Dirigo Health Agency

Request for Proposal for Health Insurance Services

October 5, 2009

1. Introduction

1.1. Objective of the Request for Proposal

The State of Maine's Dirigo Health Agency (the Agency) is seeking fully insured health insurance proposals. This Request for Proposal (RFP) provides a description of the services the Agency is seeking. Broadly, the Agency seeks a partner who will:

- Expand access to the uninsured market in the state
- Develop focused sales and marketing strategies to reach the uninsured
- Develop a Preferred Network of Insurance Producers
- Demonstrate flexibility and willingness to make necessary changes to the program as National and State Health Reform progress, including regulatory changes, demonstration projects, and pilots

Carriers must propose services and rates according to these requirements. Upon review of all of the bids, the Agency will select the Carrier whose proposal represents the best value to the State.

1.1. Background of the Dirigo Initiative

"The Dirigo Health Act" refers to the set of health reforms that the Maine Legislature passed in 2003 (P.L. 2003 Chapter 469) and subsequently revised in 2005 (P.L. 2005 Chapter 400), 2007 (P.L. 2007 Chapter 447 and P.L. 2007 Chapter 629), and 2009 (P.L. 2009 Chapter 359). Most of the Act is contained in the Maine Revised Statutes, Title 24-A and is available at:

http://www.mainelegislature.org/legis/statutes/24-A/title24-Ach87.pdf

The Dirigo Health Act created the Agency as an Independent Executive Agency to:

- arrange for the provision of comprehensive, affordable health care coverage to small employers, self-employed persons, and other individuals on a voluntary basis, and
- monitor and improve the quality of health care in the state.

The Agency is governed by a 13 member Board of Trustees (9 voting and 4 ex-officio). The Agency's Legislative Committees of oversight are The Joint Standing Committees on Insurance and Financial Services, Health and Human Services, and Appropriations and Financial Affairs.

1.2. Contractual History and Arrangements

The program of comprehensive, affordable health care coverage that the Agency has offered since 2005 is a public/private partnership, where a commercial (private) entity is responsible for the provision of health insurance and the Agency (public) is responsible for providing subsidies to eligible enrollees to support their participation in the program.

Effective January 1, 2005, the Agency entered into a two year contract with Anthem Blue Cross Blue Shield of Maine (Anthem) to offer its insurance program in a fully insured funding arrangement. The parties agreed to an additional one year contract effective January 1, 2007.

Effective January 1, 2008, the Agency entered into a two year contract with Harvard Pilgrim Health Care (HPHC) to offer its insurance program in a fully insured funding arrangement. The parties have agreed to a six month extension to this contract effective January 1, 2010.

This RFP requires a three year contract with the successful bidder beginning July 1, 2010 with a one year extension option. The Superintendent of Insurance designated the Agency's program as an "other group" under 24-A M.R.S.A. § 2808 in 2004. Under an "other group" arrangement, the Agency is the Group Policy Holder.

Due to funding issues the program has been capped since the fall of 2007 and not open to new **subsidized** enrollment (with a few exceptions). The program is open to new **non-subsidized** members except Individuals. With the passage of PL 2009, Ch 359, the funding issues of the past that caused the program to cap enrollment should be eliminated as of July 1, 2010.

It is the Agency's expectation at that time the cap will be lifted and the program will open to new enrollment. See the Agency's Annual Reports for more details on history as well as historical enrollment reports at http://www.dirigohealth.maine.gov/Pages/agency_stats.html.

The products and benefit design features of the plan have been consistent since the program inception. A summary of the plan changes follows:

DirigoChoice Plan Design Changes Effective January 1, 2007 (upon anniversary date)

- Rx copayment structure increased from $10 generic/$20 formulary/$40 non-formulary **to** $10 generic/$30 formulary/$50 non-formulary.
- Office visit co-payment increased from $20 to $25.

DirigoChoice Plan Design Changes Effective January 1, 2009 (upon anniversary date)

- Member coinsurance level increased from 20% to 30%.

Full enrollment and cost history is available at:

http://www.dirigohealth.maine.gov/Pages/agency_stats.html

More description of the program and its history can be found in the Agency's Annual reports at:

http://www.dirigohealth.maine.gov/Pages/agency_stats.html

1.3. Project Organization

The Agency is the lead agency responsible for this RFP initiative. The Agency Project Manager is:

Karynlee Harrington, Executive Director

Dirigo Health Agency

53 State House Station

Augusta, ME, 04333-0053

Voice: (207) 287-9900

Fax: (207) 287-9922

Email: dha.rfp@maine.gov

1.4. Timing

The Agency reserves the right to adjust any of the following dates. If dates are adjusted the Agency will post a revised schedule on its web site.

Event	Date
RFP Issuance	October 5, 2009
Bidder's Conference	October 16, 2009 1:30 pm Dirigo Health Agency 211 Water St., Augusta, ME
Final submission of written questions	October 19, 2009
Agency responses to written questions	October 22, 2009
Intent to Bid form due	October 26, 2009
Proposals Due	November 16, 2009

Upon receipt of the Intent to Bid Form the Agency will send, to an email provided, supplemental group experience data to assist the bidder in its proposal.

1.5. RFP Organization

This RFP is organized into four distinct sections.

Section 1 – **Introduction** provides prospective Bidders with general information on the objectives of the RFP, background information relevant to recent history and current environment, organizations involved in this procurement, and the organization of the RFP.

Section 2 – General Procedures and Instructions provides prospective Bidders with general information on the procurement process and rules. This section also describes the requirements the Carriers must follow for the packaging and submission of the proposal submitted in response to the RFP.

Section 3 – Scope of Work Requirements provides information to prospective Bidders on program requirements, project responsibilities, Agency and Carrier responsibilities, and other specifications. It is the Agency's expectation that, unless the Bidder explicitly states otherwise or the RFP provides further clarification, the Bidder will be able to, and will, perform the functions as described.

Section 4 – Response Requirements contains detailed Bidder response requirements and forms for this RFP.

In addition, the Agency is providing **Bid Forms and Appendices** as separate downloadable files. Bidders must complete and return all Bid Forms. Appendices are provided for the Bidder's information and are referred to by number throughout this RFP.

2. General Procedures and Instructions

This section of the RFP contains the solicitation procedures, general proposal format information and submission instructions.

2.1. General Instructions

This RFP is designed to select a qualified Carrier to provide a fully insured insurance contract in conjunction with a state sponsored subsidy program. Proposals must conform to mandatory requirements, instructions, and conditions of the RFP.

2.2. Type of Contract

It is expected that one contract will be awarded as a result of this procurement process between the Agency and the Carrier. The provisions of this RFP and the selected proposals will be incorporated by reference in the resulting contracts. Additionally, any clauses or provisions required by federal or state law or regulation in effect at the time of execution of the resulting contracts will be included. Appendix 2 contains the required provisions of a State of Maine Contract.

The Agency reserves the right to make contract awards without any further discussion with the Carriers regarding the proposals received. Therefore, proposals should be submitted initially on the most favorable terms available to the Agency from a price and service standpoint (i.e., best and final offer). The Agency, however, reserves the right to request oral presentations and/or conduct personnel interviews with all responsible Bidders who submit proposals that result in top scores.

The initial contract awarded as a result of this procurement process will be for a three year term with a one year Agency extension option; rates will be reviewed on an annual basis. Amendments to the original contracts will likely occur as processes change or legislative requirements are altered. It will be the prerogative of the Agency to issue a Request for Information or a new Request for Proposal based on market or plan changes without using the additional one-year extension option.

2.3. Communications With State Staff, Dirigo Health Agency Staff and the Board of Trustees

From the date of issue of the RFP and until a determination is made and announced regarding the selection of a vendor, contacts with personnel employed by the Agency or Board of the Agency, except those made pursuant to any existing obligation, are prohibited. The only exception to these restrictions is with regard to State personnel involved in any scheduled oral presentations or interviews related to this RFP.

Violation of this provision may result in disqualification of the Bidder's proposal

Prospective Bidders are advised that only the Project Manager can clarify issues or render opinions regarding the RFP. No individual member of the Agency or other member of the selection committee is empowered to make binding statements regarding this RFP. The Project Manager will issue any clarifications regarding the

RFP in writing on the Agency web site. The Agency will not be bound by any oral statement not subsequently then reduced to writing and distributed by the Project Manager on the Agency's web site.

