

ADDENDUM NO. 1

**REQUEST FOR PROPOSALS 019-FF10 FOR
MEDICAL BENEFITS, BEHAVIORAL HEALTH, WELLNESS, AND
PRESCRIPTION DRUG PROGRAMS**

**FOR
THE SCHOOL BOARD OF MIAMI-DADE COUNTY, FLORIDA**

PURPOSE OF ADDENDUM

This Addendum has been prepared to answer specific questions submitted by proposers.

ACKNOWLEDGMENT OF ADDENDUM TO RFP

As required in the RFP, proposers are reminded that they should either acknowledge receipt of this Addendum on their proposal, or attach this Addendum to their proposal.

STATUS OF ADDENDUM

To date, this is the first Addendum that has been issued for the Request for Proposals for #019-FF10, Medical Benefits, Behavioral Health, Wellness, and Prescription Drug Programs.

ADDITIONAL INFORMATION

The transcription of the Pre-Proposal Conference of December 7, 2005 is attached as a txt file.

**ALL QUESTIONS ARE RETYPED EXACTLY AS RECEIVED
(TYPOGRAPHICAL ERRORS HAVE NOT BEEN CORRECTED.)**

1. A gatekeeper quotation is requested. The Fringe Benefit Management File Layout does not seem to have a place to designate a PCP – unless field 34 has this opportunity – will this be added?

If the current eligibility file layout lacks the necessary fields for a gatekeeper product, additional fields will be added (in the event M-DCPS elects to offer a gated product).

2. There is a very complicated matrix of bids requested. (Grid enclosed) With the holidays, can an extension on the due date be granted?

Extensions are not granted at this time.

3. There is a very complicated matrix of bids requested. (Grid enclosed) How will the different bids be scored and weighted?

Proposals will be evaluated based on the overall value of each to M-DCPS. Value will include both financial and non-financial measures, including but not limited to savings associated with premiums, ASO fees/network discounts, performance guarantees, proposer responses to the questionnaire, network accessibility, match to current providers, contractual terms, proposal deviations, length of guarantees, and so on. See Section IV, Selection Criteria of the RFP.

4. Page 4 – Can a carrier quote on a different mix of products for the 7/1/06 date versus the 1/1/07 date?

Ideally, proposers will provide the same mix of products and designs for both the 7/1/06 and 1/1/07 dates. However, you may provide a different product mix for the different effective dates if you wish.

5. Page 13 – If a carrier has both an HMO license and an insurance license, can they provide a combination of products that best meets the MDCPS needs?

Yes.

6. Page 47, #48 & 49 – How many computer terminals and Service Representatives are currently dedicated by United for the medical, pharmacy and behavioral health?

United provides four representatives/computers.

7. Page 21, #46 – What are the current rebate levels?

UHC has declined to release rebate information specific to M-DCPS, claiming this information is not available on a client-specific basis for insured clients.

8. There was no pharmacy utilization data included with the RFP. Could you please release the 15 most recent months of pharmacy utilization data? We need the data broken out by retail vs. mail order and brand vs. generic.

We will request this information from UHC, however, proposers should proceed with their proposals assuming UHC may not provide this information prior to the RFP due date.

9. #87 under Communications – The carrier must utilize M-DCPS specific forms and materials, as necessary. It would be helpful if M-DCPS could provide some context around what forms and materials they are referencing.

Materials are produced and data entered by FBMC; all enrollment data is provided electronically. MDCPS must approve any communication sent from the carrier(s) to employees. Eligibility information will be provided electronically. Sample communication materials can be found on the website www.dadeschools.net on “employee” link.

10. We would like the opportunity to show claims savings through facility repricing of M-DCPS’ 30 most utilized facilities. Would we be able to receive a facility claims file that includes TIN, Facility Name, Address, City, ZIP, Claim Dollars, and Procedure Code?

We will request this information from UHC, however, proposers should proceed with their proposals assuming UHC may not provide this information prior to the RFP due date.

11. The RFP indicates that there should be 4 originals and 4 copies for each response. Please clarify this request.

The 4 ‘original’ copies should contain signed copies of the deviations and proposal certification forms. These must each be signed in blue ink. The 4 proposal copies may contain photocopies of these letters.

12. Could M-DCPS please indicate its policy for how it has historically treated information that has been marked as confidential in RFP responses?

MDCPS is required by statute to comply with all Florida Sunshine laws. All data transmitted to MDCPS as part of a proposal will become a matter of public record.

13. Exhibit 25B asks for facility specific discounts and per diems. Would M-DCPS be willing to release the total claim dollars for each of the facilities in Exhibit 25B so that we could apply our discounts and provide an overall savings total?

