goal and any response should focus on the ability to deliver a similar product.

The cost shares for specialty drugs would be the same for drugs normally provided through a retail pharmacy. Drugs that are Medicare specialty drugs are currently handled through the medical plan.

A further description of TRB programs may be found in on the TRB website www.ct.gov/trb.

7.0 Nature of the Underlying Population

To become a member of the TRB health plan one must be a participant in Medicare parts A and B. The health plan is of high quality including both a supplement plan and a major medical on top of the supplement plan. The health plans members participated in during their careers also tended to be of high quality. To be a career teacher in Connecticut one must have a Bachelors degree to be hired and complete a master's degree early in their career. The average salary at retirement is currently slightly over \$80,000 per year. The typical pension is 70% of the retiree wage and the pension has a cost of living adjustment annually.

The vast majority of the population is married at the time of retirement. The average age of individuals in the plan is currently just over age 75.

Thus, the population is relatively ideal for reaching substantive levels of longevity. While that is the goal of the program, it creates specific service requirements. Any firm taking on the effort of servicing this population must understand that there is a significant portion of the population who are in their 80's and 90's. Thus, the vendor must have specific skills and methods to deal with an elderly population. Moreover the portion of the population that is frail and at advanced ages is substantial and increasing. Given the nature of the employment of the underlying active population and the educational requirements for being a teacher in Connecticut there are not likely problems with literacy or problems with English comprehension for the employee. While there could be some such problems for spouses the incidence is likely to be relatively low. Staffing with regards to limitation associated with aging is likely to be a substantial need in care centers.

7.1 Geographic Distribution of the Population

The population of retired teachers is spread around the country and to some degree the world. The largest residence location of the retirees is Connecticut with the second most common location being Florida. Many members live in the North (Connecticut and Massachusetts) and spend the winter months in warmer climates (Florida and North Carolina). Thus a geographic distribution of participating providers is Critical. A zip code listing of the member locations is available electronically and potential vendors are encouraged to access http://www.ct.gov/trb/lib/trb/formsandpubs/TRB_Zips.pdf for a Pdf file or http://www.ct.gov/trb/lib/trb/formsandpubs/Trb_Zips.xls for an excel file. These data must be interpreted carefully as many of the retirees spend the winters in warm climates and often change their address by season. Additionally, the data is for unique addresses not by member. Thus there are only a little more than 17,000 in the count. This reflects that many of the members have two members living at the same address. While the majority of members entering the program are married the older portion of the population becomes more female as time passes given the propensity for teachers to be female and the substantial difference in longevity between the genders.

In addition to members located across the United States there are a number of members that spend a considerable amount of time outside the United States. Such members do not have coverage for routine care nor may they receive non-emergency drugs to addresses outside the United States. A number of individuals do live primarily outside the United States and return to the United States for care and to replenish drug supplies.

8.0 Plan Performance

As the medical plan is excess of Medicare and the Prescription drug plan is first dollar coverage, therefore the primary expense of the program accounting for approximately 55% of the plan costs. The average age is 75.1 years old and there are significant drug expenses compared to an active employee group. The total and net drug plan spend over the last two and a half years is illustrated in Table two.

Table 2				
Gross and Net Drug Spend				
Period	Gross spend	Net Spend	Gross PMPY	Net PMPY
1/1-6/3- 2013	\$27,216,546	\$19,898,904	\$2,664	\$1,956
1/1-12/31 2012	\$52,726,783	\$42,856,953	\$2,713	\$2,205
1/1-12/31 2011	\$50,127,479	\$40,383,505	\$2,814	\$2,267

Please Note: Six-month data is not directly proportional as the deductible is based upon a calendar year.

Table two demonstrates that the per unit drug costs have been declining. This is primarily attributed to the maintenance drugs, heavily used by seniors, coming off patent. Over the last five years the drug program has been heavily focused on encouraging the usage of mail order drugs and generics. Overall the effort has been successful. Costs increases per unit have been relatively modest over the last several years and have trended down over the last couple of years. Specialty drugs have, to some degree, been problematic composing an increasing share of the mix over the last several years. Table three outlines the recent trend for the major components of the plan.