2.4. Written Inquiries and Answers

Any request for explanation regarding the meaning or interpretation of any RFP provision must be submitted in writing to the Project Manager at the address identified in Section 1.3 (Project Organization) no later than October 14th, 2009 at 5:00 pm. Questions may be sent via e-mail to the Project Manager. Questions may also be transmitted by facsimile, but must include a cover sheet clearly indicating that the transmission is to the attention of the Project Manager. The Agency assumes no liability for assuring accurate/complete facsimile or e-mail transmission/receipt and will not acknowledge receipt except by addressing the question received. **Under no circumstances will questions be entertained except in writing.**

The Project Manager will respond no later than October 19th, 2009 to substantive questions received. Only those answers provided by the Project Manager on the Agency's web site will be considered binding. Any information, including responses to questions about the RFP and the procurement process, amendments to the RFP, and addenda to the RFP, will be posted on the Agency's web site.

2.5. Oral Presentations

At the Agency's option, oral presentations by Bidders may be requested for the purpose of explaining or clarifying characteristics or significant elements of the proposals. Bidders will not be allowed to alter or amend their proposals through the presentation process. Bidders will not be permitted to attend competitor oral presentations. The Agency reserves the right to require and conduct oral presentations with Bidders who submit proposals that result in top scores.

2.6. Personnel Interviews

At the Agency's option, personnel proposed by Bidders may be requested to participate in a structured interview to determine their understanding of the service requirements, their authority and reporting relationships within the firm, and any other relevant information. Carriers will not be allowed to alter or amend their proposals through the interview process, nor will they be permitted to attend competitor interviews.

2.7. Disclosure of Data

All proposals, correspondence, addenda, memoranda, working papers, e-mails and any other documents or material related to this RFP are public records under Maine law and will be available for public inspection when the award decision is made. This includes proposals received in response to this RFP, both the selected proposal and the proposals not selected, and all materials included with any proposal without regard to whether the Bidder considers the information provided to be confidential or proprietary.

2.8. Cost of Proposal Preparation

The entire cost for the preparation and submission, and the attendance at any oral presentation or personnel interviews will be borne by the Bidder.

2.9. Proposals

2.9.1. Submission of Proposals

To facilitate the proposal evaluation process, one (1) original and seven (7) duplicate copies of the entire proposal must be submitted in a sealed envelope/package marked "**Dirigo Program Proposal - 200909526**" by the proposal due date specified in this RFP to:

Division of Purchases
Burton M Cross Building, 4th Floor
111 Sewall Street
9 State House Station
Augusta, ME 04333-0009

Bid Forms completed electronically should be included in the package on CD or DVD media. Bidders must also include one (1) electronic version of their entire proposal on CD or DVD media.

Proposals must be received, in both hard copy and electronic format, by 2:00 pm local time on November 12th, 2009. Proposals that arrive late will be rejected. Proposals must be submitted in accordance with the instructions identified below.

Emphasis should be concentrated on conformance to the RFP instructions, responsiveness to requirements, and completeness and clarity of content. If the Bidder's proposal is presented in a fashion that makes evaluation difficult and overly time-consuming, points will be sacrificed in the evaluation process. The proposal must be numbered in strict accord with the numbering shown in Section 4 of this RFP.

2.9.2. Proposal Contents

The proposal must consist of the following, in this order:

- a Transmittal Letter signed by an individual legally authorized to bind the Bidder;
- an Executive Summary providing a condensed version of the proposal highlighting the contents of the Bidder's proposal;
- responses to all parts of Section 4. Responses should follow and include the specific questions, as presented in the order of Section 4, and
- completed Bid Forms.

2.9.3. Rejection of Proposals

The Agency reserves the right to reject proposals that contain material deviations from the requirements of the RFP. It is understood that proposals, whether rejected or not, will become part of the Agency's official file.

2.9.4. Revision of Request for Proposals (RFP)

The Agency alone reserves the right to amend the RFP prior to the proposal due date. The Agency will post on its web site any amendments to the RFP a minimum of seven (7) days prior to the due date. Should an amendment be issued with fewer than seven (7) days remaining prior to the due date, the due date will be extended. The Agency will not be responsible for any additional costs incurred as a result of any such changes in the RFP.

2.10. Rights of State Government

This RFP does not commit the Agency to award a contract, or pay any cost incurred in the preparation of a proposal in response to this RFP. The Agency reserves the right to reject proposals, and at its discretion may cancel or amend this RFP at any time. By submitting a proposal in response to this RFP, the Bidder grants the Agency the right to contact or arrange a visit in person with the Bidder's clients.

2.11. Evaluation of Proposals

The Agency will select a Bidder through a formal evaluation process, established prior to the opening and evaluation of proposals. Consideration will be given to capabilities or advantages that are clearly described in the proposal, confirmed by oral presentations or interviews if conducted, and verified by information from reference sources contacted by the Agency. The Agency reserves the right to contact individuals, entities, or organizations that have had recent dealings with the firm or staff proposed whether or not they are identified as references.

The Agency may designate a selection committee or an outside organization to evaluate the proposal responses. The selection of a vendor will be based upon consideration from all phases of the evaluation process and will be presented to the Dirigo Health Board for approval.

2.11.1. Initial Screening

The Agency will perform an initial screening of responses. Proposals may be rejected that do not meet required timelines and/or do not address all questions and complete all Bid Forms.

2.11.2. Evaluation

Those proposals that pass the initial screening will be evaluated on their ability to meet the requirements identified in this RFP based upon demonstrated experience, expert qualifications of personnel, and competitive pricing.

All questions and Bid Forms will be assigned to one of the content areas described below, which together will total a **potential 100** points. The maximum available points will be distributed as follows:

Content Area	**Score**
Cost – Status Quo	20
Cost – Alternate Plan	20
Administration	15
Value – Alternate Plan	45
Total	**100**
Value Detail (45 points)	
Actuarial Value	15
Adherence to Principles	30
Adherence to Principles Detail (30 points)	
Network	10
All Others	20

At the Agency's option, top-scoring Bidders may be requested to participate in oral presentations and personnel interviews as detailed in Section 2.5 and 2.6 of this RFP. Following presentations and/or interviews, scores may be adjusted on the basis of information presented in these settings.

The Bidder that achieves the highest rating, that is, the proposal that represents the best value to the Agency, will be awarded the Contract subject to successful negotiations and required approvals.

2.12. Contract Award

The evaluation will result in the selection of one proposal which, taken as a whole, represents the best value to the Agency. After analysis, evaluation and validation of Bidder responses, the Agency will notify Bidders of the successful Bidder in writing. Upon resolution of final contract negotiations, the Agency will prepare final contract documents and awards. If for any reason the Agency is unable to secure an acceptable contract with the selected Bidder, that selected Bidder will be disqualified. In this event, the Agency may then proceed to negotiate contracts with the Bidder with the next highest-rated proposal or may cancel negotiations at the Agency's discretion.

It is to be understood by the parties that the negotiated contract awards will be made in the best interests of the Agency and that the award decision will be final. The RFP and the proposal of the successful Bidder will be incorporated into and form the basis of legal contracts.

2.13. Required Contractual Provisions

There are certain requirements, established by the Agency, with respect to proposals submitted in response to this RFP. The words “shall”, “must”, and “will” (except when used to denote futurity) will be considered as indicative of a requirement of this RFP.

3. Scope of Work

This Section of the RFP describes scope of work requirements for the Contract resulting from this RFP.

The Carrier must comply, to the satisfaction of the Agency, with (1) all provisions set forth in this RFP and incorporated into any resulting Contract and (2) all applicable provisions of state and federal laws, regulations, and waivers. Bidder's should, in particular, be familiar with, and must comply with the provisions set forth in M.R.S.A. 24 (http://www.mainelegislature.org/legis/statutes/24/title24ch0sec0.html) and 24-A (http://www.mainelegislature.org/legis/statutes/24-A/title24-Ach0sec0.html) and the Rules and Decisions of the Maine Superintendent of Insurance (http://www.maine.gov/pfr/insurance/laws_rules.htm).

The Agency reserves the right to modify the requirements in the Contract as it deems necessary. Changes to the Contract after its execution by the parties must be made only by written agreement.

3.1. General Scope of Work

Coverage for benefits will be available to enrolled members effective on July 1, 2010.

Bidders are required to submit two proposals:

1. Status Quo: rates and benefits that meet the current DirigoChoice plan design
2. Alternate Plan: a plan that meets target revenue PMPM and corresponds to a set of principles established by the Agency Board of Directors.

Further requirements for these bids are detailed below. Bidders must describe their proposals using the worksheets and questionnaires provided in Section 4 and the required Bid Forms.

