Notes for Bidders:

1) The RFP and Bid Form 4 use inconsistent naming conventions for the different small group plans required (High Deductible, Low Deductible, and HSA in the RFP vs. Value, Basic, and HDHP in the Bid Form). Please use the High Deductible, Low Deductible and HSA titles.

2) The Agency will distribute the supplemental databook to all bidders after the Intent to Bid deadline, October 26th, 2009.

3) After distribution of the supplemental databook, the Agency will accept additional questions relating to the databook through November 3rd. The Agency will provide responses on November 6th.

4) The Agency intends to provide further information under separate cover on section 3.6.1.0 (Transition to Alternate Plan) by November 6th.

Additional Information Discussed at Bidder's Conference:

The Agency's September enrollment report is available at:
http://www.dirigohealth.com/Documents/Numbers_September09.pdf

The Agency's letter to the Joint Standing Committee on Insurance and Financial Services describing the Agency's planned eligibility changes is available at:
http://www.dirigohealth.com/Documents/Status%20report%20to%20IFS%20100509%20_2_.pdf

The Agency's asset test definition is available in Attachment A of the Board's August Discussion Document at: http://www.dirigohealth.com/Documents/board_discussion_08172009.pdf

The results of the Agency's survey are available in the Board's July Discussion Document at:
http://www.dirigohealth.com/Documents/Options_07172009_inc_income.pdf

Questions and Responses:

1	Page 15	Q. Please clarify whether the target $509.96 PMPM is a target for the base premium rate or whether it is a weighted average based on the existing enrollment mix (age, etc). A. The target $509.96 PMPM is the target revenue requirement for FY 11 not the base premium rate. We expect the base premium rate to be normalized to account for enrollment mix. That is, this target should already reflect enrollment mix such as age and area. In addition, we also expect this target to reflect assumptions for the eligibility changes that is not reflected in the base data.
2	Page 15	Q. Please clarify whether the reference to mental health parity is a reference to the state mental health parity law, the federal mental health parity law or both. Our assumption is that it is a reference to the state law since the federal does not apply to individuals or small groups. A. References to mental health parity refer to both state and federal laws. The Agency requires that the bidder apply these standards to all segments, including individuals and small groups.

3	Page 16	Q. Please provide information on the base plan to be used for determining whether the proposed plan has a minimum actuarial value of 65%. A. Please use DirigoChoice's current covered services with **no member cost sharing** as the base plan when determining an actuarial value. The actuarial value should reflect the percentage of medical expenses estimated to be paid by the insurer.
4	Page 16	Q. Please confirm whether that minimum actuarial value to test is to be applied to each plan design or on an aggregate basis. A. The minimum actuarial value to test will be on an aggregate basis.
5	Page 17	Q. Please confirm whether the core benefits must be the same only within each segment (nongroup, small group) or whether they must be the same across segments. A. Under the alternate plan the core benefits must be the same only within each segment (non-group, small group).
6	Page 18	Q. Please define "Material Subcontractor". A. Note – the RFP refers to a "Major Subcontractor." A "Major Subcontractor" is any subcontractor that possesses 10% or more of the value of the contract or any subcontractor that the bidder determines to be an important teaming partner critical to the success of the program. Bidders should identify the same "Major Subcontractors" in responding to all sections of all volumes where such identification is required.
7	Page 26	Q. Please confirm whether for the "Alternative Plan" option it is the DHA's intent for (a) all existing members to recertify their financial eligibility for July 1, 2010 and move to a July 1, 2010 renewal date, (b) for all existing members to move to the Alternate Plan as of July 1, 2010, but keep their existing renewal date and not recertify their financial eligibility until their next renewal date or (c) something else. A. The Agency intends for all existing members to recertify their financial eligibility for July 1, 2010 and move to a July 1, 2010 renewal date under the Alternative Plan.
8	Page 39	Q. Please confirm that SIC information is required only for small groups for whom industry rating applies (currently groups with 25+ subscribers). A. Industry type information is required for all small groups.
9		Q. Please provide any enrollment projections (including assumption) that reflect the enrollment impact by plan for the anticipated changes to the existing eligibility determination processes. A. The Agency's enrollment projections in the databook (Bid Form 4) reflect anticipated member distribution due to eligibility changes, excepting changes due to the population over 65 moving to Medicare. The Agency will be providing further information on the 65+ population in its supplemental databook.
10		Q. Additionally, please include the percentage of existing Plan Type B enrollees to be impacted by the new Medicaid eligibility determination requirement.