We will request this information from UHC, however, proposers should proceed with their proposals assuming UHC may not provide this information prior to the RFP due date.

14. If our facility discounts would become part of public record, even if they are marked confidential, would Deloitte Consulting be willing to sign a confidentiality agreement, which would thereby allow [proposer] to release its discounts to Deloitte for the purpose of evaluating [proposer]'s negotiated discount strength?

No.

15. Within the Eligibility Layout the following there is the following language: "This code is used by FBMC to recognize the type of coverage, and if the deduction is from the flex plan option or employee election, Acct B (Employer/Retiree paid) take precedence over Acct A. Can you confirm if we could be getting two levels of coverage and have additional interpretations?

Account A is anything paid for by the Board. Account B is anything paid for by employees through payroll deductions (e.g. spouse/DP, children, family coverage).

16. Page 21, #56 – What administrative procedures do you anticipate being maintained?

This issue is very important. Per MDCPS' agreements with its unions, benefits and procedures must be maintained for the term of the contract. Carriers cannot elect to change their policies or requirements for payment of a benefit during the contract. An example could be enacting additional requirements for coverage of gastric bypass surgery beyond those in force at the time the coverage is put in place. Another example would be changing the prescription formulary resulting in a cost increase to members.

17. Page 22, #53 – Will the School Board hold the carrier/administrator harmless for any errors caused by FBMC?

Yes, however carriers must agree to not limit retroactive eligibility changes regardless of funding arrangement. For example, MDCPS may require the carrier to retroactively enroll members mistakenly not enrolled in a timely fashion.

18. Page 24, Performance Guarantees – Must the amount at risk be quoted as a percentage of premium/fees or can it be quoted as a dollar amount?

Carriers may propose on a dollar amount basis.

19. Page 27, #16 – Can you provide a sample of the automated experience and utilization reports you currently receive?

Please refer to the monthly claim and enrollment exhibits. These are presently the only automated experience reports received by MDCPS.

20. Page 26, #5 – Can you provide a copy of the current renewal mythology?

No.

21. If Bargaining Unit accepts a proposal, would members under B.U. be allowed choice of B.U. specific plan AND general plan?

Either scenario could occur.

22. How is utilization savings (as mentioned on pg. 25) measured?

This question refers to Drug Utilization Review savings. Each proposer should present how they would measure DUR savings and this measurement will be subject to negotiation before business is awarded.

23. Rx rebates for carriers are typically determined based on carrier wide experience. How is the issue of Rx rebates handled by the incumbent carrier?

Rx rebates are fully-retained by the incumbent carrier and are not reported to MDCPS.

24. Does MDCPS currently receive monthly claim (dollar and utilization) reports, specifically utilization data? If so, can you provide the utilization data as none were provided in the RFP.

MDCPS receives monthly claims and enrollment reports which have been provided as attachments to this RFP. We will request utilization information from UHC, however, proposers should proceed with their proposals assuming UHC may not provide this information prior to the RFP due date.

25. To ensure that the Cone of Silence is not violated, can MDCPS provided the names of each individual representing the organizations on the Superintendent's Ad-hoc Insurance Committee?

The individuals holding these positions at the time the evaluation committee is convened may change from today. In addition, committee members may elect to send a representative in their stead.

26. The claims exhibits did not delineate membership counts. Can these reports be revised to include membership in addition to subscriber counts?

We will request this information from UHC, however, proposers should proceed with their proposals assuming UHC may not provide this information prior to the RFP due date.

27. Is it possible for MDC to provide the underwriting worksheet for the 2006 renewal from United Healthcare?

No.

28. No experience reports were provided for the unit identified as “Management/Confidential Exempt.” These lives include active and leave employees as well as retirees? Can an experience report be provided?

In the monthly claims and enrollment entitled “claims by suffix” you will find MEP (Managerial Exempt Personnel and Confidential Exempt (active) employees) information in the worksheet entitled MEP. Leave employees and retirees are identified under separate worksheets.

29. There is no data provided for “DASA.” Is it part of the “Management/Confidential Exempt?” If not, can census and experience data be provided?

DASA is the professional organization that represents MEP. See response to question #28.

30. No census data was provided for the units identified as “Food Service.” Is “Food Service” experience included in the AFSCME experience data?

In the census, food service personnel are included in AFSCME. In the experience reports, their experience is in the tab entitled “Food Service.”

31. No census data was provided for the units identified as “MEP.” What does “MEP” denote? Is the experience included in another experience exhibit? If so, which one?