3.2. Current Program Eligibility

The Agency defines program eligibility as the following:

3.2.1. Eligible Business (Small Group)

- means a business that employs at least 2 but not more than 50 eligible employees
- means a business where the majority (defined as greater than 50%) of the employees are employed in the State of Maine
- means a municipality of the State of Maine that has 50 or fewer eligible employees
- must complete and sign a Group Information form
- must complete and sign a Group Profile form

3.2.2. Eligible Employee (Small Group)

- means an employee of an eligible business who works on a full-time basis with a normal work week of 30 hours or more
- means a part-time employee of an eligible business who works a normal work week of 20 hours or more and the business elects to treat them as an eligible employee
- means an employee who has met the employer's designated waiting period for group health coverage
- can include an employee who resides out of the State of Maine and works for an eligible business, however the employee can not participate in the financial discount program
- can include a former employee of an eligible business with 20 or more employees pursuant to the Consolidated Omnibus Budget Reconciliation Act (COBRA)
- does not mean an employee who works on a temporary or substitute basis

3.2.3. Eligible Individual (Non Group)

- means an individual who resides in the State of Maine and:
- is unemployed
- does not work more than 20 hours a week for any single employer
- is eligible to apply for the Health Coverage Tax Credit (HCTC) Program certified under the Trade Adjustment Act (TAA) or Pension Benefit Guaranty Corporation (PBGC).
- is employed in an eligible business of 2 to 50 employees that does not offer health insurance and has not provided the individual and dependents access to an employer-sponsored benefits plan in the twelve month period immediately preceding the individual's application and is not the employer.
- is an early retiree who worked for an eligible business of 2 to 50 employees that does not contribute to the retiree's health insurance coverage
- is employed by a household and works more than 20 hours a week and is not offered health insurance coverage and has not been offered health coverage in the past 12 months. Is not self employed and considers the household their employer
- is not eligible for Medicare (policy change effective January 1, 2010)
- is an employer/employee of an eligible business and were unable to get 75% participation when the program was offered to the employees
- must complete and sign a Certification Statement

3.2.4. Self Employed Employer (Non Group)

- means the owner of a business where they are the only employee
- must work and reside in the State of Maine
- is not eligible for Medicare (policy change effective January 1, 2010)
- must complete and sign a Certification Statement

3.2.5. Eligible Dependent

- means an applicant's spouse or domestic partner who does not have coverage available through their own employer (must complete and sign an Affidavit of Domestic Partnership where applicable)
- means an unmarried child less than 23 years of age who qualifies as a dependent for tax purposes, has no dependents of the child's own, is a resident of the State of Maine or is a full-time student outside of Maine
- means a person of any age who is the child of a program enrollee and is disabled and dependent upon that enrollee

Note: child means a natural child, stepchild, adopted child or child placed for adoption with an enrollee.

3.2.6. HCTC Eligible Members

The Trade Adjustment Assistance Reform Act of 2002, Public Law 107-210 provided for a program entitled Health Coverage Tax Credit (HCTC).

The HCTC is a federal tax credit that enables eligible individuals to pay only 20 % of qualified health insurance premiums for themselves and their family members. The HCTC is available monthly as premiums become due, yearly when your federal tax return is filed, or a combination of both.

It is available to help certain trade dislocated workers and early retirees, and their dependents, buy qualified health insurance coverage. To be eligible for the tax credit, you must be receiving Trade Adjustment Assistance (TAA) benefits or retirement benefits from the Pension Benefit Guaranty Corporation (PBGC). PBGC benefit recipients must be at least 55 years old. In addition, you must meet other requirements for both TAA and PBGC benefits.

The Agency is the Health Plan Administrator for the State of Maine and works in conjunction with the State Department of Labor. The HCTC qualified have the option of choosing their health coverage with the Agency.

3.3. Subsidy Eligibility

Per M.R.S.A 24-1 §6912 the Agency may establish sliding-scale subsidies for the purchase of Dirigo Health Program coverage paid by eligible individuals or employees whose household income is under 300% of the federal poverty level (FPL).

Based on the Agency's determination of household income and assets, enrollees are assigned to one of five different subsidy levels (B, C, D, or E). These levels correspond with the annual federal poverty levels established by the Department of Health and Human Services. For more information on subsidy levels and their correspondence to FPL, please see the Agency's Annual Reports at:
http://www.dirigohealth.maine.gov/Pages/agency_stats.html

Note: the asset test becomes effective July 1, 2010.

Note: effective July 1, 2010, the Agency will no longer subsidize members who are 65 or older who are eligible for Medicare.

3.3.1. Household Income

The following is counted as income:

- Applicant gross wages, tips and salaries (before any deductions)
- Spouse or domestic partner gross wages, or tips and salaries (before any deductions)
- Net self-employment income (gross receipts minus allowable business expenses)
- Interest and investment income (dividends from stocks, bonds, annuities, trusts, mutual fund shares)
- IRA and 401K distributions
- Pensions and annuities
- Net rental income (gross rents minus allowable expenses), royalties, trusts, etc
- Unemployment compensation
- Gross child support and/or alimony received
- Farm income
- Social Security

The following deductions are allowed:

- Childcare expenses - $200 per child per month if under 2, $175 per child per month if 2 or older. Caregiver must be a person outside the household.
- Child support paid out (only allowed for children that will not be covered by the applicant's policy).
- Alimony paid out

3.3.2. Household size

Includes the plan applicant and all of his or her dependents (i.e., spouse, domestic partner, unmarried child under 19, student under 25, or child of any age who is disabled and dependent upon the applicant).

3.4. Bid 1 - Current DirigoChoice Product

The current DirigoChoice product is a fully insured PPO with in and out of network benefits. There is no requirement that members select a primary care physician (PCP) but it is recommended. Copies of the DirigoChoice benefit schedules, rates, and Certificate of Coverage are included in Appendices 3 and 5 and should be referred to for full coverage information.

Further information about DirigoChoice and the sliding scale costs is available in the Agency's Annual Reports at http://www.dirigohealth.maine.gov/Pages/agency_stats.html

Instructions on providing a bid for this product are in Section 4 and in the required Bid Forms.

3.5. Bid Two – Alternate Plan

Bidders should propose an alternate plan that meets a target PMPM and corresponds to principles established by the Agency's Board of Trustees. Bidders are encouraged to propose HMO, PPO, and/or POS products that meet these goals.

3.5.1. Target PMPM

Bidders must provide plan designs that meet an aggregate target revenue PMPM of $509.96.

3.5.2. Plan Principles

The plans must correspond to the Principles established by the Agency's Board of Trustees. These Principles are:

1. Include robust prevention, wellness, and disease management benefits.
2. Include mental health parity.
3. Do not exclude pre-existing conditions.
4. Reduce over-use and under-use of health care by aligning quality and efficiency incentives among providers across the continuum of care so that physicians, hospitals, and other health care providers are encouraged and enabled to work together towards the highest standards of quality and efficiency. For example, provide tiered networks based on quality metrics and/or pay for performance (P4P) incentive models.
5. Adhere to evidence-based best practices and therapies that reduce hospitalization, manage chronic disease more efficiently and effectively, and implement proven clinical prevention strategies.
6. Do not pay for "never" events.
7. Target a medical care ratio of 90% (i.e., at least 90% of every dollar must go toward medical services as opposed to the carrier's administrative costs or profit).
8. Include strong incentives to promote the use of generic medications when available.
9. Promote the use of medical homes and primary care.

10. Provide an actuarial value of at least 65%.

Consistent with these principles the Agency has adopted a value-based purchasing strategy and is looking for a partner that will help advance the following goals:

- Encourage our members to make informed decisions about their health care
- Provide incentives for members to seek care from high-value providers
- Reward providers who demonstrate high-value

3.5.3. Plan Segments

Small Group – eligible businesses as defined above under plan eligibility

The Agency is looking for a set of options in the small group market to ensure employer choice. To this end, Bidders should propose the following options:

- High Deductible
- Low Deductible
- HSA

These plans are for all income levels. The projected distribution of membership between these plans can be found in the databook in Bid Form 4.

Non-Group - eligible individuals and self-employed employers as defined above under plan eligibility

The Agency is looking for a set of options to ensure that there are plans where the member's total financial exposure is limited by their average household income. In the case of the non-group products, total exposure must not exceed 22% of the average household income of the subsidy levels for which the plans are targeted. For information on average household income of the current program population see the databook (in required rate Bid Forms).

