REQUEST FOR PROPOSAL (RFP) FOR
GROUP MEDICAL, PRESCRIPTION, VISION
AND EAP SERVICES

DEPARTMENT OF ADMINISTRATION
OFFICE OF GROUP INSURANCE
304 N 8th Street Room 434
P.O. Box 83720
Boise, Idaho 83720-0035

October 15, 2012

Sealed proposals will be received by the State of Idaho Department of Administration, Office of Group Insurance until 3:00 P.M., Mountain Time, November 15, 2012 for furnishing group medical, prescription, vision, and EAP coverage for the employees and group medical and prescription coverage for retirees of the State of Idaho. **Late proposals will not be considered**. The Department of Administration reserves the right to extend the proposal due date. The Department also reserves the right to cancel the RFP and to reject any or all proposals in the best interest of the State.

Proposals will be held confidential until time of award. Proposals will be available for inspection at the Office of Group Insurance after the notice of intent to award has been made.

No potential contractor may withdraw its proposal after the aforementioned receipt deadline.

Any resulting contract is not effective until the appropriate State official has signed the contract. The State is not responsible for reimbursing the provider for any services rendered prior to the appropriate signature by the State official and the arrival of the effective date of the contract. The State of Idaho is not liable for any cost incurred by the potential contractors prior to the execution of a contract.

The Department of Administration reserves the right to contract with more than one provider to provide the insurance coverages which are the subject of this RFP, in order to meet the needs of the State.

SIGNED: _____

Teresa Luna, Director
Department of Administration

State of Idaho
Request for Medical Proposals
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Employee census

Three years paid claims and enrollment by month

Three years large claims history

Sample deduction register and premium summary

Sample itemized self-pay reporting form

One year of detailed pharmacy claim experience to be delivered via Secured File Transfer Protocol (SFTP) (for informational purposes to support your underwriting and pricing of pharmacy benefits)

SECTION 1: GENERAL INFORMATION

I. Overview

It is the purpose of this Request for Proposals to solicit responses from experienced, capable, and innovative insurers who can assist the State in meeting financial objectives and provide high quality medical, prescription, vision and EAP benefits and service. Idaho Code Section 67-5762 summarizes the State's goals and intentions as follows:

> It shall be the director of the department of administration's objective to procure and maintain on behalf of officers and employees the most adequate group coverages reasonably obtainable for the money available for required premiums and prepayments. In the selection of insurers provide such coverages, the director shall give consideration to factors, other than lowest apparent premium or prepayment, such as risk retention, reserves, extent to which the insurer will facilitate administration, and to its reputation and record for promptness and fairness in the treatment of claims, as well as to its financial dependability.

The State of Idaho is seeking proposals for a fully insured statewide Medical Plan, including prescription, vision and EAP coverage for active employees and prescription coverage for retirees. .

The State of Idaho's general objectives in issuing this RFP are to:

- Minimize overall plan costs;
- Achieve effective cash management, with special attention to the economic recognition of timing differences through interest credits or other mechanisms;
- Achieve budgetary stability in funding group medical insurance; and
- Achieve effective and efficient claims management expertise and to assure employee and retiree needs and concerns are met.

II. RFP SUBMITTAL REQUIREMENTS

A. Response Communication

1. All questions regarding this proposal must be sent via email, no later than Friday, October 26, 2012 to:

   Amy Johnson, Administrator
   Office of Group Insurance
   Amy.Johnson@adm.idaho.gov

2. Answers to all questions will be shared with all bidders via email. Please acknowledge receipt of this RFP to the email address above and provide the email address for responses to questions.

3. The State of Idaho will not meet with any carrier until finalist determinations are made. Proposals must be received no later than 3:00 pm, Mountain Time, on November 15, 2012. Provide two hard copies and three CD's to the address on page 1.

4. Respondents must supply the name of a contact person within your organization who is readily available and who can reply in writing to questions about products and services included in your response.

5. Complete all information requested according to the format specified. Please provide answers to the questions and provide, where appropriate, information which clearly indicates your capability to provide the service, including past similar experience and processes and resources used.

6. Proposals shall be held firm for 250 days, with a July 1, 2013 effective date assumed.

B. Acceptance of Vendor Proposals

Acceptance of the proposal is contingent upon review of all the proposals and acceptance of final contract terms by the State of Idaho.

1. Proposals must be submitted in a plainly marked, SEALED ENVELOPE. The name of the RFP must be indicated on the outside of the envelope. Provide two hard copies and three CD's to the address on page 1.

2. Proposals must include such literature and illustrations as may be required to provide a responsive proposal. Such information must describe and clearly identify all vendors and product suppliers that will be used to provide the fully insured plan's services, products and supplies. Any exceptions as to services or supplies availability must be disclosed. The proposal should demonstrate the potential contractor's business expertise, experience and current working relationships with governmental entities as well as any secondary vendors and/or suppliers contained in the proposal. Any exceptions to or deviations from the requirements of this RFP must be fully disclosed and explained in a cover letter. Any proposal, which, in the opinion of the Department of Administration, does not meet the requirements of this RFP will not be considered.

3. Proposals must include a total price for the services herein specified. The price quoted may not include any state or local taxes, other than premium tax. Two (2) original hardcopies and three (3) copies on CD of the proposal must be submitted. The original hardcopies must contain an original signature binding the potential contractor to its proposal. Attachments may be submitted in hardcopy format. The Department, upon request, will return the copies of the proposals after evaluation and execution of a contract.

4. In the event it becomes necessary to revise any part of the RFP, written addenda will be provided to all entities receiving the original RFP.

5. All potential contractors must provide complete responses to Sections two (2) through six (6).

C. The Department of Administration reserves the right to:

1. Request a potential contractor to clarify its proposal or supply additional material or information it deems necessary.

2. Make reasonable and independent inquiry, including inquiry to the potential contractor or third parties, to determine the ability of the potential contractor to satisfy the requirements set forth herein. Such inquiry may include but is not limited to inquiry regarding financial stability and responsibility by way of financial statements, credit ratings, references and past performance. If a potential contractor is requested to provide such information and unreasonably fails to promptly supply any requested information, its proposal may be rejected.

3. Modify or otherwise alter any of the benefits listed herein, after receipt of proposals. In such event, all potential contractors whose proposals fully address the requirements of this RFP will be given an equal opportunity to modify their proposals in those specific areas only.

D. Registration of Corporation; Benefit Compliance

By submitting a proposal, the potential contractor certifies that it is in compliance with the State of Idaho's statutory requirements governing registration of corporations, and/or assumed business names and with the laws applicable to it regulating insurance corporations and benefits in the State of Idaho.