Table 3		
Pharmacy Trends		
Trend element	Calendar year 2011	Calendar year 2012
Gross Trend PMPM	-3.3%	-3.6%
Non Specialty Gross Trend	-4.5%	-3.5%
Specialty Gross Trend	12.5%	37.2%
Price Inflation	6.9%	2.3%
Utilization	-8.3%	-1.8%
Drug Mix	-1.3%	-4.0%

Table three demonstrates that costs have declined for non-specialty drugs while specialty drugs have increased substantially. Given that unit prices have increased, although at a lower level this did not result in unit cost increases because of the change in the mix.

The Board believes the current vendor has experienced administrative difficulties that have affected mail order utilization. Table four indicates that there was an actual drop in the percentage of drugs provided through mail order between 2012 and 2013. This has reversed a long-term trend towards increased level of mail order services for the TRB. Given that there is a specific financial incentive for the use of mail order (5% of drug plan costs) there is an expectation that mail order will be a major component of the program.

Table four provides a summary of plan operating parameters. The average age of participants continues to grow showing a half-year increase in a one-year period. Table four also identifies the mail order and generic utilization. The use of generic drugs is encouraging and has been a major force in cost reduction. Spend by tier and source are also identified in Table four. The class's generic, name brand and non-formulary name brand are cross-listed by retail versus mail order delivery. These parameters all seem to moving in the right direction with movement towards less expensive substitutes growing. The only outstanding difficulty with current plan operation is the failure of the mail order program to achieve more share.

Table 4		
Plan Parameters		
	2012	2013
Avg. Eligible Users	19,000	20,404
Average Member Age	74.6	75.1
Avg. Utilizers	71.3%	72%
Gross Cost PM	\$219	\$222
Net Cost PM	\$161	\$163
Member Cost Share	26.8%	26.9%
Single Source Brands	23.8%	20.4%
Multi Source Brands	1.8%	1.5%

Generic Dispensing Rate	74.4%	78.1%
Generic Substitution Rate	97.6%	98.1%
Total Scripts	580,920	630,306
% Retail	76.8%	77.9%
% Mail	23.2%	22.1%
Days Supply	104	103
Specialty gross cost PMPM	\$25	\$29
Specialty % Total Gross Cost	11.2%	13.1%
Specialty % of Total Scripts	.3%	.4%

9.0 Mail Order and Generic Utilization Statistics

The top ten therapeutic classes listed by spend and members are identified in Table five. This utilization includes both retail and mail order delivery. The therapeutic class stability tends to be very high and spend appears to be primarily affected by changes in costs that are associated with patent expirations.

Table 5				
Top Therapeutic Classes				
Rank	Previous rank	Therapeutic Class	Gross Cost	Utilizing members
1	1	Antihyperlipids	\$7,552,066	10,702
2	3	Antidiabetics	\$3,782,269	2,489
3	2	Antiasthmatic	\$3,711,210	8,895
4	5	Ulcer drugs	\$3,692,149	2,614
5	4	Ophthalmic	\$3,080,856	4,845
6	7	Antineoplastic	\$2,139,509	4,327
7	11	Psychotherpuetic	\$2,001,359	665
8	6	Analgesics	\$1,907,041	775
9	12	Analgesics	\$1,845,552	2,993
10	8	Antidepressants	\$1,788,480	4,124

Table six identifies the most common drugs categorized by the number of doses used by our members. The classes of drugs used have stayed relatively similar over time as the need for the drugs has stayed relatively constant. The only significant change here has been the level of drugs used in specific brands given the change in patent expirations. Statins are the most used drugs however the brand and cost has changed dramatically as the first and second drugs were previously the highest

spend drugs (i.e. Lipitor and Zocor). Name brand drugs are identified in Bold.