- Plan 1 – Target income group B
- Plan 2 – Target income group C
- Plan 3 – Target income group D and above

For the purposes of these plans, Bidders should assume that the Agency will subsidize the premium charged to the member. The total amount of the premium subsidy will depend on the cost of the plan; however, it is the goal of the Agency to keep member monthly premium costs consistent with current levels.

Core medical benefits should be the same for all plans.

Networks

Bidders whose networks have adopted pay-for-performance (P4P) metrics, who are tiering networks based on quality, and/or using or proposing reimbursement models based on outcomes will receive higher scores. This scoring is consistent with the vision articulated in Guiding Principles 4 and 5 above.

Bidders who do not have network structures such as these in place today but are willing to consider working with the Agency to create these structures should describe their flexibility and willingness to implement pilot programs or make network changes consistent with these principles.

3.6. Administration

3.6.1. Carrier Experience

The Carrier should demonstrate experience in providing insurance to the small group and non-group market, including documented experience increasing plan enrollment through recruitment of previously uninsured or underinsured individuals or groups.

3.6.2. Key Personnel

The Carrier must designate key management and technical personnel who will be assigned to the Contract.

The Carrier must maintain the overall level of expertise, experience, and skill required to meet the requirements of this RFP and the Contract that may result from it.

Account Representative

The Carrier must have a qualified individual to serve as the Account Representative for the product. Among other responsibilities, the Account Representative will promptly research individual claim or provider issues and operational issues, including but not limited to such issues when presented by the Agency. The Account Representative shall also be responsible for coordinating the Carrier's compliance with the reporting requirements of the Contract.

3.6.3. Subcontractors

The Carrier remains responsible for performing and for any failure to perform all duties, responsibilities and services under the Contract regardless of whether the duty, responsibility or service is subcontracted to a third party for actual performance. The Carrier must:

actively monitor the quality of care and services, as well as the quality of reported data, provided under any subcontract;

notify the Agency in writing at least 60 days prior to re-procurement of services provided by any Major Subcontractor;

notify the Agency in writing immediately upon determining to terminate a subcontract with a Major Subcontractor or upon receiving notification from the Major Subcontractor of its intent to terminate such subcontract, and

notify the Agency in writing within one business day of determining to enter into a subcontract with a new Major Subcontractor, or a new subcontract for newly procured services of an existing Major Subcontractor.

3.6.4. Enrollment

The Carrier and the Agency shall share responsibility for enrollment of members into the program in the manner described below.

Agency responsibilities include, but are not limited to:

- Ensures completeness of application materials
- Determines eligibility for the subsidy program and other components of plan eligibility
- Determines 75% participation is met for small employers
- Determines employer waiting period is met for new hires to small groups
- Communicates information regarding the subsidy level and amount to the applicant

Carrier responsibilities include, but are not limited to:

- Provides quotes to new and renewing accounts for the non-discounted cost of coverage
- Enrolls the applicant in the insurance product
- Performs the required compliance checks. Compliance checks include:
    - student verifications,
    - minimum participation levels,
    - number of employees within small groups;
    - domestic partner verifications; and
    - disabled dependent eligibility.
- Sends the appropriate information to the Member.
- Makes all appropriate changes to the account during the plan year
- Standard COBRA processing
- Filing all required rates and enrollment/renewal materials with the Bureau of Insurance.

Quotes

New and renewing accounts must first obtain a quote for the cost of their coverage from the Carrier. It is the Carrier's responsibility to provide a quote for the requested plan(s).

Submission of Application to the Agency

Accounts shall submit to the Agency the completed application packet. The packet must be post marked no later than the last day of any month to ensure effective date of coverage as the 1st day of the second month following post mark of application (i.e. December 31st for February 1st coverage; March 31st for May 1st coverage).

Processing of new applications by the Agency

The Agency will process the subsidy application and notify the applicant of the subsidy determination. Once the subsidy determination has been made, the Agency will forward the subsidy level along with the applicable application materials to the Carrier for processing. The Agency does not forward the financial subsidy application or any personal financial information to the Carrier. The Agency will forward information on a daily basis to the Carrier.

Effective Date of Coverage

Will be the first day of the month following the month in which an applicant enrolls in the program.

Will be the day following termination of a member's prior coverage if the new member had prior coverage through an individual or small group policy.

Processing of renewals by the Agency

Renewal packets will be provided by the insurance carrier to all enrolled subscribers at least 60 days prior to their coverage renewal date. Completed renewal materials must be received at the Agency by the first of the month preceding the subscriber's renewal date (i.e. December 1st for a January 1st renewal date).

If accounts do not return their renewal materials prior to the renewal date, subsidy(s) will not continue past the renewal date (the Agency allows small group enrollees to maintain their subsidy levels beyond renewal if their employer is late in returning the renewal material). The Carrier should note that Maine's guaranteed issue requirements mandate that the Carrier must continue to provide insurance coverage to the member, regardless of whether the member has submitted the renewal material, but the Agency will terminate the subsidy.

Once this process is complete, the Agency forwards the subsidy level and applicable application materials to the Carrier. The Agency does not forward the financial subsidy application or any personal financial information to the Carrier. The Agency will forward information on a daily basis to the Carrier.

Application Material

The Carrier and the Agency will jointly develop all application and renewal material. The Carrier must produce and distribute the application and renewal materials for the program to anyone requesting application materials. The complete application packet is the packet of documents that must be signed and submitted to the Agency to apply for participation in the program.

All applicants, regardless of whether or not they are applying for a subsidy, must complete the subsidy application. Applicants who are not applying for a subsidy do not need to supply financial information with the subsidy application, but do need to certify that they are not requesting a subsidy. Small Group employees must seal their subsidy application and supporting documentation into a confidential envelope before returning it to their employer. This process maintains the privacy of the employees' financial information.

The Carrier is responsible for filing all required enrollment/renewal materials with the Bureau of Insurance.

Member Identification (ID) Cards

The member ID card issued to members must be the same as the Carrier's standard ID card except the card will include an Agency specified logo in addition to the Carrier's logo.

The Carrier must issue the ID card or temporary ID card on or prior to the effective date of coverage. If the Carrier cannot ensure that the permanent card arrives prior to the effective date of coverage, it must ensure that the card arrives no later than ten (10) days following the effective date of coverage.

The Carrier must reissue the member ID card if a Member reports a lost card, there is a Member name change, or for any other reason which results in a change to the information disclosed on the ID card.

Certificate of Coverage

Members must receive certificate of coverage (COC) within 10 days following the effective date of coverage that describes their rights, how to access services, where to access information on Providers, how to file grievances and other general information necessary for utilizing their health insurance benefits.

Changes

The Agency will notify the Carrier of subsidy changes through the membership file transfer process. The Carrier must make these changes effective the date the Agency specifies.

Other changes received at the Agency will be forwarded via email and fax to the Carrier in order for the change to be made. The Carrier must report these changes as well as any changes made by the Carrier directly to the Agency via the member file transfer process.

Renewals

The renewal process resembles the initial enrollment process. There is an additional step taken with renewals to assist the Individuals, Self Employed of One, and Small Groups with submitting the material prior to their renewal effective date. The Agency contacts all Individuals, Self Employed of One and Small Groups failing to send in renewal material by the 1st of the month prior to their renewal effective date. The Agency provides the Carrier with a listing of all those failing to submit renewal paperwork by the 15th of the month prior to their renewal date. The Carrier conducts follow-up calls to the unresponsive renewals. The Agency will discontinue the subsidies for members who have failed to renew on their renewal effective dates.

Synchronization

The Carrier and the Agency must each send a full enrollment file (formatted as described in Appendix 1) to each other on a daily basis to maintain coordination between the Carrier's membership data and that of the Agency. It is through this synchronization file that adds, changes, and terminations of accounts and members take place.

3.6.5. Sales and Marketing

The Dirigo Health Agency will partner with the successful Bidder on developing and executing a sales and marketing plan designed to meet the target market; low-income uninsured small groups, individuals, and self-employed that meet the eligibility requirements.

Sales and Marketing Plan

The Carrier must specify its willingness and capability to create a network of select producers and agree to produce a sales and marketing plan prior to July 1, 2010.

Program Training

The Carrier must provide initial and ongoing training specific to the plan product to its sales staff and broker network. Staff from the Agency will be expected to attend and participate in the trainings. Additionally, the Carrier must conduct at least two focus groups annually with the select network producers selling the product. Staff from the Agency will be expected to attend these sessions as well.

Assessment of Sales and Marketing Plan

The Carrier and the Agency will assess the success of the marketing strategies through monthly reports of activity and target enrollment achievement per segment. Such reports shall include recommendations for changes to the sales strategies based on success of the plan compared to established growth goals.