E. Alteration of Proposal

A proposal shall be rejected if it contains any material alteration or erasure, unless before the proposal is submitted, each such alteration and erasure is initialed in ink by the person signing the proposal and a certification is signed by the same and attached to the proposal.

F. Examination of RFP

It is understood that the potential contractor, before submitting its proposal, has made a careful examination of this RFP and the attachments hereto and other information

referred to in this RFP, and has fully informed itself concerning the type and character of the service required.

The State will not be responsible for any loss or unanticipated cost that may be suffered by the potential contractor as a result of the potential contractor's failure to acquire full information concerning conditions or information pertaining to this RFP.

G. Accuracy of RFP

The Department of Administration has, in good faith, presented information, which is, to the best of its knowledge, complete and accurate. The Department of Administration cannot guarantee, however, that this information is free of error and will not be held responsible for any loss resulting from an error.

H. Confidential Information

The Idaho Public Records Law, Idaho Code sections 9-337 through 9-348, allows the open inspection and copying of public records which may include any writing containing information relating to the conduct or administration of the public's business prepared, owned, used, or retained by any state or local agency regardless of the physical form or character. Certain information contained in your response to the RFP may be considered a public record. The Public Records Law contains certain exemptions. If you consider any element of your proposal to be exempt from disclosure, please mark upon the pertinent document that it is to be treated as confidential and provide an explanation for the basis for the claimed exemption. **The entire proposal document cannot be marked as "Confidential"**. The State, to the extent allowed by law, will honor such a request of confidentiality. However, you will be required to defend any claim of disclosure exemption in the event of an administrative or judicial challenge to the State's nondisclosure. Any questions regarding the applicability of the Public Records Law should be presented to your legal counsel for review.

I. Incurring Costs

The Department of Administration will not be liable for proposal preparation costs or any other costs incurred by potential contractors prior to execution of a contract.

J. Rejection of Proposals

The Department of Administration, reserves the right to reject any and all proposals received as a result of this RFP, or to negotiate separately with any source in any manner necessary to serve the best interests of the State of Idaho.

K. Ensuing Contract

The requirements of this RFP and the proposal of the successful contractor shall become contractual obligations in the ensuing contract.

L. Burden of Proof

It shall be the responsibility of the potential contractor to furnish the Department of Administration with sufficient data to determine if the services offered conform to the RFP requirements.

M. Retention Charges

Retention charges must not include any commissions, broker fees, or marketing fees.

N. Subcontractors

If a potential contractor chooses to propose a solution to this RFP, which solution includes subcontractors or some other partnering or cooperation approach, the qualifications and references of all such subcontractors (or partners) must be provided with the potential contractor's response.

O. Premium Payments

The premium payment arrangement is outlined in Section 4, Question II. B. Contractor will certify ability to meet the premium payment arrangement or propose an alternate arrangement that is mutually suitable to the State.

P. Award of Contract

An evaluation team composed of representatives of the State of Idaho will review the submitted proposals. Proposals will be ranked based upon how fully each proposal meets the requirements of this RFP, including cost. If, upon completion of the initial evaluations, the evaluation team determines additional information is needed, potential contractors may be invited to give oral presentations to the evaluation team. The evaluation team will make a recommendation to the Director of the Department of Administration after its evaluation. The Director has final statutory authority to negotiate and enter the contract. A separate contract will be negotiated and signed upon completion of final negotiations.

SECTION 2: GENERAL TERMS AND CONDITIONS

I. General Terms and Conditions

This proposal includes the following terms and conditions, and encompasses, but is not limited to, parts I. through VII.; and statutes of the State of Idaho, particularly Title 41 and Title 67, Chapter 57, Idaho Code. Please review and confirm your ability to meet all of the following terms and conditions, or advise of any deficiencies or inability to meet the terms and conditions in full.

A. Term of Contract

The term of the contract shall be from 12:00 a.m., Mountain Time, July 1, 2013 through June 30, of the rate guarantee period. Thereafter, the contract is subject to renewal annually on July 1 by mutual agreement between the parties. Any proposal not meeting this requirement will be rejected.

B. Primary Responsibilities

The successful contractor will be required to be the sole point of contact with regard to contractual matters, including payment of any and all charges resulting from this contract, providing reports, meeting with Department of Administration staff and ensuring implementation of all requirements. The successful contractor shall be responsible for fully and efficiently servicing the State's account, which includes, but is not limited to, providing full reports of the status of the State's plan on a quarterly basis, tracking utilization trends and receipt, adjudication and payment of claims.

C. Rate Guarantee

The rates quoted in any proposal must be guaranteed through June 30, of the rate guarantee period. Any proposal not meeting this requirement will be rejected.

D. Frequency of Rate Change

Rates quoted cannot be changed except on the policy anniversary of July 1, and a written notice must be given to the Office of Group Insurance at least 120 days in advance of the policy anniversary itemizing and justifying any contemplated rate change.

E. Continuity of Coverage

To effect a smooth transition of coverage for all current members, the successful contractor must agree that all members currently insured under the plans will be covered on the effective date of the new contract.

In the event that more than one plan option is offered, an open enrollment period will be held during which employees can change plans. Employees electing any new plan will have to complete a new enrollment application.

F. Enrollment

The State will not require new enrollment applications to be completed. The successful contractor must accept all currently enrolled members.

G. Anti-Discrimination Clause

Acceptance of the contract binds the contractor to anti-discrimination terms and conditions in that no person in the United States shall, on the grounds of race or national original, color, sex, age, political or religious opinion or affiliation, handicap or for being a disabled or Vietnam era veteran, be denied the benefits of or be subject to discrimination under any program or activity. The contractor also agrees to comply with all applicable Americans with Disabilities Act requirements.

H. State of Idaho Minimum Wage Law

It will be the responsibility of the contractor to fully comply with the Idaho Code regarding the minimum wage law for residents hired in Idaho.

I. News Releases

News releases concerning this RFP or any contract entered into pursuant to this RFP will not be made without the State's approval and then only in coordination with the Department of Administration.

J. Termination

Termination of the contract may be made by the State when the contractor has been notified, in writing, or default or non-compliance and termination can be made within a reasonable time after issuance of such notice. Without limiting any other rights, if the contract is canceled for non-compliance, the contractor will be responsible for any cost incurred by the Department of Administration for placement of a new contract(s). The State, upon termination for non-compliance, reserves the right to take any appropriate legal action it may deem necessary.