		A. As noted above, assumptions pertaining to eligibility changes are included in the Agency's enrollment projections in the databook (Bid Form 4). The Agency anticipates 34% of B enrollees will be potentially eligible for Medicaid (non-group enrolled in Family and Employee + Child(ren) contracts). Of these, the Agency anticipates that 50% will not choose to apply. Of the remaining 50%, the Agency anticipates that some portion will be excluded due to assets or other factors.
11	Page 2	Q. Does the state have funding approval for the premium subsidy for multiple years or on a year-by-year basis? A. The Agency has funding through 24-A MRSA § 6917 (passed as PL 2009 Chapter 359). The law is available at: http://janus.state.me.us/legis/ros/lom/LOM124th/124R1/PUBLIC359.asp. The law establishes a flat 2.14% access payment on paid claims.
12	Page 5	Q. Please explain the annual rate review process including the expected timing for each step and the key decision criteria used to adjust rates. A. The State's rate review process is described under the Bureau of Insurance rule Chapter 940 and is available at: http://www.maine.gov/sos/cec/rules/02/031/031c940.doc
13	Page 18	Q. Are retroactive terminations for non-payment or subsidy allowed? A. Please see Bureau of Insurance bulletin 288 at: http://www.maine.gov/pfr/insurance/bulletins/288.htm
14	Page 23	Q. Are the adjusted community rate and the account charge the same thing? If not, please provide an example like the non-group example provided. A. In the case of small groups, the adjusted community rate and the account charge are the same. In the case of non-group, the account charge is the adjusted community rate less the account's subsidy. In each case the account pays the Agency and the Carrier is responsible for reporting/billing the Agency for the account's portion of the total premium.
15		Q. Does the small group have a choice of whether the subsidy is via an electronic benefits card or direct deposit in a designated account (each person's bank account)? It appears as though the Agency will handle the subsidy payment under either method? A. It is the small group employee who determines whether the Agency should send his/her subsidy via EBT card or via direct deposit. The Agency handles the subsidy payment under either method.
16		Q. Responsibility of the Agency in relation to responsibility of the account – If the member does not pay 100% of premium (partial payment) as due, the Agency will not pay the subsidy. If they subsequently pay the balance due on the following month's invoice, will the Agency retroactively pay the subsidy for the prior month? A. Yes.
17		Q. Is the membership fee in addition to the targeted $509.96 monthly premium? A. Yes.
18	3.6.10 - Transition	Q. Under section 3.6.10 (Transition) & 1099 expectations - Will this require merge with old carrier to produce 1099's?

		A. The Agency does not currently produce 1099 forms. The tax status of DirigoChoice subsidies may vary from situation to situation. The Agency cannot give tax advice or specify what tax status the subsidy may have for any particular member. Members should consult with a qualified tax professional.
19		Q. List out any expected SLA's A. The Agency has no specific requirements for performance guarantees or service level agreements as part of this proposal. The Agency expects that the successful bidder will provide reporting on performance/service levels that may form the basis of future arrangements.
20	Page 32	Q. Please explain the rational for carrier's requirement to participate in the State of Maine's Workers Compensation pool and the requirement to keep an automobile liability insurance policy in-force. Are these related to Maine insurance regulations imposed on all Maine health insurers by the Bureau of Insurance? A. Please disregard these requirements.
21		Q. Would the Agency allow the Contractor to transition to a different network (presumably one designed for the needs of the Agency and the DirigoChoice population) following the first year of the contract? A. Yes, as long as both the network provided in the first year and subsequent years both meet the requirements detailed in the RFP and all applicable State regulations (see especially Bureau of Insurance Rule Chapter 850 at: http://www.maine.gov/sos/cec/rules/02/031/031c850.doc)
22		Q. Would the Agency be willing to accept two rate proposals from the Carrier for its Alternative benefit plan? The intent would be to differentiate between what is currently contemplated in the RFP and the potential scenario whereby the Agency requires all DirigoChoice enrollees to transition to the new Alternative plan on July 1, 2010. A. No. It is the intention of the Agency that the Alternate Plan requires all members to transition on July 1, 2010. Bidder's proposed rates should reflect that intention.
23	Page 33	Q. Can DHA provide some examples of the unique financial reimbursement arrangements with providers mentioned in this section? A. The Agency is interested in exploring opportunities to negotiate reimbursement arrangements directly with a health system(s) or individual hospital(s).
24	Page 39-40	Q. What percentage of the DirigoChoice total enrollment was sold through brokers? A. 66% of small groups, 20% of sole props, 17% of individuals.
25	Page 40	Q. What is the Agency member hotline? Does the $143,550 include personnel costs as well? If so what is the breakdown been phone costs and personnel costs? A. The Agency's member hotline is a dedicated 800 number for member inquires and assistance. The $143,550 is primarily for personnel costs, with $12,550 dedicated for IS support.