3.6.6. Member Services

The Carrier shall provide a telephone member service unit that responds to all inquiries from members.

At a minimum, the Carrier must provide:

- "live" operator assistance between the hours of 8:00 a.m. and 5:00 p.m. Monday through Friday (local time) and 24-hour, seven-day-per-week voice message service for after-hours coverage;
- bilingual and TTY services for Members with special needs;
- an automated logging system to track and report telephone service performance (e.g., volume, response time, abandonment rate, etc.), and
- Member Service staff with online access to eligibility, enrollment and claim information to respond to Member inquiries, resolve problems, and make appropriate call referrals when necessary.

The Carrier must ensure that after hours, on weekends, and on holidays the Member Service Call Center inbound telephone lines are answered by an automated system with the capability to provide callers with operating hours and instructions on what to do in cases of emergency. A voice mailbox must be available after hours for callers to leave messages. Member calls received by the automated system must be returned by the Carrier's Member Service representatives on the next working day.

3.6.7. Billing

The Carrier is responsible for billing accounts on behalf of the Agency. Accounts make payment to the Agency. The Carrier must then bill the Agency for accounts, indicating the account charge and any additional Agency charge. The Agency will remit the entire payment (account and Agency shares) to the Carrier.

Non-Group

The Carrier must bill Individuals and Self Employed of One groups the net amount of their coverage cost after the application of the subsidy on a monthly basis. The Carrier must bill the Agency for the account charge and the subsidy amount.

For example, if an Individual has a rate of $450, and the subsidy for the Individual is $100, the Carrier would bill the Individual $350. The Individual would remit $350 to the Agency. The Agency would remit $450 to the Carrier.

Small Groups

The Carrier must bill Small Groups the adjusted community rate. The Agency will supply members enrolled through Small Groups with their subsidies via an Electronic Benefits Card or via direct deposit into a designated account. The Carrier must bill the Agency for the account charge.

Membership Fees

There is an annual membership fee for participation in the program. The Carrier must incorporate the fee in its monthly billing and forward fees received from accounts to the Agency. The fee schedule is as follows:

Group / Size	Annual Fee	Monthly Fee
Non Group	$150	$12.50
Small Group 1- 9	$150	$12.50
Small Group 10 – 24	$250	$20.83
Small Group 25 -50	$350	$21.17

Responsibility of the Agency in relation to responsibility of the account

The Agency will remit its share of the coverage charge when the account has remitted 100% of its coverage charge. If the account does not pay, the Agency will not pay the subsidy. If the account makes only a partial payment, the Agency will not pay the subsidy.

Delinquency and Termination

The Carrier is responsible for managing the delinquency and termination process for accounts, including mailing dunning notices and notifying the Agency when accounts have terminated for non-payment.

Any collection activity the Carrier wishes to pursue in relation to delinquent accounts must be taken by the Carrier with notice to the Agency.

Administration / Workflow of the Billing Process

Each month, the Carrier issues bills to accounts reflecting charges as described above.

Each month, the Carrier submits a single electronic bill file to the Agency on a secure server detailing the account charges, the Agency charges, balances, payments received, and any adjustments (full specifications of this file are included in Appendix 1). The Carrier may submit adjustments in subsequent files using the same format.

Daily, accounts make payment to the Agency through a contracted lockbox service.

Daily, the Agency remits payment to the Carrier for those payments received in the lockbox that day plus Agency payments. The remittance includes:

- Electronic file serving as remittance advice (full specifications of this file are included in Appendix 1)
- Electronic funds transfer to account specified by the Carrier
- Electronic file submitted by lockbox vendor indicating payments received in the lockbox that day (for validation purposes) (an example of this file is included in Appendix 1)

Note: those payments that the lockbox vendor submits in exception status (i.e., account it unidentified) will be identified by the Agency prior to submission of the payment to the Carrier.

3.6.8. Claims Processing

The Carrier will be responsible for processing and managing claims for the program.

The Carrier is expected to process and pay claims in a timely and accurate manner. The Carrier is required to have systems in place to minimize the chance of fraudulent claims being accepted. The Carrier must have a quality assurance program in place, including an internal audit function, to assure the accurate and timely payment of claims. At its option, the Agency may request the Carrier to sponsor a site visit to its claims and services facilities for Agency staff. In addition, the Agency may audit the Carrier's claim administration performance upon advance notice to the Carrier.

Explanation of Benefits (EOB)

The Carrier is required to provide an EOB detailing each service provided to a member on a particular day.

Coordination of Benefits

The Carrier must have a system in place to identify and collect third party payments.

Claims Reporting

The Carrier will be required to provide quarterly performance reports in the areas of claims adjudication accuracy, claims adjudication timeliness and claims customer service.

3.6.9. Reporting

The Carrier will be required to provide periodic cost, utilization, and management reports as follows:

Report	Periodicity
Loss Ratio	Monthly
+50K	Quarterly
Benefit Analysis	Quarterly
Paid Claim by $	Quarterly
Covered Lives / Total Paid by Age	Quarterly
Diagnosis Ranked by Total Paid	Quarterly
Lag Report (Triangle)	Monthly
Rx	Monthly
Large Claim Detail	Quarterly

In addition, the Agency is frequently required to perform analysis of its experience or to provide data to other entities to perform analysis. The Agency expects to work with the Carrier to satisfy these requirements.

3.6.10. Transition

Status Quo

Accounts currently enrolled in DirigoChoice with the current Carrier will transition to the new Carrier effective July 1, 2010, but maintain their current renewal date. For example:

Plans that enrolled or renewed in DirigoChoice on July 1, 2009 would renew with the new Carrier effective July 1, 2010.

Plans that enrolled or renewed in DirigoChoice on May 1, 2010 would enroll with the new Carrier July 1, 2010, but renew with the new Carrier effective May 1, 2011.

The Carrier will replicate the previous Carrier's premium rates for the period between July 1, 2010 and each account's renewal date. Accounts with a July 1, 2010 renewal date will be billed at the new Carrier's July 1, 2010 rates. Accounts with a renewal date after July 1, 2010 will be billed at their current rates until renewal.

Accumulators

Beginning July 1, 2010, the current Carrier will begin to send daily files (synched with its claims payment cycle) to the new Carrier detailing paid claims incurred and applied to the deductible and out-of-pocket limits in October 2009– June 2010 for DirigoChoice members under contracts with the current Carrier. This daily file will continue through December 31, 2010. The new Carrier must accept these files and apply these payments to members' 2010 deductibles and out-of-pocket limits.

For example:

A member of a group incurs a claim on June 15th, 2010. The previous carrier pays the claim July 8th, 2010. If the claim were applied to the member's deductible this claim amount should appear on the daily file.

A member of a group incurs a claim on November 12, 2009. The previous carrier pays the claim December 22nd, 2009. If the claim was applied to the member's deductible, this claim amount should appear on the first daily file sent to the new Carrier.

Alternate Plan

All accounts currently enrolled will shift to a new plan effective July 1, 2010 with new rates. The anniversary date for all accounts from the point of transition forward will be July 1.

Accumulators

All deductible and out-of-pocket limits will be reset effective July 1, 2010. Annual deductibles and out-of-pocket limits will run on the calendar year (January – December). The Carrier will roll-over claims incurred July 2010 – December 2010 to the 2011 deductible and out-of-pocket limits to synchronize the program to the new deductibles. Subsequent years require only a three month (October – December) roll-over.

4. Response Requirements

4.1. Compliance and Full Disclosure

Failure to provide required assurances and/or to disclose any of the information required in this RFP may result in disqualification of the Bidder or cancellation of award. The Agency may conduct reference checks to verify the accuracy of submitted Major Subcontractors and to ascertain the experience of the Bidder. If a reference check results in discovery of substantial error, omission or misrepresentation on the part of the Bidder, the Bidder will be disqualified.

To be considered for award, the Bidder must address all applicable RFP specifications to the Agency's satisfaction. If requested by the Agency, the Bidder must provide the Agency with information necessary to validate any statements made in its Proposal. This includes, but may not be limited to, granting permission or access for the Agency to verify information with third parties, whether identified by the Bidder or the Agency. If any requested information is not provided within the timeframe allotted, the associated Proposal may be rejected.

4.2. Economy of Presentation

Bidders shall not submit information or attachments not explicitly requested in the RFP.