K. Official Agent and Employees of the State Not Personally Liable

It is agreed by and between the parties hereto that in no event shall any official, officer, employee or agent of the State of Idaho be in any way personally liable or responsible for any covenant or agreement herein contained whether expressed or implied, nor for any statement, representation or warranty made herein or in any connection with this agreement.

L. Assignments

No contract or order or any interest therein shall be transferred by the contractor to whom such contract or order is given to any other party, without the approval in writing by the Department of Administration. Transfer of a contract without approval shall cause the annulment of the contract so transferred, at the option of the State. All rights of action, however, for any breach of such contract by the

contracting parties are reserved to the State. No member of the Legislature or any officer or employee of any branch of the state government shall directly, himself, or by any other person execute, hold or enjoy, in whole or in part, any contract or agreement made or entered into by or on behalf of the State of Idaho, if made by, through or on behalf of the department in which he/she is an officer or Employee; or if made by, through or on behalf of any other department unless the same are made after competitive proposals.

M. Governing Law

The contract shall be construed in accordance with and governed by the laws of the State of Idaho.

N. Contract Relationship

It is distinctly and particularly understood and agreed between the parties that the State of Idaho is in no way associated or otherwise connected with the performance of this contract on the part of the contractor, nor as to the employment of labor or the incurring of other expenses; that the said contractor is an independent contractor in the performance of each and every part of the contract, and solely and personally liable for all labor and other expenses, except as otherwise stated herein, in connection therewith and for any and all damages in connection with the operation of this contract whether it may be for personal injuries or damages of any other kind.

Contractor shall exonerate, indemnify, and hold the State of Idaho harmless from and against and assume full responsibility for payment of all federal, state and local taxes or contributions imposed or required under unemployment insurance, social security, workers' compensation and income tax laws with respect to the contractor's employees.

O. Insurance and Indemnity

Prior to the commencement of any services provided under the contract and until the contract is terminated, the contractor must maintain in effect all insurance as set forth below; and shall provide the State with a Certificate of Insurance and shall comply with all limits, terms and conditions stipulated therein. The contractor shall require all subcontractors to comply with all requirements of this section. Services under the contract shall not commence until evidence of all required insurance is provided to the State of Idaho's Department of Administration.

The contractor shall indemnify, defend and hold harmless the State of Idaho and its officers, employees and agents from and against any claims, suits, actions, liability, damages, costs, losses, and expenses, including reasonable attorneys' fees, (for purposes of this paragraph, "claims") caused by, arising out of or related to the activities, acts or omissions of contractor, its officers, employees, subcontractors or agents under the contract or caused by, arising out of or relating to contractor's failure to comply with any applicable state, federal, or local law, statute, rule or regulation. Contractor shall have no indemnity or defense obligation for any claims arising out of or related solely to the negligence of the

State of Idaho, its officers, employees or agents (excluding contractor as agent). Any payment of benefits made as a result of a claim shall be charged to Experience under the State's plan. Any other payment made pursuant to this provision, including, without limitation any punitive damages award, shall be paid by contractor from its own funds.

Contractor shall obtain and maintain insurance at its own expense as required herein for the duration of the agreement, and comply with all limits, terms and conditions stipulated. Policies shall provide, or be endorsed to provide, all required coverage. The contractor shall provide certificates of insurance or certified endorsements as applicable for the insurance required. The contractor shall not commence work under this Agreement until satisfactory evidence of all required insurance is provided to the state.

All insurance, except for Workers Compensation, and Professional Liability/Errors and Omissions shall name the State of Idaho as an additional insured. All insurance shall be with insurers rated A-, VII, or better in the latest Bests Rating Guide, and be in good standing and authorized to transact business in Idaho. The coverage provided by such policies shall be primary. Policies may contain deductibles, but such deductibles shall not be deducted from any damages due the state.

If any of the liability insurance required for this agreement is arranged on a "claims-made" basis, "tail coverage" will be required at the completion or termination of this agreement for a duration of twenty-four (24) months thereafter. Continuous "claims-made" coverage will be acceptable in lieu of "tail-coverage" provided the retroactive date is on or before the effective date of this agreement, or twenty-four-months "prior acts" coverage is provided. Contractor will be responsible for furnishing certification of "tail coverage" or continuous "claims made" coverage.

By requiring insurance herein, the state does not represent that coverage and limits will necessarily be adequate to protect the contractor, and such coverage and limits shall not be deemed as a limitation on the contractor's liability under the indemnities granted to the state.

P. Contractor shall maintain insurance in amounts not less than the following and comply with all insurance requirements:

1. Workers Compensation Insurance in amounts as required by statute in all states in which the contractor performs work, and Employers' Liability with a limit of $500,000 Bodily Injury by Accident-each Accident, $500,000 Bodily Injury by disease-each employee, $500,000 Bodily Injury by Disease-policy limit.

2. Commercial General Liability (CGL) with a limit of not less than $1,000,000 each occurrence, and $1,000,000 annual aggregate, if defense is outside the limits. If defense is inside the limits, the limit must be $2,000,000 each occurrence, and $2,000,000 aggregate. If necessary, a commercial umbrella or excess policy may be used to meet the limits required, providing the CGL is

listed on the underlying insurance in the umbrella or excess policy, and the umbrella/excess policy meets the requirements above for acceptable carriers.

3. Automobile Liability including non-owned, and hired liability with a limit of not less than $1,000,000 each occurrence, and $1,000,000 aggregate. If necessary, a commercial umbrella or excess policy may be used to meet the limits required, providing the Auto is listed on the underlying insurance in the umbrella or excess policy, and the umbrella/excess policy meets the requirements above for acceptable carriers.

4. Professional Liability/Errors & Omissions with a limit of not less than $1,000,000 each claim, and $2,000,000 aggregate if defense is outside the limits. If defense is inside the limits, the limit must be $2,000,000 each claim, and $4,000,000 aggregate.

The policy must be endorsed such that the insurance afforded therein shall be primary insurance and any insurance or self-insurance carried by the State of Idaho shall be excess and not contributory insurance to that provided by the contractor.

Q. Grace Period

The State will be granted a grace period of sixty (60) days for the payment of each premium.

R. Provisions for Contract Termination

There will be an experience accounting and run-off of reserves in the event of termination of this contract on or off anniversary.

S. Clerical Errors

Clerical errors by the contractor or by the State shall not invalidate insurance otherwise validly in force, nor continue insurance otherwise validly terminated.