In the census file, Managerial Exempt Personnel (MEP) is identified as Bargaining Unit #6.

32. No COBRA census was provided although a COBRA experience exhibit was provided. There does not appear to be a COBRA identifier on the census provided. Are these subscribers included in other experience exhibits? Can a revised census identifying COBRA participants be provided?

The census provided does not contain COBRA enrollees and this is clearly stated on page 3 of the RFP (thus there is no identifier on the census file). COBRA experience is

included in the claim reports. Accurate census information for COBRA participants cannot be provided at this time.

33. There was no census data provided for the AFSCME Hospital Only plan. The experience report provided shows no lives and claims are a negative amount. The experience report is included in the retiree total. The RFP shows 600 employees enrolled. Where are the lives and claims associated with this plan?

There are no claims for this group. These are active employees with a special plan arrangement as described in the RFP. Census data is not available.

34. The retiree experience exhibit appears to be only post 65 retirees. Please confirm. If so, to which bargaining unit do they belong?

If a scenario develops where MDCPS allows Bargaining Units to bifurcate we will consider providing retiree census data by bargaining unit at that time.

35. There are 619 pre-65 retirees with “Unknown” shown on the census as the bargaining unit. Is it possible to ascertain to which bargaining unit the majority of these lives belong?

At the present, this information is not available.

36. The experience report shows three “leave” employees while the census shows 1,775. It is assumed that 1,772 “leave” employees are included in the experience report of the bargaining unit to which they belong. Please confirm.

We will request this information from UHC, however, proposers should proceed with their proposals assuming UHC may not provide this information prior to the RFP due date.

We assume these members are included in other claim data.

37. Please define “other claim payments” as shown in the experience exhibits? If so, can they be separated in each report?

We will request this information from UHC, however, proposers should proceed with their proposals assuming UHC may not provide this information prior to the RFP due date.

38. Are the POS out-of-network claims included in the experience exhibit? If so, can they be separated in each report?

We will request this information from UHC, however, proposers should proceed with their proposals assuming UHC may not provide this information prior to the RFP due date.

39. Is it possible for MDC to provide large claims report for the most recent 12 month period (10/1/04 through 9/30/05)? Can it be separated by bargaining unit?

We will request this information from UHC, however, proposers should proceed with their proposals assuming UHC may not provide this information prior to the RFP due date.

40. Have incurral factors been applied to the claims shown in the experience exhibits?

We will ask UHC to confirm the answer to this question.

41. The number of employees listed in exhibit 9a. medical Network Accessibility, is different then the counts listed in Exhibit 9b. Which counts should Proposer use to complete the exhibits, 9a or 9b?

The exhibits in 9b use different counts than 9a as these reports require summarization of the data in a different manner. However, all reports in 9b foot to the census data provided in 9a. Proposers will not be able to summarize the results of 9a for exhibit 9b.

42. Is the R and C of 80th Percentile noted in the Medical Network Reimbursements Exhibits 23 and 24 based on Ingenix? If the Proposer bases their R and C on Medicare allowable, is it appropriate to complete form at 80% of Medicare allowable?

The proposer should indicate their reimbursement at the 80th percentile of R&C, and this will depend on how each proposer defines R&C (e.g. Ingenix, HIAA, self-defined, etc.).

43. With respect to Exhibits 23 and 24: If the services are paid under a Global Capitated arrangement, is it appropriate to mark “Capitated Services” rather than a reimbursement amount?

Please indicate which services are covered under a capitated arrangement in your financial deviations document, but for purposes of responding to exhibits 23 & 24, please indicate your estimate of the dollar value of these reimbursements.

44. Questionnaire – General, Question 49 – Is this terminal/rep for PBM and/or MBH in addition to the terminals/ reps requested in Question 48?

This is only necessary if these services are carved out to separate carrier(s) and are not bundled with the medical carrier.

45. Please clarify what specifically needs to go into the Blue Envelopes.

The blue envelope provided by Procurement may be taped to the box containing your proposal.

46. What is the expectation for deductibles and out of pocket maximums for the 18 month quote? Will the deductible and out of pocket maximums remain on a calendar year basis?

Yes, deductibles and CY maximums will remain on a calendar year basis.

47. Should claim projections be provided on a by union by product basis or just on a by product basis?

Claim projections should be provided by product only. MDCPS is not requesting bargaining unit specific proposals at this time.

48. The RFP outlines 5 labor organizations and 2 professional organizations. The claim experience provided includes claim experience for the 5 labor unions outlined in the RFP plus additional groups. The additional groups are: COBRA, Food Service, Leave Employees, MEP and Under 65 retirees. Where will these additional groups be included for the negotiations? Which claim experience belongs to the 2 professional organizations?