4.3. Submission Requirements

All Bidders must respond to the following submission requirements. A response to these requirements will constitute the Bidder's Business Specifications. The Bidder's Business Specifications must be clearly marked with the Bidder's name, the RFP number, and the RFP submission date. An individual authorized to legally bind the Bidder must sign the Business Specifications.

As described below, the Bidder's Business Specifications shall include:

- a Transmittal Letter signed by an individual legally authorized to bind the Bidder
- an Executive Summary;
- Responses to all confirmations, data requests, and questions specified in this section and;
- Completed Bid Forms.

The Agency assumes no responsibility for knowledge of any material that is not presented in accordance with the Agency's instructions.

4.3.1. Executive Summary

Submit an Executive Summary that, at a minimum, includes:

- a brief description of the Bidder, including its organizational structure and its experience in marketing to, sales to and servicing the small group and individual markets, particularly the low-income and uninsured populations
- a description of any substantive business, economic, legal, technical, or practical assumptions that underlie the Bidder's response to the RFP, including the specific section(s) of the RFP to which such assumptions apply. Assumptions that contradict provisions of the RFP or current law may render the Proposal non-responsive.

4.3.2. Bidder Identification and Information

Submit the following information:

- the Bidder's legal name, trade name, or any other name under which the Bidder does business, if any;
- the address and telephone number of the Bidder's headquarters office;
- the type of ownership (e.g., nonprofit corporation, public company, partnership, Subsidiary);
- if the Bidder is an Affiliate or Subsidiary, identification of the parent organization;
- if any change of ownership of the Bidder's company is anticipated during the 12 months following the Proposal due date, the Bidder must describe the circumstances of such change, indicate when the change is likely to occur and what implications it would have for the Agency should the Bidder be awarded a Contract;
- the name and address of any sponsoring corporation or others who provide financial support to the Bidder and type of support, e.g., guarantees, letters of credit, etc. Indicate if there are maximum limits of the additional financial support, and
- the state in which the Bidder is incorporated and the state(s) in which the Bidder is licensed to do business as a PPO. The Bidder must also indicate the state where it is commercially domiciled, if applicable.

4.3.3. Subcontractor Information

If the Bidder is proposing to use one or more Major Subcontractors, the Bidder must identify such subcontractor(s) and provide the information required in this section regarding such subcontractor(s). The Agency reserves the right to disqualify any bid in which the following information is not provided on a Major Subcontractor(s) that the Bidder proposes to use.

Bidders must submit the following for each proposed Major Subcontractor, if any:

- a signed letter of commitment from each Major Subcontractor that states the Major Subcontractor's willingness to enter into a subcontractor agreement with the Bidder and a statement of work for activities that are to be subcontracted. Letters of Commitment must be provided on the Major Subcontractor's official company letterhead and signed by an official having the authority to bind the company for the work to be subcontracted;

- the Major Subcontractor's legal name, trade name, or any other name under which the Major Subcontractor does business, if any;
- the address and telephone number of the Major Subcontractor's headquarters office;
- the type of ownership (e.g., proprietary, partnership, corporation);
- if the Major Subcontractor is an Affiliate or Subsidiary, identification of the parent organization;
- if any change of ownership of the Major Subcontractor's company is anticipated during the 12 months following the Proposal due date, the Bidder must describe the circumstances of such change, indicate when the change is likely to occur and what implications it would have for the Agency should the Bidder be awarded a Contract
- the state in which the Major Subcontractor is incorporated, commercially domiciled, and the state(s) in which the organization is licensed to do business;
- what provisions the Bidder has in place to monitor the performance of subcontractor on an on-going basis and to provide for corrective action plans, revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate;
- what arrangement(s) the Bidder is willing to provide to the Dirigo Health Agency to guarantee delivery of service under the Contract in the event of a Major Subcontractor's insolvency, and
- whether the Major Subcontractor had a contract terminated or not renewed for nonperformance or poor performance within the past five years. If the Major Subcontractor had a contract termination or non-renewal, the Bidder must describe the issues, the parties involved, and provide the address and telephone number of the principal terminating party. The Bidder must also describe any corrective action taken by the Major Subcontractor to prevent any future occurrence of the problem leading to the termination or non-renewal.

4.4. Corporate Clients and Experience

List the name(s) of any clients that individually represent twenty percent (20%) or more of your business' revenues, and provide the corresponding percentage for each such client.

Provide references for the Bidder's five largest Maine clients. Include the following information:

- client name and address;
- name, telephone, and e-mail address of the person the Agency could contact as a reference and that can speak to the Bidder's performance;
- services the Bidder provides to the company or organization, and
- the number of employees or participants enrolled in the Bidder's plans for each client.

Should the Bidder not currently possess any Maine clients, provide comparable information taken from the Bidder's national book of business.

Describe any penalties, contract cancellations, terminations, sanctions, reprimands, or administrative proceedings or lawsuits in connection with any contracts, including full disclosure of any instance in which the customer charged the Bidder with inadequate performance or breach of contractual obligations.

Include any regulatory action and/or fines imposed by any federal or state regulatory entity within the last 3 years, a description of any letters of deficiencies, corrective actions, findings of non-compliance, and sanctions.

If the Bidder has been sanctioned or placed under corrective action for prohibited Marketing practices by the Centers for Medicare and Medicaid Services (CMS), a state agency in Maine, or by another state, describe the basis for each sanction or corrective action and explain how the Bidder would ensure that it would not commit any practices prohibited by the CMS or the State in its Marketing activities.

The Agency may, at its option, contact these clients or regulatory agencies and any other individual or organization whether or not identified by the Bidder.

The Agency may include in its RFP review process evaluations of a current contractor's performance under an agreement with a state agency in Maine, including but not limited to any corrective actions or liquidated damages imposed by another government agency.

4.5. Litigation History

Indicate if the Bidder has settled out of court or been sued on issues regarding possible malpractice by providers, quality of care, access to care, or claim denials within the past five years. If so, identify the general nature of each settlement or lawsuit. Also, identify how they were resolved:

Resolution	%
Settled out of court	
Resolved in favor of plaintiff:	
Resolved in favor of the Bidder's organization	

Provide a list of the allegations and the outcome for all settlements and lawsuits in which the Bidder or its subcontractors have been sued within the last three years. If the Bidder is not willing to provide this list, explain why.

Is the Bidder currently involved in any settlement cases or lawsuits against vendors or clients of your company? If so, state the general nature and status of these proceedings.

4.6. Miscellaneous Contract Provisions

Confirm that the Bidder will send to each employer group and individual enrolled in the program a copy of the participation agreement. (Sample in Appendix 6)

Confirm that the Bidder will send to each member a Certificate of Coverage. Please provide a sample Certificate of Coverage.

Confirm the Bidder's willingness to represent and warrant that the Bidder is or will be in compliance with all federal and state laws and Maine Bureau of Insurance statutes, regulations, and bulletins, applicable to the

services the Bidder proposes to perform and/or benefits it proposes to provide under the Contract. If the Bidder cannot issue such a confirmation, describe why the Bidder is unwilling to agree to this request.

Confirm that the Bidder's contracts will be situsedin Maine and will comply with Maine Bureau of Insurance requirements and regulatory approvals, including the Maine Pharmacy Act.

Confirm that the Bidder will sign the HIPAA Business Associate Agreement attached as Appendix 4 to ensure that member privacy is maintained.

Confirm that the Bidder's organization is compliant with the electronic interchange and health data security rules as set forth in the HIPAA privacy guidelines.

Confirm that the following organizational structures are in place to prevent fraud and abuse:

- The Bidder's staff includes a compliance officer who is accountable to senior management;
- The Bidder's organization includes a compliance committee that is accountable to senior management;
- The Bidder has written policies, procedures, and standards of conduct that articulate the organization's commitment to comply with applicable federal and state standards; and
- The Bidder has a published compliance plan that is designed to guard against fraud and abuse.

Provide the following written assurances:

- Neither the Bidder nor any of the Bidder's agents (i.e., principals, employees or subcontractors) has presently, or will have during the term of the Contract, an actual or potential conflict of interest or lack of objectivity pertaining to the RFP requirements, the handling of the Agency's confidential information, or the health care administration or contracting business of the Agency.
- The Bidder's organization and staff will during the Contract period act in conduct with the Contract, and no member of its staff will engage in unauthorized lobbying, program policy promulgation, procurement, contracting negotiations, or other activities reserved to the Agency.
- The Bidder assures that if required during the initial or any subsequent Contract Periods, its organization will negotiate in good faith with the Agency for one or more Contract amendments for the purpose of adding closely related work components to the work requirements.