T. Underwriting and Actuarial

The contractor must provide all underwriting and actuarial services, including but not limited to projection of costs for each line of coverage, projection of claims costs, projection of savings or increases in cost of potential plan modifications as may be requested, a yearly estimate of the “Incurred But Not Reported” claims liability by line of coverage and advice on plan design, based upon studies of existing benefit costs as determined by management reports and other sources.

U. Plan Materials

The contractor must provide:

1. Written plan documents that will qualify under ERISA and all other applicable legal requirements. Amendments will be expected at no charge as frequently as changes in the law or the change dictates.

2. All forms as may be required under the plan.

V. State and Federal Requirements

The contractor must provide information on legal requirements imposed by state or federal laws for employee benefit plans.

W. Other

The contractor shall suggest any needed contractual, administrative, and financial changes to the State's plan.

X. The Department of Administration Responsibilities

The Department of Administration shall:

1. Request and review any additional actuarial and administrative reports with the contractor.

2. Assist members and agencies with questions concerning benefit structures and plan procedures.

3. Communicate benefit plan, procedures and related information to members and agencies and provide claim filing assistance to members.

Section 3: ELIGIBILITY PROVISIONS

I. Eligibility

Please review the following eligibility provisions under the plan and confirm your ability to administer with no system conflicts.

A. Employee – An employee is eligible for benefits if they are: an officer or employee of a state department, agency, or institution working twenty (20) hours or more per week and whose term of employment is expected to exceed five (5) continuous months.

Additional information can be found in the individual plan documents or contracts at: http://ogi.idaho.gov/employees/benefits_summary_and_contracts.html

B. **Eligible Retiree** - An officer or employee of a state agency, department or institution, including state officials, and elected officials who was hired on or before June 30, 2009. The retiree must be under age 65, have at least ten (10) years (20,800 hours) of credited state service, be receiving monthly retirement benefits from a State Retirement System and retire directly from state service. Retirees hired after June 30, 2009 are not eligible for coverage unless they have credited state service of at least twenty thousand eight hundred (20,800) hours before June 30, 2009 and subsequent to reemployment, election or reappointment on or after July 1, 2009 accumulate an additional six thousand two hundred forty (6,240) continuous hours of credited state service and are otherwise eligible for coverage.

C. Dependent - Eligible Dependents include the following:
- legal spouses
- dependent children up to their 26th birthdays

Children include:
- natural children
- stepchildren
- adopted children
- children in the process of adoption from the time placed with the employee/retiree
- children legally dependent upon the employee/retiree or employee's/retiree's spouse for support where a normal parent-child relationship exists with the expectation that the employee/retiree will continue to rear that child to adulthood (please see the Benefits Summary and Plan Contracts at the above link for more detail)

D. Dual Coverage Prohibition

No one may be simultaneously insured under any of the State plans:
1. As a member of more than one insurance class;
2. As an insured individual and an insured dependent; or
3. As more than one insured individual or insured dependent

E. Permitted Coverage Extensions and Duration

Please consult with the Employee Group Insurance Handbook for permitted leaves of absence under the plan.
http://ogi.idaho.gov/employees/pdf/fy13_summary_of_benefits.pdf.

F. Disenrollment from the plan

Coverage under the various State sponsored benefit plans ends on the earliest of these dates:

- Termination of employment. If active status ends:
  - Before the 15th of a month, coverage will continue through the end of that month; or
  - On or after the 15th of a month, coverage will continue through the end of the following month.
- The member ceases to be eligible or declines coverage).
- The plan is terminated.
- The end of the month in which a retiree attains age 65.

For enrolled dependents, coverage ends when employee coverage ends or the end of the month in which they cease to be eligible for the plans—whichever comes first. Coverage for enrolled retiree spouses/dependent children may be continued until the end of the month in which the spouse attains age 65.

SECTION 4: VENDOR QUESTIONNAIRE

The following questionnaire is designed to request specific information regarding your ability to administer a plan of benefits such as this for an employer the size of the State of Idaho.

I. General Requirements

A. Please provide the following:

Name of proposing company
Address
Phone number
Name of individual to contact regarding proposal
Direct phone number for this individual
Email for the assigned individual

B. Please list the following information about your company:

AM Best Rating
Standard & Poor's Rating

If no ratings are available, please provide the most recent 3 years of financial statements.

C. Please describe any organizational changes (mergers, acquisitions, divestitures, business partners) that have occurred within the past year or are scheduled to occur within the next year that may impact the way in which you deliver service to your clients.

D. Please provide a brief overview of your short-term and long-term strategic goals..

E. List five (5) client references of similar size with whom you do business:

Company
Person to Contact
Title
Phone Number
Email
How long have they been a client?
Company size and industry

If the preference is that references are only contacted upon finalist selection please specify, but include the list of references in either case.

1. Please provide a more extensive client listing of your top 20 regional accounts including client name, industry, number of employees and length of relationship.
2. Please list two (2) clients that have terminated with you in the past two years in excess of 2,500 lives. List the client name as well as a contact name and phone number.

F. Who will be responsible for servicing the State of Idaho account? Outline their experience, background, training and areas of responsibility. Where will these personnel be located? How often will they be willing to meet with the State of Idaho personnel in Boise?

G From time to time, the State of Idaho may require assistance in enrollments or marketing various programs. Would sufficient resources exist within your organization to provide this type of assistance, if required?

H. The State of Idaho provides plan renewal information and benefit handbooks to employees. The successful contractor will be responsible for certain communications to plan participants. Communications may include, but not be limited to, changes in applicable state and federal laws affecting benefits and/or notification of termination of coverage. The successful contractor will be responsible to mail these communications directly to members at their homes. Please outline your internal capabilities and expertise to provide these communications. Please indicate whether your retention quote includes any of these services.

The State provides renewal brochures, benefit handbooks and periodic newsletters which are on the State's website. This includes copies of the actual contracts as well. However, if an enrollee requests the carrier provide a copy of the contract, the State would expect the carrier to provide a copy of the contract directly to the enrollee.

1. Would you be willing to take on full responsibility for distribution of the Summary of Benefits & Coverage as required by ACA, including but is not limited to the minority county provisions? If so, please outline any additional cost separately. If not, describe your proposed role with regard to the SBC.

I. Affordable Care Act Compliance: All provisions required by the Affordable Care Act must be included in benefits and contracts required by the State.

J. Please provide an overview of your program to assure compliance with HIPAA. Include in your overview the steps you have taken to assure compliance and how those steps would be applied to the State of Idaho's contract.

K. Discuss in detail the steps you anticipate will be needed to ensure a smooth transition if your proposal is selected. Include a description of any required changes and a timetable for their completion.