Negotiations will be held for the entire plan (all groups). In the monthly claims and enrollment entitled "claims by suffix" you will find MEP (Managerial Exempt Personnel and Confidential Exempt (active) employees) information in the worksheet entitled MEP. Food service are AFSCME employees. The other groups are self-explanatory. COBRA, Leave, and Retirees are not identified by bargaining unit.

49. Mature ASO fees have been requested. What time period is expected for payment of run-out claims under the ASO arrangement?

Run-out fees should be paid for a minimum of 9 months. However, proposals to pay run-out claims for a longer period of time will be viewed favorably.

50. ISL and ASL pricing have not been requested for the ASO quote. Is this something that will be requested?

ISL and ASL proposals are not requested at this time.

51. Questionnaire – Pharmacy, Question 203 – Please clarify. Does the question mean generic alternatives (meaning another generic in the same therapeutic class) or the generic equivalent (meaning the member wants the brand name drug instead of the generic)? I think the question means if the member chooses a brand and the generic equivalent is available, then they will pay the standard copay. Are these only the three disease states they want for this benefit (asthma, diabetes, cardiac/circulatory)? Will the group be submitting the drug list they want at \$0 copay?

Equivalent means identical active ingredients in this usage. These are the only disease states for now. Carriers should provide the drug list.

52. In reviewing the claims experience data provided with the RFP, it appears that no pharmacy claims data for mail and retail were provided. Can M-DCPS provide this information?

Monthly pharmacy claims were provided in the financial exhibits. We will request mail order and retail claim data from UHC, however, proposers should proceed with their proposals assuming UHC may not provide this information prior to the RFP due date.

53. Are PBM vendors required to submit a proposal that include both fully-insured pricing and self-insured pricing? If we do not provide an offer on a fully-insured basis is this considered a deviation?

No, PBMs can elect to propose self-insured arrangements only, if they wish. This will not be considered a deviation.

54. In Exhibit 12b, Scenario 1, the RFP asks us to run our network against all employees, early retirees enrolled in the current POS and HMO plans. How do we identify the early retirees? Are they categorized as “leave” under employer status? Or are they in the “active” or the “retiree” group?

By excluding waivers, Medicare Risk HMO and Medicare Supplement enrollees, the remainder will reflect the actives/early retirees in the HMO & POS plans.

55. Within our proposal response is M-DCPS looking for the broadest retail pharmacy network, or is M-DCPS open to limiting some pharmacy choices while keeping access constant and deepening overall retail pharmacy discounts?

The RFP does not specify. Proposers must, at a minimum, propose their broadest retail pharmacy network. In addition, proposers are free to propose select networks, but must complete (duplicate) all applicable network and financial bid forms and address all

questions in the questionnaire where responses would differ due to the offering of a limited network.

56. On page 2, proposals are requested on a full-replacement and a partial replacement basis. Will M-DCPS award contracts to multiple vendors?

MDCPS does not contemplate awarding business to more than 1 PBM.

57. On page 2, according to the RFP there are 6,900 eligible lives covered under HMOs. Will prescription drug benefits be carved out from HMOs as a possible option?

Drug benefits may be carved out of the HMOs as well.

58. Can you please tell us if there will be any incentive for completing the Health Risk Assessment? If yes, would the incentive include spouses and retirees and their spouses?

The HRA is for employees only. Currently, a \$10 Walgreen's gift card is provided for completion of the HRA. There are six grand prizes (1 per bargaining unit) consisting of a one-year membership to Bally's Total Fitness program.

59. If we are responding to only one service section (PBM), how would you like us to handle the other sections? Should we state Not Applicable for each section, not applicable for each question under those sections, or not include the section at all. Same for the exhibits; do we need to include exhibits that do not pertain to our proposal.

You do not need to provide exhibits that do not pertain to your proposal. Please note any excluded exhibits in your deviations response.

60. In Section 2, Part B (Proposal Specifications), question 17 reads:

Carrier agrees to provide one computer terminal and one service representative for every 6000 employees enrolled in their plan(s) at M-DCPS' Risk Management office for medical claims data inquiry, customer service, verification of employee coverage, etc. These representatives will adhere to regular business days/hours pursuant to the M-DCPS business schedule. Additionally, if one of the service representatives is on vacation or unable to work, the carrier agrees to provide a fully trained replacement. The cost associated with this responsibility will be included in your premiums/fees.

Is this requirement applicable to PBM's?