Table 6			
Most Common Drugs by Doses			
Rank	Drug	Gross Cost	Total Users
1	Atorvastatin Calcium	\$2,586,182	4,241
2	Simvastatin	\$128,412	3,147
3	Lisinopril	\$73,244	2,737
4	Metoprotol	\$647,644	2,448
5	Amlodipine	\$105,446	2,546
6	Hydrochlororothiazide	\$55,012	2,130
7	Atenolol	\$34,301	1,398
8	Omeprazole	\$136,371	1,849
9	Synthroid	\$46,390	2,009
10	Crestor	\$1,677,787	1,416
11	Levothyroxine Sodium	\$69,067	1,521
12	Furosemide	\$27,671	1,648
13	Metoprolol Tartrate	\$39,294	1,408

14	Warfarin	\$60,485	1,364
15	Tamsulosin	\$171,727	1,284
16	Metformin	\$47,835	1,150
17	Nexium	\$1,842,023	1,133
18	Losartan Potassium	\$202,235	5,737
19	Diovan	\$913,961	903
20	Pravastatin	\$38,629	927
21	Synthroid	\$149,353	2,009
22	Allopurinol	\$23,984	4,427
23	Pantoprazole sodium	\$147,875	902
24	Zolpiderm	\$17,452	1,106
25	Zetia	\$775,045	634

Bold face denotes a brand name drug.

Table seven provides the top drug usage by cost. This list is dominated by name brand drugs with nine of the top ten drugs being classified as name brands. There are opportunities for cost reduction as some of these drugs, most notably Nexium, is coming off patent. Again, the bold print signifies name brand drugs.

Table 7**Drugs by Spend**

Rank	Drug	Gross Cost	Utilizers
1	Crestor	\$937,724	1,321
2	Nexium*	\$907,358	940
3	Atorvastatin	\$847,447	4,203
4	Diovan	\$529,497	836
5	Revlimid	\$509,289	14
6	Advair Diskus	\$472,433	539
7	Zetia	\$423,148	565
8	Spiriva	\$413,999	388
9	Januvia	\$405,662	343
10	Cymbalta*	\$381,276	342
11	Enbrel	\$372,518	32
12	Namenda	\$367,651	314
13	Celebrex	\$321,302	522
14	Metoprolol	\$299,629	2,338

15	Pradaxa	\$299,252	254
16	Gleevec	\$289,739	8
17	Benicar	\$261,649	449
18	Evista*	\$245,911	307
19	Losartan	\$239,093	1050
20	Humira	\$238,449	18
21	Copaxone	\$230,400	10
22	Clopiogrel	\$229,108	824
23	Niaspan*	\$205,992	220
24	Montelukast	\$196,223	615
25	Lantus Solostar	\$185,311	211

Note: Bold denotes name brand drugs; * denotes a generic launch rate during 2013 or 2014.

10.0 State Contract Form

The State Attorney General's office is the legal representative of the Teachers' Retirement Board. As a result of that relationship they have prepared a standard contract that is to be used by potential vendors. We ask that you share this contract with your legal counsel to identify any potential issues. This should be done during

the RFI period. An area is identified in the questionnaire to provide for response on the contracting issue. While the contract can be modified to reflect the nature of the agreement between the parties the Attorney General's office has shown limited flexibility with regards to some of the contractual provisions such as limits of liability and public disclosure of contract provisions. The TRB would like to identify firms that are able to agree to the provision put forth by the State. This contract may be accessed at

http://das.ct.gov/images/1090/Form_Contract_AGENCY.doc

This RFI is not a contract and shall not be interpreted as such. Rather this RFI serves as an instrument to collect information about the abilities and characteristics of potential vendors. It does not form an agreement or actionable agreement.