How would your firm assist the State of Idaho in the implementation of plan design changes if you are selected? Please describe the flexibility you have in plan designs utilized by the State of Idaho.

L. Briefly describe the top three attributes that set you apart from your competition.

M. Please provide, in general terms, a workflow diagram that illustrates how the various disciplines within your company (claims, care management, underwriting, reporting, marketing) interface. How is this interface extended to the client?

N. Please identify any pending litigation against your firm.

II. Administrative Requirements & Establishment of the Plan

Professionalism and experience in the execution of this contract are essential. Please confirm your ability to administer the program as outlined below. Any necessary deviations should be outlined in a manner that illustrates impact to the State and its members.

The Insurer Will:

A. General Requirements

Many rules and regulations impacting the administration of this contract are enumerated in this RFP and the Group Insurance Handbook (labeled **FY2013 Benefits Summary** found here: http://ogi.idaho.gov/employees/benefits_summary_and_contracts.html) including eligibility rules, definitions, terminations, self-pay regulations and conversion rules. It is imperative that the insurer have the administrative, technical, and professional skills to immediately implement and maintain the plans in accordance with these rules.

B. Premium Payments

Payments to the insurer will be made by the Office of Group Insurance twice a month. Premiums are withheld and forwarded to the Office of Group Insurance through the payroll system. There are three main payroll centers: the Office of the State Controller, which produces payroll for the majority of state agencies, Boise State University and Idaho State University.

The majority of the monthly premiums will be transferred to the insurer on the fifteenth of each month for which premium is due, with the remainder to follow on the last working day of the month.

The insurer will receive a deduction register and premium summary for active and retired employees. (Sample enclosed.) The State Controller's Office and the univiersities also provide premium deduction information via electronic reporting. Those employees self-paying premium will be itemized monthly through a reporting form. (Sample enclosed.)

The insurer will receive a monthly billing report along with the premium summaryfor political subdivisions participating in the State's plan.

Premiums for retirees are withheld from monthly retirement benefits paid by the Public Employee Retirement System, Judicial Branch retirement system and Department of Labor retirement system and are forwarded to the Office of Group Insurance along with a deduction register. Retirees enrolled in the plan whose monthly retirement benefit is less than the monthly premium due must be billed directly by the insurer.

Please confirm your ability to conform with this payment structure.

C. Service

The insurer shall be responsible for fully and efficiently servicing this account, which includes, but is not limited to, processing and filing all enrollment applications; receipt and audit of all premium payments and advising the State of any errors, omissions, overpayments or concerns in a timely manner; providing full reports of the status of the program on a monthly basis. Examples of some, but not all reports which may be required, are outlined in Section VIII.

D. Underwriting & Actuarial Services

All underwriting and actuarial services, to include projection of costs for each line of coverage; projection of claims costs; projection of savings or increases in cost of potential plan modifications as may be requested; a yearly estimate of the "Incurred But Not Reported" claims liability by line of coverage; advice on plan design, based upon studies of existing benefit costs as determined by management reports and other sources; and, review of health statements for late enrollments.

E. The insurer will provide the following, at a minimum:

1. Written plan documents which will qualify under ERISA and all other legislative requirements. Amendments will be expected at no charge as frequently as changes in the law or a plan change dictates.

2. Enrollment forms.

3. Administrative manuals for the Group Insurance Manager with all necessary billing forms, claim forms, etc.

4. Member I.D. cards.

5. A conversion policy which complies with state laws.

6. Information on legal requirements imposed by state or federal governments for employee benefit plans.

7. The full scope of COBRA administration including but not limited to: responses to all inquiries from employees, retirees and dependents, all COBRA communications (initial notice upon enrollment, conversion, and other rights upon termination of coverage) and billing of all applicable monthly premium. The State recognizes that COBRA is ultimately the responsibility of the employer and will hold the carrier “harmless”.

8. Payment of expenses for written and audio visual programs communicating these benefits, benefit changes, and related information to employees; and provide professional expertise in the development and distribution of same.

9. A dependent eligibility verification audit. Please provide your pricing at various levels and types of dependent audit services based on the following levels of service:

Level 1

Assume a random audit of 1,000 plan participants with dependents. Provide a listing of services included.

$_____ Cost per employee surveyed

$_____ Estimated cost of printing and postage

$_____ Any other additional costs (please detail)

Level 2

Full audit by affidavit. Please provide a listing of services included.

$_____ Cost per employee surveyed

$_____ Estimated cost of printing and postage

$_____ Any other additional costs (please detail)

Level 3

Full audit by document review. Please provide a listing of services included.

$_____ Cost per employee surveyed

$_____ Estimated cost of printing and postage

$_____ Any other additional costs (please detail)

If hourly or variable charges are listed, please also include a "not to exceed" top end figure.

F. Legal Assistance

1. The insurer shall litigate on behalf of the State and the insurer any suits for subrogation, and defend suits filed against the State or insurer. All legal expenses including awards of attorney fees and punitive damages shall be paid by the insurer out of its retention. Any benefit payments made as a result of court action shall be charged to experience under the plan.

2. How do you provide legislative updates? Provide examples of this material, and indicate how frequently it is distributed. Does the material incorporate specific information on state by state changes?

G. The insurer shall suggest any needed innovative contractual, administrative, and financial changes to the plan.

The Office of Group Insurance shall:

Please confirm your agreement to the State's responsibilities below. If any deviation from the carrier responsibilities above causes additional responsibilities to fall on the State, please outline those in the appropriate section below.

A. Review all enrollment applications and forward them to the insurer. The majority of employees enroll via the state's online enrollment program and enrollment is transmitted electronically; however, employees of the universities and political subdivisions complete hardcopy forms.

B. Collect, audit, and process all funds due to the insurer.

C. Track utilization trends, and the financial status of the program through reports provided by the insurer.

D. Request and review any additional actuarial and administrative reports with the insurer.

E. Assist employees, claimants, and agencies with questions concerning benefit structures, and plan procedures.

F. Communicate benefit plan, procedures and related information to insureds and agencies with assistance of the carrier.

G. Negotiate contracts, and administer innovative efficient changes in the plans.

III. Reporting

For the reports listed in this section, please indicate your capability of producing these reports, or if not, indicate the type of alternate report available.

A. Management Reports - Claim Reporting

The State receives monthly financial settlement reports from its current insurer which provide an analysis of earned revenue, paid claims, incurred but unpaid reserve and administrative expenses. It provides an overall picture of the adequacy of the plan contributions versus paid claims, incurred but not reported claims, and administrative charges (retention). It also includes an aggregate excess loss analysis, headcount, earned interest analysis, cash flow reserve analysis, and premium tax summary. The report is segregated by active employees, retired employees and total group. It is produced monthly and indicates current month and contract year-to-date information. Custom ad hoc reports are also provided by the current insurer upon request.