No, but a similar requirement does apply to PBMs. See question #49, page 47.

61. In Section 2, Part D(program Design Specifications), question 43 reads:

If a carrier is awarded medical and prescription drug coverage, the carrier must agree to report all pharmacy rebates received due to M-DCPS member utilization and to use these rebates to offset claim expenses (to the extent the rebates are retained by the carrier).

Is this requirement applicable to applicants proposing only PBM services?

PBMs must be willing to report all rebate information to MDCPS, regardless of whether 100% of rebates are remitted to MDCPS. It is not necessary to remit 100% of rebates to MDCPS; PBMs are allowed to propose arrangements in which some or all rebates are retained by the PBM and used to offset administration and provide more aggressive discounts. However, the PBM must clearly indicate how rebates will be handled in their financial proposals.

62. Is MAC pricing for mail services a requirement?

If any scripts are priced on a MAC basis for mail order, you must provide MAC pricing and the % of scripts that are paid at MAC.

63. In regards to financial exhibit 21C, you state:

Estimated annual rebates (include assumption of total drug spend).

Is M-DCPS looking for the total dollar value of the rebates being offered deducted from the total drug spend?

Based on your guaranteed rebate offer, please estimate the annual rebates that will be remitted to MDCPS.

64. Could M-DCPS provide a full claim detail file broken out by NDC number.

Exhibit 14 provides all the prescription drug data for the HMO and POS plans for the 10-1-2004 to 9-30-2005 time period, by NDC code. Additional detail will not be provided at this time.

65. On page 4, the RFP states that rates for proposals with 7/1/06 effective dates should be guaranteed for 18 months (12 months minimum). Rates for proposals with 1/1/07 effective date should be guaranteed for minimum of 12 months. Do these statements apply to the fully-insured offers only?

Yes. Also on page 4 we indicate that ASO fee proposals must be guaranteed for 42 months.

66. On page 4, the RFP states that if proposals are competitive so that a union is interested in negotiating a plan effective 7/1/06, rates may be negotiated based on individual bargaining unit proposals. What does this mean? Will vendors be negotiating with M-DCPS or a union?

In all instances, proposers would negotiate with MDCPS for services (rates/fees, plan design, etc.) specific to any union as the Board is the contract holder.

67. On page 33, the RFP states that if M-DCPS wishes to purchase only an insured HMO your organization, and other coverages from other carriers, rates must remain firm. Will M-DCPS select multiple PBMs for the carved-out pharmacy benefit?

MDCPS does not contemplate awarding business to more than 1 PBM.

68. On page 34, #4 the RFP states that fees are paid within a 30 day period without penalty. Is M-DCPS flexible on this issue?

This issue may be subject to negotiation during the finalist process.

69. On page 49, #57, is it correct to assume that the Medical Carrier will produce ID cards?

Yes, in the ideal situation, the medical carrier(s) will produce the ID cards and list the PBM and/or MBH contact information on the card.

70. In the table appearing on page 68, reference is made to R&C. In a PBM environment, what should we translate R&C to mean? Is this the discounted price, the U&C price, MAC price? Please clarify.

Usual and Customary Price (undiscounted).

71. Please describe how traditional COB is processed when M-DCPS does not provide the primary benefit. What is the current fee structure and amount?

The cost of performing COB is included in the premium rates. Each carrier should describe how they propose to process COB on MDCPS' behalf.

72. Please describe your current Medicare Part D COB process at retail and mail. What is the current fee structure and amount?

MDCPS is seeking the Medicare Part D subsidy directly. Carriers will be expected to provide data and support necessary for this process.

73. Please provide a list of clinical services and programs in place today.

We will request this information from UHC, however, proposers should proceed with their proposals assuming UHC may not provide this information prior to the RFP due date.

74. Please provide a list of medications that require prior authorization along with rule protocols. How many prior authorizations take place per year?

We will request this information from UHC.

75. Please describe your SUR program edits.

We will request this information from UHC, however, proposers should proceed with their proposals assuming UHC may not provide this information prior to the RFP due date.

76. Please describe any disease management programs currently in place.

We will request this information from UHC, however, proposers should proceed with their proposals assuming UHC may not provide this information prior to the RFP due date.

77. We will be bidding only on the Behavioral Health portion of this RFP. Please clarify which specific questions and/or sections we are not required to answer.

You are not required to respond to the medical, pharmacy and wellness sections of the questionnaire. You are also not required to respond to the medical, pharmacy and wellness exhibits.

78. As an organization bidding only on the Behavioral Health portion of this RFP, will we be required to produce ID cards for District employees?