Questionnaire

Section	Title	Page
I.	Firm General Information	21
II.	Telephone/Internet Services	23
III.	Financials (Pricing)	25
IV.	Administrative Fees	27
V.	Installation	28
VI.	Formulary Development	29
VII.	Geo Access	30
VIII.	Managed Care Protocols	30
IX.	Performance Guarantees	31
X.	State Contracting Requirements	31

I. Firm General Information

1. What is the name and address of your Firm?
2. What is the location of your local office that would be in a position to service the TRB Account?
3. What is the background of the typical Account representative that would provide services to the TRB account? Examples are useful.
4. What is the background and training of the person that would be assigned as an account manager? Please include a biography/resume for example purposes.
5. How many accounts would the account manager be assigned to other than TRB?
6. Please list the other types of members of the account management team providing services to an organization such as TRB.
7. If your firm is not publicly traded please provide us with the most recent annual financial statement.
8. Who or what parties own more than 5% of your firm? Please list any holders with more than 5% and what percentage they own?
9. How many employees do you employ within the State of Connecticut. Please include the number and percentage of total employees.

10. Please identify any claim, administrative, medical review or customer service process that is provided (if you were servicing this account) from an offshore location i.e. outside of the United States or Canada.

11. What is the primary business of your firm? If you are a subsidiary or division of a large firm please provide information on both.

12. What portion of your firm's business is devoted to Prescription drug plan management?

13. Do you provide the full services associated with EGWP Programs within your firm or do you subcontract services?

14. If the answer was no to question 13 please identify the primary subcontractors and the role that they would play in providing services to customers such as the TRB.

15. How many prescription drug plan clients does your firm do business with?

16. How many members are serviced in prescription drug plans that your firm manages?

17. How many EGWP plans does your firm manage?

18. How many members participate in the EGWP plans that you service?

19. Does your firm administer your own PDD?

20. Does your firm have the ability to identify non-covered part D drugs in the claim system?

21. Does your firm collect these in the prescription drug event (PDE) data report?

22. Does your firm report PDE events to CMS directly or is there a separate reporting system firm that is subcontracted?

23. How often do you file the PDE with CMS?

24. Does your system provide for TRB to review member OOP and True OOP reports for members?

25. Identify three Medicare product clients that would serve as references for your firm's services? It would be preferable if they are: 1) Other state retirement systems,

2) Public entities, 3) More than 5,000 covered lives. Please identify their contact information.

26. Please identify three firms who have terminated your firms Medicare services during the last two years as well as their contact information.

27. What has been the growth rate in costs for EGWP programs that you manage after the conversion to an EGWP compared with your PPO population?

28. Please identify any current lawsuits between your firm and a customer or past customer.

29. Please identify any current regulatory actions against your firm by state or federal agencies.

30. Would TRB be able to provide enrollment updates in real time?

31. Please provide copies of your standard report materials as well as a description of frequency of the reporting.

32. Please confirm that your firm has a successful SSAE16 and that you will provide a copy to TRB on an annual basis.

33 Please confirm that your contracts with suppliers purchased on behalf of TRB are available for review.

II. Telephone/Internet Services

1. Where is the primary telephone service center located that would provide services to the TRB located?

2. What are the operating hours of such centers?

3. What hours does your firm normally provide telephonic services to clients?

5. If the service center hours are exceeded by the service day, how are the telephone calls routed?

6. What are the secondary and if necessary tertiary call centers that provide the service once the primary service center is non-operating?

7. Are any of the service centers located outside the continental United States? Would they be involved with TRB? If so where are they?
8. What is the protocol associated with telephone calls being routed to secondary telephone service centers?
9. Within service centers is there a TTY service available?
10. Please explain the services center personnel training that is provided to deal with individuals who have age related deficiencies in perception and sensory limitations.
11. Given the size and scope of services need by the TRB how would the Service center staff be set up for receiving calls? This is a particularly important issue to TRB for two reason: 1) the TRB has a relatively unique benefit program where the member costs are based upon a percentage of the discounted cost of the program and 2) the TRB which is currently in an Account with the State employees retirement fund participants has difficulty with service based upon a lack of appropriate cross recognition of the differences in the plans between the two Connecticut state agencies.
12. What is the protocol for reaching a customer service representative?
13. Are the telephone systems voice activated with regards to responses by members or key based?
14. What is necessary to opt out of recording?
15. What is the average wait for an opt out to talk to a live person?
16. What is a peak hours wait for an opt out to talk to a live person?
17. How do you monitor customer service representatives for compliance and behavior?
18. If a member has a complaint about the behavior of a customer service representative how is the complaint made?
19. Will members have access to records through an Internet portal?
20. Please provide a graphic of the primary screens provided through such portal?
21. What is the password protocol for the Internet portal?
22. What records can be accessed from the Internet portal?