Pharmacy Reports (semi-annual at a minimum)
Aggregate cost and utilization (number of prescriptions)
By Dispensing Channel: Mail. Retail and Specialty and
By drug type within channel: single source brand, multi-source brand, generic
Ingredient cost, dispensing fee, taxes (as applicable)

Plan costs, participant cost-share, total cost
Top 25 drugs by number of prescriptions
Top 25 drugs by cost

B. Additional Reporting Capabilities

1. Are these reports included in the standard package of reports? Is the cost of your standard report package included in the administrative fee? If not, please indicate the cost of your standard reporting package.
2. What other standard reports are available and with what frequency? Please provide a copy of your standard reports.
3. Would you have the capability to provide custom ad hoc reports if the reports available were not satisfactory? If so, what charge, if any, would apply to ad hoc reports?
4. Are you willing to assign an individual who would be responsible for working with the State on their report requests?
5. What formats are available for reports (web access, electronic, hardcopy, diskette, CD, etc.)?
6. For year-end reports, is data available for purposes of comparison? Can you provide a comparison of the State's costs to your total book of business, considering regional cost factors and similar employers?
7. Please describe any web-based tools available to the client for their own access to healthcare reporting? Please provide specific information on any web-based tools and how they provide the capability for the client to analyze the operational, financial and clinical aspect of their healthcare programs.
8. Are the web-based reports customizable? To what extent?
9. Are benchmarks provided in the web-based reporting tool?
10. Can your healthcare database incorporate data for reporting from another vendor (such as data from a separate pharmacy benefit manager [PBM])?
11. Do you have the ability to integrate medical and prescription drug data in your reporting?

IV. Claim Processing

A. Please provide the location(s) of your claims office(s) which would service this plan.

B. Describe the method your claims office uses to pay claims. Is a dedicated unit assigned or are claims handled by a wide variety of people? How is it integrated with other departments such as customer service, utilization review, medical policy, medical case management, and fraud?

1. What is the average experience level of claim processors?

2. Describe your training program for a claims processing position. Describe any ongoing training and client specific training provided to claim processors.

3. Does your fidelity coverage extend to claim processors?

4. Are contingency plans in place for high claim volume, vacations, and/or absences?

5. How do claim processors screen for fraud?

6. How do claim processors screen potential third-party recoveries? (Please identify any outside firms you use to recover such payments, if applicable.) Please detail procedures for recovery. Are charges made for the services. If so, please detail.

7. What type of client-specific reference materials is available to representatives? How is this information stored (e.g., hardcopy or electronic)?

8. Describe your procedures pertaining to coordination of benefits.

C. Proposed Plans

1. Can you accommodate/administer The State's current benefit plan designs as outlined in the plan summary and contract?

D. Claim Adjustments and Refunds

1. How are adjustments and refunds handled? What is the collections process? How are funds credited back to the client?

2. Describe your Escheat process.

E. Claim Forms

1. Are claim forms required? If yes, please provide a copy of your standard claim form for medical.

F. Systems

Provide information on how your organization provides and maintains a fully automated claims adjudication system in compliance with electronic transmission standards and security requirements and all other regulations as required by HIPAA. Also provide information on integration of systems (claims, customer service, utilization review, etc.)

1. Describe a general overview of your claims systems and its capabilities. How does your system hierarchy work?

2. Describe any major software or system modifications you have planned.

3. How much flexibility does your system have? For instance, what is required to change or modify the way the system is programmed to calculate benefits? Do you re-program these changes internally, or is the system subject to purchasing changes from an outside source?

4. Are there any limitations to the number of different plans that can be handled by your system for any given client?

5. Describe workflow within your operation once claim is received. Is there a claims registration or other steps prior to claim adjudication?
6. How long is claim information kept on your system? Is there an archive process?
7. Flowchart your electronic claims process. What percentage is processed electronically, and what is the audit process?
8. Does your system have software to identify provider-billing issues, such as unbundled charges? What system edits are in place to avoid costly errors, such as duplicate payments, over-utilization, and fraud or abuse?
9. Provide a description of the online (web) capabilities available. What capabilities can you provide to employees? To the client?
10. Describe your disaster control programs and how they would facilitate customer service and claim processing in the event of a regional disaster.
11. Describe the steps taken to ensure that the client plan provisions match the plan provisions loaded in your claims systems.

G. Quality Controls

1. Describe the internal and external claim audit process and any control measures used to ensure efficient, timely, and accurate claim processing? Do you have systems in place to track client-specific control measures?
2. Do you agree to allow The State's internal auditors perform on-site audits?
3. What are the performance standards for:
    a. Claim timeliness (e.g., % of claims processed within 10 days, 21 days, 30 days, etc).
    b. Processing accuracy
    c. Financial accuracy.
    d. Eligibility accuracy

    Please provide your 2010, 2011, and year-to-date 2012 statistics for these categories.
    e. Would you be willing to provide financial guarantees with regard to claims performance standards? If so, what standards and penalties do you propose for those guarantees? What are the dollar amount penalties you are proposing relating to these standards?
    f. What levels of authority exist in the claim office? Please indicate the dollar levels where claims may be passed along for additional review and payment authorization.
    g. Describe the steps taken to ensure that the plan provisions match the provisions in your claims systems.

4. Explanation of Benefits

    a. Provide samples of your explanation of benefits showing examples of claim determinations.

    b. Can EOBs be customized for the client?

    c. Does your system have the capability to provide a combined EOB for more than one family member if claims are processed on the same date?

5. Pre-certification, Utilization Review, Medical Policy, and Appeals

    a. How is medical policy established?

    b. Describe your internal medical review procedures on claims. For example, describe use of medical consultants, specialists and other specialty vendors.

    c. Please detail your use of peer review boards and their function, to include types of services reviewed, authority of the review board, and the frequency with which they are used.

    d. Describe your appeals process, including timelines. Please provide samples of communications. Does your appeal process meet ACA standards for grandfathered and non-grandfathered plans? Does the general administration fee include the cost for Independent Review Organizations (IROs)?

    e. Do you provide precertification and utilization review functions? If so, please describe staffing and program procedures. How is information communicated? Please provide samples of all communications.

    f. Is there an additional fee for precertification and/or utilization review functions or is it included in the administrative fee?

    g. To what extent does this unit participate in Discharge Planning and Retrospective Review?