In the ideal situation, the medical carrier(s) will produce the ID cards and list the PBM and/or MBH contact information on the card.

79. In regard to page 47, question 49: Please explain further what it means to provide a computer and service representative.

You will provide a full-time employee with a computer to work onsite at MDCPS.

80. In regard to page 23, Section F, question 65, second bullet point: The file format received from the District, as provided on CD, asks for TIN numbers. Our provider agreement do not allow us to release any confidential information on our providers (such as TIN numbers) without their written permission. We can, however, supply the District with names, addresses, professional levels, cities, states, and ZIP codes. Is this acceptable?

This is not ideal, but is acceptable. You must note the lack of TINs as a proposal deviation.

81. In addition to the existing behavioral health benefit plan information, please clarify all applicable preauthorization requirements. Please confirm that the plan has not changed over the period of the utilization data, and will not change for the period requested.

Historic and current plan design information has been provided. In addition, we have clearly described the proposed MBH plan design for 2006. Services requiring preauthorization in 2005 will also require preauthorization in 2006 unless otherwise specified.

82. Please provide utilization and claims reports for MMH for the last three complete plan years(two complete years minimum) that included the following:
- a. The employee and member counts applicable to the utilization data. Since the RFP asks for rates by tier (Employee Only, Employee + Child(ren), Employee + Spouse, Employee + Family, One Child, Two or more children), we will also need the count of each number of enrollees and members in each tier.
 - b. Separate utilization data by In Network and Out of Network
 - c. Inpatient Care: Number of Inpatient cases, and number of days of Inpatient care, or same per 1,000 members
 - d. Residential Care: Number of cases and number of days, or same per 1,000 members
 - e. Partial Hospitalization care: Number of cases and number of days, or same per 1,000 members
 - f. Intensive Outpatient care: Number of cases and number of hours, or same per 1,000 members
 - g. Outpatient Care: Number of cases and number of hours, or same per 1,000 members
 - h. Residential and Partial may be combined into Subacute. If your data shows only IP or OP, please advise where Partial, Residential and IOP are classified.
 - i. For each of the above settings in b) through g), [Propoer] will need the total allowed and paid amounts, or the per unit allowed and paid amount, or the PMPM care cost.

We will request this information from UHC, however, proposers should proceed with their proposals assuming UHC may not provide this information prior to the RFP due date.

83. Please indicate if the utilization and claims are on an Incurred or Paid basis, and if incurred, please provide the number of months of run out included in each period of the data.

Claims data provided thus far has been on a paid basis. MBH “claims” reflect capitation payments made from UHC to UBH.

84. If MBH (insured or ASO basis) may be offered on a per-bargaining-unit basis, we request the above information from question 2 and 3 for each bargaining unit.

If a scenario develops where MDCPS allows Bargaining Units to bifurcate we will consider providing additional claims and utilization data by bargaining unit at that time.

85. In regard to page 36, question 23, please confirm that MBH carriers do not need to use pooling charges due to the limits provided in the benefit design.

Confirmed.

86. In regard to the MBH communications piece, would it be possible for MBH carriers to piggyback with the District’s mailing?

MDCPS will provide information regarding MBH in its annual enrollment materials. Any other mailings will be performed directly by carriers after MDCPS approves communication materials.

87. Page 15, Item a entitled “Proposal Specification (Confirmation Statements)” requires “Commercial General Liability Insurance in an amount not less than \$5 million per occurrence and \$5 million aggregate for bodily injury and property damage.”

a. Does this requirement apply to Alternative Medical Plans as well?

Yes.

b. If not, what is the minimum amount that would satisfy the MDCPS?

N/A.

88. Page 17, Item#25 entitled “Financial Rating” – with regards to Alternative Medical Plans, would the MDCPS be satisfied with confirmation that the Plan has met the financial solvency and surplus requirements of Florida’s Office of Insurance Regulations(OIR)?

Proposers should provide their latest agency rating(s). In addition, if proposers satisfy the financial solvency and surplus requirements of the FL OIR, they may indicate so in their response.

- c. As a follow-up to question #2, are Alternative Medical Plans required to provide the confirmation listed under Page 35, Item #15.

Yes.

89. Page 21, Item#49, please clarify the statement that “The proposer must provide currently insured participants continued coverage on a no-loss, no-gain basis.” What is the MDCPS’ definition of “no-loss, no-gain basis”?

- d. This term is also used on page 35, Item#15.

“No-loss, no-gain” is a health insurance provision stating that, when an employer decides to change insurance companies, the new insurer must provide benefits similar to those of the previous insurer for existing conditions. This protects employees from suddenly losing coverage for benefits that would have been provided by the prior insurer.