4.7. Financial Requirements

Confirmations

The Carrier must assure the Agency of financial stability and requisite protections of the Carrier.

The Carrier must hold all necessary licenses required to do the work within the scope of this RFP and must meet all Bureau of Insurance solvency and reserves standards.

The Carrier must participate in the State of Maine's worker's compensation pool prior to or upon execution of the Contract. The Carrier shall furnish the Agency with written or photocopied verification of the existence of such worker's compensation coverage.

The Carrier must keep in force a liability policy relevant to the services described in this RFP's scope of work issued by a company fully licensed or designated to do business in this state for liability insurance by the Maine Department of Professional & Financial Regulation, Bureau of Insurance. The policy must include the activity to be covered by the Contract with adequate liability coverage to protect the Carrier and the Agency in the event of legal action. Prior to or upon execution of the Contract, the Carrier shall furnish the Agency with written or photocopied verification of the existence of such liability insurance policy.

The Carrier must also keep in force an automobile liability policy

Questions

1. Are there any restrictions or pending reviews by state or federal authorities for non-compliance with state or federal regulations? If yes, please provide details for the past three years, including the outcome.
2. Do you have a hold harmless agreement that prohibits network providers from billing or collecting from patients more than the coinsurance or copayment designated in the plan design?
3. What reinsurers does your organization currently interface with? Do you have a separate stop loss vendor?
4. Please provide your financial ratings from the following institutions:

Institution	Rating	Date of Rating
Weiss		
AM Best		
Standard & Poor's		

4.8. Overall Goals

Confirm your organization's commitment to the overall goals of the Agency:

- Expand access to the uninsured market in the state

- Develop focused sales and marketing strategies to reach the uninsured
- Develop a Preferred Network of Insurance Producers
- Demonstrate flexibility and willingness to make necessary changes to the program as National and State Health Reform progress, including regulatory changes, demonstration projects, and pilots

Describe your approach to achieving these goals, with specific references to other answers and material provided in your proposal, where appropriate.

4.9. Quality and Reimbursement Strategies

Confirm that your organization does not reimburse for "never" events (see Appendix 7)

Confirm your organization's willingness to work with the Agency in administering unique financial reimbursement arrangements with providers, including but not limited to hospitals, physician hospital organizations, Federally Qualified Health Centers, etc.

1. Please state if your organization currently performs hospital and physician performance measurement to assess variations in cost, quality, and patient safety for in-network and non-network providers? Please indicate the various performance measures used by your organization when making these assessments categorized by unit cost, efficiency, quality, and patient safety. Is this information available to enrollees? Is this information available to plan sponsors? Please provide the website address as well as any printed information and performance reports.
    a. For hospitals? If yes, for the hospital overall or by service line?
    b. For PCPs?
    c. For specialists? (please state specialties included and percent of Maine practitioners in each specialty included in measurement)

2. Does your organization rank or otherwise distinguish hospitals and physicians by their level of performance?
3. Are physician performance measures captured at the group, practice, or individual level? Are you willing to require measures at the individual level? Are you willing to restructure contracts so that incentive payments are made at the individual level?
4. Are physician incentive payments made at the group, practice or individual level?
5. Is physician network tiering done at the group, practice or individual level? Are you willing to tier your network at the individual level?
6. What is the methodology used to assign providers to various tiers?
7. How often is tiering re-assessed?

8. Do you offer products that include incentives for enrollees to access high performing providers? How would you propose to achieve patient migration?
9. Is your organization currently administering any evidence-based benefits for any Maine clients? Please describe these programs and their initial results.
10. Describe how your organization monitors evidence-based research and examines strategies to incorporate that information into (a) your physician education and outreach services, (b) your disease management programs, and (c) benefit design.
11. Can you administer these evidence-based programs regardless of funding arrangement?
12. What is your position on and capability to administer an evidence-based design that treats patients in different health situations differently? For example, the general rule may be first colonoscopy at age 50. But for individuals with a certain personal or family history, the first colonoscopy is indicated at an earlier age and with greater frequency.

4.10. Disease Management

1. Please provide a description of those disease management programs that you provide. Describe how each program monitors and follows up with individuals that have started a disease management intervention to make sure they are continually engaged and completing activities.
2. Indicate the data sources you will use to identify and stratify program participants for your disease management program(s). Please provide documentation that describes how you apply data in each of the applicable programs and processes.
3. Please provide your definitions of your disease management acuity levels and briefly describe the process by which you engage candidates for optimal results (i.e., number of phone attempts to enroll participant, followed by failure to reach letter over what time period, etc.). If your definitions vary by disease, please describe how they differ.
4. Indicate whether your disease management programs are currently managed “in-house” or “outsourced” to a partnering organization.
5. Are there components of your disease management services (screenings, provision of DME, ongoing health coaching, print/educational communications, tracking, reporting, and care coordination) that are performed by community-based practices?
6. How do you incentive and reward members for active participation in your disease management programs?
7. Please provide the staffing structure for your program(s), including number of FTEs and ratio of staff to participants for the past 3 years.
8. Describe the analysis that your organization has conducted on current disease management services. Please describe in detail your ROI methodology for your disease management program. Provide the actual ROI calculation(s), noting all elements and assumptions.
9. Are you willing to guarantee a defined ROI for all or selected disease/care management programs?

10. Please describe the media and format (i.e., print, phone, web) that you use in your disease management programs.

4.11. Provider Networks

1. Describe your provider networks. Please include a description of the primary care network, physician specialist network, specialized network for behavioral health, networks or any other arrangements for advanced imaging, and hospitals. Your description should include the following:
2. The geographic areas covered by the proposed provider networks. Please provide a GEO access analysis on the expected availability of PCPs (including open and closed practices), specialists, and hospitals. The Databook in the required Rate Bid Form provides the location of members by zip code.
3. The types and volume of providers: hospitals, PCPs, specialist physicians, behavioral health, and ancillary providers.
4. Please provide a complete provider network listing, including hospitals.
5. Are your networks owned and operated by your organization?
6. How are providers selected and qualified for participation in the network? Please describe any financial incentives for adherence to primary care protocols. Are primary care practices required to comply with clinical guidelines developed by your organization or other parties?
7. Describe the current financial arrangements with network providers:
    a. Hospitals and other institutional providers:
        i. Discount off charges
        ii. Case rates
        iii. Global fees
        iv. Other
    b. Primary care physicians and specialists:
        i. Capitation
        ii. Fee schedules
        iii. Discount off charges
        iv. Other
    c. Behavioral health providers (psychiatrists, psychologists, LCSW, etc.):
        i. Capitation
        ii. Fee schedules
        iii. Discount off charges
        iv. Other
8. Describe any risk sharing arrangements between your organization and providers relative to in-network referrals and use of out-of-network providers.

9. What are the credentialing criteria for network physicians? Specifically address the following:
    a. Do you check state license status?
    b. Do you check the federation of state medical boards?
    c. Do you check disciplinary actions or license modification by the State licensing authorities?
    d. Do you check the status of the physician's registration with the Drug Enforcement Agency?
    e. Do you check for malpractice claims?
    f. With what frequency do you review credentials?
    g. With what frequency and with what criteria do you review physician performance?
    h. Do you screen for hospital admitting privileges and adverse clinical privileges actions?
    i. Do you review for Medicare/Medicaid sanctions?

10. How do you address enrollee complaints against physicians?
11. Please provide a copy of the standard contracts with primary care physicians, specialists, and hospitals. For what period of time are the providers committed under the terms of your contracts?
12. On what basis can the network terminate agreements with providers? Within the past three years, how many physicians have been dis-enrolled from the network based upon a decision by your organization? What were the reasons for each of the terminations?
13. Describe any network arrangements your organization maintains with out-of-state providers available to our members traveling and or living out-of-state, i.e. college students.