6. Medical Case Management / Disease Management

    a. Describe your medical case management function.

    b. Do you have internal medical case management or do you contract with outside vendors? What are typical savings attributed to this program?

    c. Is there an additional fee for this service?

    d. Are there other similar programs offered that the State should consider (i.e., information lines, pregnancy program, etc?) Do you have any disease management program? If so, describe programs and procedures to identify candidates for these programs. Are these programs mandatory or voluntary? What chronic conditions are covered? How are the services charged to the State?

    e. Is there a specialized program for transplant patients?

    f. What type of reporting is available to the client with regard to case management and/or disease management programs?

g. What changes have you made in this unit to comply with mental health parity and substance abuse?

h. What is the expertise of the individuals who provide preauthorization and case management for mental health and substance abuse areas?

V. Customer Service

A. Customer Service

Please provide information on the timely response to inquires from plan participants and providers regarding items such as eligibility and status of claims, correspondence, complaints, payments and any other information requested by such parties in a manner that will limit The State's involvement in day-to-day inquires.

Please provide the following information regarding your customer service unit for all components of your medical administration business, if applicable (i.e., claims customer service, preauthorization customer service, case management customer service):

1. Where is your Customer Service Unit located? What are the hours of operation?
2. What is the organizational structure of your customer service department? How is it staffed? Is a dedicated staff available to the State's account? How is the department integrated with other departments such as claims, utilization review, medical policy, medical case management, and fraud?
3. Are toll-free numbers available to participants? If so, are the fees for the lines charged separately to the State or is it a part of the overall administrative fee?
4. What is the average experience level of representatives?
5. Describe your training program for a customer service position. Describe any ongoing training and client-specific training provided.
6. What quality control measures are used to ensure efficient and accurate responses? Do you have systems in place to track client specific control measures?
7. What are the performance standards for:
    a. Speed of answer/average hold time?
    b. Abandon rate
    c. Accuracy of response
    d. Call-back response times
8. Would you be willing to provide financial guarantees with regard to customer service performance standards? If so, what standards do you propose for those guarantees? What is the dollar amount of penalties you are proposing relating to these standards?

9. Are calls voice recorded or manually tracked? If recorded, what type of reporting is available from call records? Can reporting be broken down into categories by reason for the call?

10. Are contingency plans in place for high call volume, vacations and/or absences? Please describe.

11. Are calls for precertification handled by the customer service unit or by utilization review department? What is the average speed of answer for precertification calls? Are those calls recorded? Are responses audited for accuracy?

12. What type of client-specific reference materials is available to representatives? How is this information stored (e.g., hardcopy or electronic)?

13. Provide a description of the online capabilities available. What capabilities can you provide to employees? To the client? What kinds of web site programs are available to members on your website? Is there access regarding provider information or how to contact customer service for questions?

B. HIPAA Compliance

Please provide information for verification that your organization is in compliance with all Federal, State and local laws, regulations, policies and procedures as related to HIPAA.

1. What types of HIPAA controls are in place? Please describe the controls and training procedures.

C. Eligibility and ID Cards

1. What are your capabilities for receiving eligibility and what is your preferred method of receiving this data? How long does it take to update your medical system? How long does it take to update the pharmacy system? Can you accept eligibility based on the State's described systems?

2. Can eligibility information be manually updated/corrected between automated eligibility information transfers?

3. Describe basic steps of eligibility certification when a claim is received. Is your eligibility unit separate from your claim processing area?

4. Provide a copy of your standard healthcare ID card. Can the ID card be customized, including the potential to include information about a separate dental provider network that may be not be affiliated with your organization?

5. How long does it take to produce ID cards after eligibility is received? Is there a fee associated with ID card, or is it included in the general administrative fees?

VI. Preferred Provider Plan

The State of Idaho offers a preferred provider plan with benefit differentials. The various plan designs are detailed in the Schedule of Benefits and Contracts. Please provide the following information regarding the networks you have in place for offering such programs.

A. What is your basic philosophy regarding managed care?

B. How long has your current PPO product been in operation?

C. What types of networks are available (i.e., types of provider networks: hospital, physician, behavioral health, etc.)?

D. Are benefit differentials required to participate in your network?

E. How are discounts generated within the network? How do you calculate the savings?

F. List the average percentage discount for:

   1. Providers

   2. Facilities

   3. Other

G. What are your general standards for access to providers and hospitals in your network (i.e., access to a preferred provider within 10 miles, access to a hospital within 30 miles)?

H. On a county-by-county basis within the State of Idaho, please provide a breakdown of the total number of primary care and specialty physicians as well as the number of hospitals contracted for inpatient services in each county. Are there areas in these counties that you consider to be underserved? Are there specialties in certain counties where you do not have contracts with providers? Please detail any shortcomings in contracted providers on a county-by-county basis.

I. Is the network contracted with your company directly or do you contract with an outside organization (owned or leased)? If your network(s) include providers from leased or rental networks, please provide the name(s) of the network owner(s). If more than one network is used, please indicate the networks used by county. Describe how you integrate with national networks and if there are charges associated with them.

J. How are claims re-priced or are discounts applied in-house? If claims are re-priced off-site, please describe the process and time involved in pricing claims.

K. Describe your provider relations process and organization including recruitment and contracting for providers, provider credentialing, quality of care standards, and frequency of review for adherence to quality care standards.

L. Describe your basic methodology used for contracting with providers. Are contracts based upon discounted fee for service, RBRVS, set fee schedules, some other methodology, or a combination of these factors?

M. Describe your basic methodology used for contracting with hospitals (e.g., percentage discounts, per diem, or DRG). Do you have multiple contracts (for instance 30% of hospital contracts percentage discounts, 20% per diem, etc)?

N. Does your network contract for specialty care on major claims or have centers of excellence for treatment such as transplants, burn treatment, or cardiac procedures?

O. What is the length of contracts and what percentages of contracts are not renewed? What is the average turnover percentage of network providers?

P. Please describe any upcoming changes with re-contracting. Please be sure to include implementation dates and expected impact on discounts.

Q. Are providers charged an access fee to participate in your network?

R. What is your access charge to clients? Does it apply only to those patients who access care through the network, or all participants in general? Is the fee based on percentage of savings, flat access fee, or a combination of both?

S. Are there specific types of providers that are not contracted (such as chiropractors, physical therapists, durable medical equipment vendors, home health care agencies, etc.)?