23. Can drugs be ordered from the Internet portal?
24. How and where are physician scripts processed for mail order?
25. Where are the mail order centers?
26. Are mail centers 24/7 operations?
27. Is the portal opening screen customizable to the Customer?
28. Are drug costs live on the web site for mail order prices?
29. Do customer service reps have live access to mail order pricing?
30. What is protocol if mail center does not have a drug in stock?

III. Financials (Pricing)

The Pricing section here is set up to provide the TRB with an understanding of the relative economics of the cost of the services/premium. The premium quote if your firm decides to provide one would be an estimate of what the monthly premium would be PMPM for 2015.

For self funded quote estimates for the program assume that the network to be provided is the large open network provided by your firm. The reporting on the network is covered elsewhere in this document.

Claims terms: Assume that the arrangement provide will be based upon a transparent full pass through of rebates for the retail, mail and specialty pharmaceutical products.

Plan prices will be based upon the lower of U&C, MAC or AWP discount guarantee based upon the guaranteed level.

Administrative fees are to be provided as an estimate for the set of services outlined and are to be all encompassing to operate the program

For the specialty drugs please provide a list of all NDC number and discounts to AWP to be offered.

MAC list- Please provide the MAC list of drugs and price discounts used for calculation here.

Rebate Eligible product list. Please identify the expected level and expected amounts of rebates under this program.

Pricing Assumptions
1. Discounts across products are to be separable.
2. AWP is to Medi-span based.
3. Drugs dispensed at a retail pharmacy will be considered name brand or Generic not specialty

AWP Discount

Retail

Brand Guarantee	%
Generic Guarantee	%
MAC	%

Mail Program

Brand Guarantee	%
Generic Guarantee	%
MAC	%

Specialty Drug	%
-----------------------	---

Dispensing Fees

Retail

Brand Guarantee	\$
Generic Guarantee	\$

Mail

Brand Guarantee	\$
Generic Guarantee	\$

Rebates

Retail

Guarantee Per script (use base of all scripts) \$

Mail

Guarantee Per script (use base of all scripts) \$

Please Provide your best estimate as to the January 1-Dec 30 2015 total cost to TRB PMPM. Taking into account expected revenues from the Federal government.

IV. Administrative Fees

I. Fees for Administrative Services

A. Base Fee Structure

1. Fee per member per month

Please include the following in the PMPM:

Network management

CMS reporting

Standard reporting package

Prescription Drug Event File creation and Submission to CMS

Production and Mailing of EOB's

Archiving of historic claim transactions

Communication Allowance \$1 per member per year

2. Fee for paper claim (US)

3. Fee for paper claim (foreign)

4. Fee for management of Rebates (full pass through of revenues from manufacturer)

5. Fee for medical management

Please include the following items under any medical management fees PMPM

Concurrent DUR Program

Retrospective DUR Program

Medication management Programs

Prior Authorization Program

Step Therapy Programs

Operating appeals process

6. How does your firm negotiate rebates? Is it in house or transferred through another entity?

7. If it is performed by another entity what is the formulary management fee paid to the secondary entity?

8. If the formulary process is subcontracted do you charge a fee on top of the formulary management fee paid to the subcontractor?