90. Page 24-25: are the Performance Guarantees listed applicable to Alternative Medical Plans as well?

Yes.

- e. If yes, is the MDCPS seeking levels of performances that are similar or exactly the same as those set for traditional Medical Plans, such as HMO, POS, PPO?

The same levels (or better) are expected.

91. Page 29, the term “Alternative Innovative/Creative Arrangement” is used. Does that term encompass Alternative Medical Plan?

“Alternative Medical Plan” is not defined in the RFP, but it is generally taken to be a type of health benefits provider/carrier/administrator. The term “Alternative Innovative/Creative Arrangement” refers to plan design.

92. Page 35, Item#14: is the requirement for delegation of fiduciary responsibility applicable to Alternative Medical Plan?

Yes.

93. Page 35, item #16: is the requirement for a waiver of all pre-existing condition limitations and exclusions applicable to Alternative Medical plans?

Yes.

94. Page 54: please confirm that items 80-82 listed under “COBRA” do not apply to Alternative Medical Plans?

This is not confirmed. Alternative Medical Plans may be required to offer COBRA coverage and conversion to COBRA enrollees.

95. Page 56, item#95: please confirm that this item does not apply to Alternative Medical Plans.

This is not confirmed. If the Alternative Medical Plan covers members who seek care from providers in New York State, NYHCRA payments must be made on behalf of MDCPS.

96. Page 56, item#97: please confirm that this item does not apply to Alternative medical Plans

This is not confirmed. If the Alternative Medical Plan offers a Medicare Risk HMO, retiree direct billing is required.

97. Program Design Specification, Specification 47. If coverage is offered to dependent children without covering the employee, who is the card holder for purposes of eligibility?

We don't have an answer to this question at this time. Eligibility will be verified by FBMC. Please provide your process for receiving child-only and children-only eligibility.

98. Program Design Specification, Specification 49. Please provide additional information regarding the on-site service representative's role at the M-DCPS office.

This representative will perform the functions of an onsite member service representative to answer questions about the plan and to help resolve member service issues relating to eligibility, claims payment and customer service.

99. Program Design Specification, Specification 57. Assuming that M-DCPS selects a carve-out PBM, does M-DCPS desire combined or separate medical/PBM

member ID cards? If a combined card, would it be produced by the medical carrier or the PBM?

In the ideal situation, the medical carrier(s) will produce the ID cards and list the PBM and/or MBH contact information on the card.

100. Financial Bid Response Exhibit. For care-out ASO PBM bids, does M-DCPS have a preference in receiving financial offers with either a retail pass-through or a guaranteed rate (“spread”) pricing structure? If yes, which option would M-DCPS prefer?

MDCPS prefers a guaranteed discount approach to assist with financial planning.

101. General Questionnaire, Question 27. Regarding an “outside, independent appeals process,” does M-DCPS want the PBM to actually establish a review process with reviewers who are independent of the PBM and M-DCPS? Or will M-DCPS designate an outside appeals reviewer and require the PBM to establish a process to work with that reviewer?

The PBM would be expected to contract with a separate 3rd party independent appeals organization for appeals that exhaust the PBM’s internal appeals process.

102. General Questionnaire, Question 59. Does “enrolled member,” for the purpose of ID cards, refer to each contract holder, or each individual person? If this refers to each individual person, is there a minimum age (such as excluding small children) or other such categorization of individuals? Would it be sufficient to send cards to members other than the contract holder only upon request?

Enrolled member refers to each covered life. Proposers should provide at least 2 cards per household for each employee with coverage beyond employee only. Members in this household must be able to request additional cards. It is acceptable to only send additional cards upon receipt of a request.

103. Financial Exhibit 21b. Should the pricing in this exhibit be shown as the guaranteed rates or the estimated rates?

Exhibit 21b requires guaranteed discounts. Refer to row 42 for a definition of guaranteed discounts.

104. During the pre-proposal meeting it was stated that the alternative medical program would be targeted toward lower paid employees. What will the threshold

be for eligibility and how many employees would qualify to participate in the program?

The answers to these questions are not known at this time.

105. Can the RFP deadline be extended for one week?

An extensions is not granted at this time.

106. Will the selection committee consider a consumer directed program as an alternative plan design?

Due to the inclusive nature of this RFP process, proposers are free to offer such a program. However, it should be noted that Consumer Directed Health Plans were not specifically requested.

107. Can we be supplied membership by month, by plan, and by data units for which experience has been supplied for 1/1/04 – 9/30/05?

