PartnerRe

Specialty Accountable Care Organization (ACO) - Request for Quotation

CLIENT SPECIFIC INFORMATION	
Provider Name:	Date:
Principal Address:	# of Years in ACO:
Domiciled State:	Current Carrier:
Reason, if ever, left ACO, and when:	

MEDICARE ACO SEPARATE BY ARRANGEMENT		
ACO Payment Arrangement:	☐ Track 2 ☐ Track 3 ☐ Next Generation ☐ Track 1+	
Note: Track 1 is a shared savings only model and not eligible for coverage		
Estimated # of Covered Persons:	Covered Services Medicare Parts A & B:	☐ Yes ☐ No
If No, please explain:		
If less than 3 years with ACO, do you have prior or current experience with Medicare Advantage plans?		☐ Yes ☐ No
If Yes, please describe your arrangements and loss ratios:		
Max amount of loss share:	$_____ _____ %	

COMMERCIAL ACO SEPARATE BY ARRANGEMENT	
Contracted Payer:	
Estimated # of Covered Persons:	
Covered Services:	
Methodology for establishing the budget and actual PMPMs:	
Covered services in the budget and chargeable PMPM by each Policy Period:	
Ratio and terms of provider's loss of actual charges to budget:	
Max amount of loss share:	$_____ _____ %

MEDICAID ACO SEPARATE BY ARRANGEMENT	
Contracted Payer:	
Estimated # of Covered Persons:	
Covered Services:	
Methodology for establishing the budget and actual PMPMs:	
Covered services in the budget and chargeable PMPM by each Policy Period:	
Ratio and terms of provider's loss of actual charges to budget:	
Max amount of loss share:	$_____ _____ %

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REQUESTED COVERAGE	
Policy Period:	
Final settlement due date: *(e.g. 6, 12, 18 months after the end of the period)*	
Are you looking for specific coverage?	☐ Yes ☐ No
If yes, please indicate preference:	☐ Specific Deductible $_____ ☐ Policy Limit $_____ ☐ Coinsurance _____ %
Reimbursement/Payment Methodology:	_____%
If different, please indicate:	
Are you looking for aggregate coverage?:	☐ Yes ☐ No
If yes, please indicate preference:	☐ Attachment Point: _____% *(e.g. 105%, 108%) Minimum is 105%* ☐ PMPM Budget: _____ ☐ Policy Limit: $_____ ☐ Coinsurance: _____%

PROVIDER NETWORK

Please provide the following information for your provider network:

	Name	Location	Est. days per thousand
Owned facilities			
Physician groups			
Contracting hospitals			
Referral hospitals			

Describe any specialized expertise, e.g. medical specialists, nursing professionals, allied health professionals, etc., in the box below:

ON-SITE DUE DILIGENCE TO BE PERFORMED

DOCUMENTS TO ATTACH WITH THIS FORM

- Preliminary or final baseline/benchmark report; “base period aligned beneficiary expenditures for Medicare coverage only"
- Managed or unmanaged experience for the prior three years
- Actuarial verification of Benchmark or PMPM and projected savings
- Claims probability distribution supporting the Benchmark or PMPM
- ACO contracts for non-Medicare ACO coverage

PartnerRe America Insurance Company
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Broker of Record	
Broker of Record (BOR): ☐ Yes ☐ No	If yes, # of years as BOR:
Quotation Due:	Broker Commission (expiring):
	Broker Commission (requested):

Signature	
This proposal will be based upon the information transmitted with this form. The undersigned warrants that he or she has made a diligent effort to verify this information and that, to the best of his or her knowledge and belief, this information accurately represents the facts, and no requested information has been omitted or altered.	
Signature:	Date:
Title:	E-mail:
Phone:	

CONFIDENTIALITY

This document and any attachments are confidential and also may be privileged. If you are not the named recipient, or have otherwise received this document in error, please notify the sender immediately, delete the document, and do not disclose its attachments to any other person, use them for any purpose, or store or copy them in any medium. Thank you for your assistance.

WARNING: This form contains personal and Protected Health Information under HIPAA and may be transmitted only in a HIPAA compliant medium. **DO NOT SEND VIA AN UNSECURED E-MAIL TRANSMISSION.**

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