4.12. Prescription Drugs

1. What percent of prescriptions are not in your formulary today? What percent of prescriptions do you anticipate will not be in your formulary in 2010 and 2011?
2. Provide the utilization rate of prescriptions for 2008 and 2009, expressed as number of prescriptions PEPM
3. What was the percent of prescriptions that were generic in 2008 and 2009? What percent of prescriptions do you anticipate will be generic in 2010 and 2011?
4. What was the average paid amount per prescription in 2008 and 2009? What do you anticipate the average amount paid per prescription to be in 2010 and 2011?
5. Describe the Bidder's formulary development process and prior authorization processes. Please include information on notification and education of pharmacies, physicians and Members of formulary changes or changes in prior authorization processes. The State is considering requiring prior authorization of all dispense-as-written (DAW) prescriptions. Please describe your organization's ability to PA all DAWs and the impact of such a requirement.
6. Describe the Bidder's mail order program. Include an explanation of how the Bidder manages its mail-order facility and assures quality. Include an explanation of how the Bidder will transition Members to mail order prescriptions.

a. Are specialty drugs dispensed from the same mail order facilities identified above? If not, specify the geographic locations of the facility you intend to use to dispense specialty drugs.

b. What is your definition and internal standard for mail order dispensing accuracy?

c. What is your definition and internal standard for mail order turnaround time? How is mail order turnaround time measured? What, if any, medications are excluded from your measurement of mail order turnaround time?

d. What is your protocol for contacting the member if incomplete information is supplied on a prescription?

e. What is the protocol for contacting the physician if incomplete information is supplied on a prescription?

f. Provide a list of over-the-counter (OTC) medications by your formulary. Are OTC medications offered through mail service? If yes, are OTC medications advertised on your member web site? How are OTC medications shipped to mail service members? Is there an additional charge associated with the shipping of OTC medications?

g. Describe how a mandatory mail order program is designed and managed.

h. What is your standard approach for shipping mail order prescriptions (e.g., US Postal Service or UPS)?

7. Describe the Bidder's clinical programs, including both concurrent and retrospective drug utilization review (DUR) programs. Describe the Bidder's ongoing efforts to monitor and improve clinical programs to assure quality services for the members in the most cost-effective manner.

4.13. HMO or POS product

1. How often can members change primary care physicians?
2. Can each family member select a different primary care physician?
3. If members are referred to services from out of network providers are they protected from charges above usual and customary?
4. If members self-refer to out of network providers are they protected from charges above usual and customary?

4.14. Care Management, Case Management and Utilization Management

1. Confirm that your organization is participating in Maine's Patient Centered Medical Home pilot project
2. Describe what outpatient utilization/care management programs your organization offers for ambulatory surgery and diagnostic services. Are there different levels of prior authorization and utilization review?
3. Describe the care management and utilization review services that are offered for behavioral health and substance abuse cases. Can your organization's behavioral health/substance abuse services be integrated with an employer-sponsored EAP? If yes, please explain.
4. How are new technologies and procedures evaluated and recommended for inclusion as covered services and approved treatment protocols?

5. Does the same case manager follow the case throughout its course in case management?
6. Does the case manager perform file review/follow up to ensure that a patient is not regressing after completion of the case management program?
7. How often do physicians review cases? What are the criteria for a nurse to refer a case for physician review?
8. Provide a list of services (procedures, drugs and therapies) that your organization recommends be pre-certified.
9. Is inpatient concurrent review conducted, telephonically, on-site (if so, how are facilities elected?), or both?
10. When does discharge planning begin? Is there preadmission discharge planning for selected procedures? If yes, please list these procedures.

4.15. Health Risk Assessments

1. Does your organization use a health risk assessment (HRA) to identify care management opportunities or to risk stratify enrollees? Please identify the HRA tool that is used and describe how responses to the HRA are used to identify and manage high-risk members. Does your organization have experience offering incentives to encourage responses to HRAs?
2. Can you provide a paper HRA? If so, what is the turn-around time for processing results and getting them to HRA participants?
3. Can you provide a web-based HRA?
4. Does an individual receive a real-time personal report following completion of your web-based HRA?
5. Please provide a sample print HRA questionnaire, individual results report, aggregate client report and demo URL with access instructions.

4.16. Nurseline

1. Describe the nurse call line services that are offered by your organization. Provide a detailed explanation of the services available and the utilization experience of current clients.

4.17. Administration

4.17.1. Organizational Description

Submit an organizational chart (Chart A), showing the current corporate structure and lines of responsibility and authority in the administration of the Bidder's business.

If the Bidder is proposing to use a Major Subcontractor(s), include an organizational chart demonstrating how the Major Subcontractor(s) will be managed within the Bidder's local organizational structure, including the primary individuals at the Bidder's organization and at each Major Subcontractor organization responsible for overseeing such Material Subcontract. This information may be included in Charts A or B, or in a separate organizational chart(s).

4.17.2. Enrollment

Confirm your ability to meet the requirements and responsibilities described in Section 3.6.4. Provide sample communications that the Bidder sends to members and employers, including information sent both before and after enrollment into a plan.

Confirm that you are willing to provide COBRA administration for members and describe what services you will provide.

Confirm that you will utilize a disenrollment survey with groups that disenroll from the program

Confirm that you will capture the Standard Industry Code (SIC) or other industry identification code as part of your small group enrollment process.

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4.17.3. Sales and Marketing

Confirm your ability to meet all sales and marketing requirements set forth in Section 3.6.5.

2. Describe the Bidder's broker distribution channels. Include the number of agencies and brokers per county and in totality.
3. Explain any differences in the brokers that the Bidder partners with based on the following market segments: individual, small group (2-50), large group.
4. Detail what percentage of the Bidder's total sales are handled through the broker distribution channel for each of the Bidder's market segments: individual, small group (2-50), large group
5. Describe your direct sales distribution channels. Provide the percentage of sales handled through the direct sales distribution channel for each of your lines of business. Include the number of direct sales agents that are employed by the Carrier.
6. Provide sample sales reporting metrics to include monthly activity such as close ratios, terms, etc. specific to the small group segment for 2008and first quarter 2009.
7. Explain whether the Bidder has a broker advisory committee and if so, please describe the committee. Confirm that an Agency representative will be invited to participate as an active member of the committee.

8. Describe how the program will be incorporated into the Bidder's product portfolio, including addressing possible issues with current market offerings.
9. Describe what strategies you will utilize to achieve the membership goals of the Agency with particular attention to strategies to enroll uninsured and underinsured small employers.
10. Describe how the Bidder will assess the success of the marketing strategies utilized when marketing the program. Confirm that the Bidder will report its findings on these marketing strategies to Agency staff on a quarterly basis and that the report will include recommended changes to improve outcomes.

4.17.4. Member Services

Confirm your ability to meet all member services requirements set forth in Section 3.6.6

Confirm your willingness to provide specialized training to Member Services representatives

Confirm your willingness to support the Agency's member hotline. The total projected cost in SFY 2010 is $137,300 and in SFY 2011 is $143,550.

Confirm your willingness to distribute Provider Directories to members as part of the transition process and upon request thereafter.

1. How do you evaluate patient satisfaction with the following services: quality of care in office visits, medical treatment for acute and chronic conditions, administrative functions and office procedures?
2. Are customer service personnel available to assist enrollees in:
3. Enrollment process
4. Selecting a primary care physician
5. Selecting specialists
6. Locating other types of care (e.g., physical therapy, home health)
7. Describe the methods used to maintain focus on service to the customer throughout the organization. How do you evaluate the performance and effectiveness of your customer relations operations?
8. Provide a copy of your most recent member satisfaction survey along with the aggregated results. How often is the member survey sent and is it sent to a random sampling of members? Please describe.
9. Describe your organization's appeal/grievance procedures for subscribers.
10. In the past two years how many members have filed formal appeals for denied claims? How many members have filed complaints with the Bureau of Insurance during the same period?
11. What is your current performance standard for turnaround time on inquiries from members on claims questions, eligibility/enrollment issues, and complaints regarding providers?
12. Please provide a flowchart that depicts the process the Bidder will employ, from the receipt of a request through each phase of the review to notification of disposition, and document the average time for resolution over the past 12 months in member Grievances and Appeals, stratifying expedited and non-expedited grievance reviews, from date of receipt to date of member notification. If the Bidder did not operate in Maine, provide data for its three (3) largest fully insured clients, and identify such clients and their data.

13. Do you provide a dedicated 800 number for Member Service?
14. Do you provide an AT&T Language Line or other comparable translation services?

4.17.5. Reporting

Confirm that you will be able to provide the reports specified in Section 3.6.9.

Confirm your willingness and ability to work with the Agency to provide the appropriate data and analysis when the Agency must satisfy requirements to produce such data and/or analysis.

1. Please provide samples of the periodic reports you will provide the Agency.
2. Please describe your process for developing ad-hoc and custom reports for the Agency. Be specific in regards to average time to completion and approvals required.
3. Please describe your ability to provide the Agency with access to its data through an on-line reporting and data portal, including access to eligibility and claims files. The Agency must have the ability to develop queries of the eligibility and claims experience of the program. The Agency must be able to save queries should the Agency need to replicate a query in the future.

4.17.6. Transition

Confirm that you will be able to provide the transition services specified in Section 3.6.10.