We will request this information from UHC showing membership by plan by month, however, proposers should proceed with their proposals assuming UHC may not provide this information prior to the RFP due date. We do not understand the request for “data units for which experience has been supplied for 1/1/04 – 9/30/05.”

108. Can we be supplied enrollment by tier (single, ee+sp, ee+ch, ee+fam) by month, by plan, and by data units for which experience has been supplied for 1/1/04 – 9/30/05?

We will request this information from UHC showing enrollment tiers by plan by month, however, proposers should proceed with their proposals assuming UHC may not provide this information prior to the RFP due date. We do not understand the request for “data units for which experience has been supplied for 1/1/04 – 9/30/05.”

109. Are the Prescription Drug rebates included in the experience supplied? If so, are they in the Rx Claims?

Rx rebates are fully-retained by the incumbent carrier and are not reported to MDCPS. Rebates do not offset the claim experience in the data provided.

110. What kinds of claims can be found under the heading “Other Claim Payments?” Please provide response by product.

We will request this information from UHC, however, proposers should proceed with their proposals assuming UHC may not provide this information prior to the RFP due date.

111. What Claim elements (FFS, Capitation, RX) are included in the lag reports?

We will request this information from UHC, however, proposers should proceed with their proposals assuming UHC may not provide this information prior to the RFP due date.

112. Can we get a lag report that spans the 1/1/03 – 9/30/05 (33 months)? If not, can we have a lag for claims incurred 1/1/03 – 12/31/03 and paid 1/1/03 – 9/30/05 and one for the claims incurred 1/1/04 – 12/31/04 and paid 1/1/04 – 9/30/05?

We will request this information from UHC, however, proposers should proceed with their proposals assuming UHC may not provide this information prior to the RFP due date.

113. Can we get Mental and Nervous claims broken-out?

UHC capitates MH/SA claims through United Behavioral Health (UBH). These capitation payments have been provided in the monthly claims data. Additional detail is not available.

114. Can we be provided a census of enrollees by plan and by unit for which experience has been supplied (including gender, date of birth, tier, and zip)?

No.

115. United has supplied “claims” information, is it truly “paid” or are they reporting them as “incurred”?

Claims data provided thus far has been on a paid basis. MBH “claims” reflect capitation payments made from UHC to UBH.

116. We have completed an analysis of M-DPS’ claims and 01/01/2006 rate information, and want to double check if there is a discrepancy between United’s 01/01/2006 rate action and M-DCPS’ actual 2004/2005 claims. We have provided the methodology for our analysis below:

Rate Analysis:

Using the census and fully insured rates that were provided in the RFP we were able to determine the current composite POS and HMO rates. Please confirm that our rate development is accurate, and if M-DCPS’ enrollment switches, please correct the enrollment.

POS		01/01/2006 Premium Rate	EE Contrib	EE Contrib (if Flex \$ are used to offset Dep Contribs)	Enrollment
	Employee Only	\$408.95	\$0.00	No offset	32,412
	Spouse	\$848.41	\$328.57	No offset	1,576
	Child(ren)	\$790.94	\$277.23	No offset	2,533
	Family	\$1,196.05	\$539.12	No offset	1,241
		\$478.78	Required Premium PEPM		37,762
HMO - 62					
	Employee Only	\$373.90	\$0.00	\$0.00	2,789
	Spouse	\$775.70	\$205.60	\$185.60	639
	Child(ren)	\$723.15	\$176.79	\$156.79	1,517
	Family	\$1,093.55	\$361.14	\$344.14	990
		\$626.47	Required Premium PEPM		5,935
HMO - 63					
	Employee Only	\$348.48	\$0.00	\$0.00	2,789
	Spouse	\$722.95	\$172.86	\$132.86	639
	Child(ren)	\$673.98	\$147.62	\$107.62	1,517
	Family	\$1,019.19	\$309.78	\$269.78	990
		\$583.88	Required Premium PEPM		5,935

Self-Funded Claims Analysis

The 2004/2005 claims are 89% of M-DCPS' 2005 annualized premium requirement.

Based on the information shown on the Historical Premium and Contribution Rates, it would appear United asked for a 2.0% rate increase for 01/01/2006. Please confirm that this increase is accurate and contains no retrospective premium funding at the end of the policy period, and has no opportunity to reprice mid-year if medical inflation or trend increases 2004/2005 paid medical claims levels.

We have made no attempt to reconcile your financial analysis above. UHC did provide a 2% increase for the 2006 plan year. This does not include any retrospective premium funding at the end of the policy period, nor can UHC reprice mid-year in the event they experience unforeseen medical trend increases.