V. Installation

1. Please provide a Gant chart of how the installation process would work assuming a January 1, 2015 start date.

2. Describe the process that your firm would use to install the account.

3. What is your member communication plan that you use for accounts?

4. What special allowances are made for accounts where the average age is over age 75?

5. What is your program outline for training TRB staff in your firm's operating protocols?

6. Provide the data layouts that your firm would need for the various inputs during install.

7. Provide a glossary for data inputs.

8. Can you provide a CMS compliant transition for TRB?

9. Do you manage Medicare Part B drugs through your system?

10. Are you able to administer the CMS benefit for individuals eligible for the LICS program?

11. Describe your LTC pharmacy network program.

12. Confirm that your LTC pharmacy network program meets the requirements established by CMS.

13. Do you offer contracting terms to all providers that meet CMS minimum terms?

14. Does the Medicare plan conform to a CMS approved Medicare Compliance plan?

15. Do you operate under an ERISA type appeal procedure when administering governmental plans?

16. Do your internal policies and procedures conform to CMS part D requirements?
17. Do you provide contractual auditing requirements that conform to the HHS standard?
18. Do you have established procedures to deal with Fraud, Waste and Abuse (FWA)? Please outline such procedures and how you implement and monitor FWA in the plan operation.
19. Do you provide enrollment to CMS for PDPs or MAPDs?
20. Do you report Quarterly rebates consistent with CMS standards?
21. Do you provide toll free access for member to provide information to providers about the Medicare pharmacy benefit provided herein?
22. Where is it staffed?
23. What are its hours?
24. What is the training of employees who staff the response staff?
25. Please identify what changes would be necessary to modify the TRB program to conform to EGWP plan provisions.

VI. Formulary development and controls

1. Please review TRB's top twenty-five drugs and identify the formulary status of each.
2. Please describe your process for evaluation of drugs for inclusion of formulary.
3. How often do you review formulary inclusion and how are changes communicated to members?
4. When formularies change how do you intervene in the process to encourage formulary compliance?
5. As TRB provides for blister packs for routine drugs provided to people with special need and care levels can your process accommodate these needs?
6. How are controlled substances handled?

7. How is it confirmed that the patient receives mail order drugs?
8. How do you field audit pharmacies?

VII. Geo access report

- 1) Please provide us with a 1 and 2 within 5 miles analysis for members of the groups.
- 2) Please provide us an average distance to closest pharmacy analysis.
- 3) Please identify all member locations where your firm is unable to provide access within 10 miles.

VIII. Managed Care Protocols

1. Do you have a Medication Therapy Management program that is approved by CMS?
2. Please provide sample copies of your Medication Therapy Management programs.
3. Please provide a description of your quantity limits programs?
4. Under your early refill program do you have flexibility to manage the drugs doses provided on a dynamic basis?
5. Please describe the medications that are managed through your prior approval programs.
6. How does the appeals process for prior approval denials work?
7. Please describe your expedited appeals process?
8. Are you a licensed managed care provided in Connecticut as required by the CGS?
9. Please describe you genetic screening capabilities and programs (TRB currently operates a tamoxifen-screening program).
10. Please provide your firms' 2013 first level appeal results.
11. How long is the turn around for your firm on expedited appeals? Use 2013 data.

12. How long is the turn around for non-expedited appeal procedures?
13. How many expedited appeals are successful for the member?
14. How many non-expedited appeals are successful for the member?
15. What are the most common reasons for a member to have a successful appeal?
16. Provide the hours of operation for your pharmacy enrollment and coverage team.
17. Provide a sample of your standard report to support the annual Part D process.
18. Describe your ability to provide and maintain a CMS compliant formulary program for TRB.
19. Describe the support that you give the client during CMS audits.
20. Describe your firms' process for monitoring claims from excluded providers.
21. Describe the process for a member to get online and on phone confirmation of coverage or exceptions.

IX. Performance Guarantees

1. Please identify the type, amounts and trigger for performance guarantees that your firm would be willing to put forth concerning the implementation and operation of the TRB plan.

X. State Contracting Requirements

1. Please confirm that your organization can agree to the terms of the State of Connecticut contract.
2. Please confirm that you have sent the contract to attorney for review.