T. What other types of provider arrangements do you have in place that may result in discounts for the State?

U. Are there preferred provider arrangements for physicians and/or facilities outside the United States?

V. Provide any Quality Management Programs you currently have in place with regards to your networks.

W. Provide any other information you feel is pertinent regarding your PPO network.

X. How are out-of-network claims handled?

1. What is the database, methodology, and/or vendor used to determine usual and customary fees or limiting charges for out-of network providers? How often is this information updated?

2. Does the UC or limiting charge data include the following items:

    a. Physician charges

    b. Hospital charges (facility only)

        >Inpatient (room & board and ancillaries)

        >Outpatient

    c. Ancillary services:

        >X-rays and lab testing

        >Physical therapy

        >Ambulance services

        >Durable medical equipment

        >Anesthesia

        >Other miscellaneous services

Y. Describe your provider locator services (i.e. telephone-based, web-based, etc.). How often is data updated? Does the directory indicate whether the practioner is accepting new patients?

Z. Please describe your provider network development and maintenance strategy (department size, centralized or decentralized, etc.).

AA. Have there been any significant changes in the size of your network in the last three years (> or < 25%)? If yes, please describe the change and the reason for the change.

BB. Provide an electronic list of Idaho providers with name, TIN, ZIP Code, and PPO/Participating/Non-Participating.

VII. Network Savings and Disruption Analysis

Milliman will provide you with electronic medical and vision claim lists via their Secured File Transfer Protocol (SFTP). For each record, please add the allowed charge that would be applied at the claim incurral date and a network match type. The network match type should be PPO, Par, or Non-Par. Please also complete the summary tabs. Please return the electronic file via SFTP. Please send the name and e-mail address of the person sending the file to Milliman : dan.simenc@milliman.com so that we can set up an account.

- PPO is for PPO providers.
- Par is for providers who are not in the PPO network but the State of Idaho will still get a contractual discount.
- Non-Par is for providers that are not in the PPO network and there is no discount agreement.

VIII. Health Education and Wellness

A. Please submit a proposal for creating a health education and wellness strategy. Describe your process in assisting a client in the development of a successful health and wellness education strategy. Include work steps and a timeline as well as ideas and examples of health education and wellness strategies your organization has developed.

B. Describe your experience working with a company that has a strong brand identity and how communications effectively aligned with the brand. Please submit communication examples.

C. Describe, in detail, the health education campaigns (i.e., weight loss, fitness, etc.) you currently provide to existing clients.

D. Please submit information regarding any web-based tools you utilize for health and wellness education and knowledge management. How do you encourage client membership to participate in the education process?

E. Do you have a process for measuring the success of health and wellness education communication projects? If yes, please outline the process. Also, please share the material and results of 1) a project that was successful and 2) one that did not achieve desired results. Please report the ROI current clients typically experience with your program.

F. Does your organization offer a health risk assessment? If so, describe, in detail, the assessment and whether it is available online and/or in paper form. Is this program available as a stand-alone product? Is it available to both members and nonmembers alike? Please provide examples of participant and client reporting for your health risk assessment.

G. Describe your experience in delivering multi-media communications tools. How have you designed programs to effectively integrate web-based communications, print communications, and face-to-face communications?

H. Describe your approach to effectively managing costs of a health and wellness education and communication strategy.

I. Detail the pricing for the various programs you may have outlined.

IX. Value-Added Services

The State values the expertise that administrators can offer. They expect the administrator to be innovative and proactive by keeping the State informed and by making recommendations that will result in a positive impact to the cost or administration of the benefit programs.

A. How does your company view this expectation and what is your approach on sharing the following information.

1. Information on new products, strategies, or consolidation of services whenever possible.
2. Advice on potential problems that exist due to plan design or administrative services.
3. Advice on procedural changes in plan administration that would provide a positive impact to the cost of the benefit program.
4. Legislative advisories on State and Federal issues.
5. Overviews of legislative issues and an interpretation of the potential impact on plans.
6. Bulletins, notices and/or letters advising of other pertinent issues such as cost management techniques.

B. Plan Design Recommendations

The State generally plans benefit change implementations approximately one year in advance. As a result, it is important that an ongoing dialogue exists regarding administrative and plan design changes.

1. How would you use plan data management to recommend benefit design changes? Describe the process. Would it include industry trends and benchmarking?

Section 5: Prescription Drug

I. General Information

A. How do you propose to deliver pharmacy services to the State? Is your program run internally or performed by a third party? If the latter, who is the third party and how long has this relationship existed?

B. Indicate the following for the most recent twelve (12) month period:

	Number of Prescriptions Processed
Retail	_____
Mail	_____
Specialty Pharmacy	_____

C. Indicate any pending or legal actions against the vendor relating to incorrect dispersing of medication or government agencies for trace practices.

D. Provide the name of three clients who have used the proposed vendor services.

E. To what extent can the vendor customize the programs the State may want to implement?

II. Claims Adjudication

A. Is the basic processing system for claims owned by the vendor or leased from a third party?

B. To what extent can the system handle various plan designs, for example multi-tier copays or coinsurance plans with an out-of-pocket maximum.

C. How does the claims system audit the accuracy of copays, pricing, etc.? Do you audit these functions? Are audit results available to the State? If errors are found, describe the process set up for system correction and claims adjudication correction.

D. What lead time would be required to have the State's program in place by July 1, 2013? Describe procedures to test benefits input prior to the effective date. If design changes are made in the future, what is the required lead time to implement these changes?

E. Describe how your in house processing programs interface with the pharmacies in your network. For example, retail fill too soon, pre-authorization for quantity limits, etc.

F. Mail Services

The State does not currently participate in a mail order program. These questions are hypothetical based on future considerations the State may make.

1. Do you own or contract with a mail order facility? If so, where is it located?
2. At what percentage of capacity is the mail facility currently dispensing?
3. What is the average turnaround time on a claim?
4. What is your percentage error ratio on mail order claims?
5. Are OTC products available by mail?
6. What is the average days supply dispensed through mail?

G. Specialty Pharmacy

1. Describe your process for handling specialty pharmacy prescriptions.
2. Describe the distribution channels you commonly use to dispense these medications.
3. What programs do you have in place to contain costs related to specialty benefits. Detail the programs available to the State.
4. How are emergency prescriptions or refills handled?
5. Include your specialty drug list with your proposal.

III. Eligibility & Systems

A. Can you accept eligibility as outlined in the State's basic requirements of the RFP?

B. If eligibility is fed from the insurer's system, describe the update process and timing to update the pharmacy system.

C. Are there work-arounds available if the medical system is updated and the pharmacy system is on a delay? If so, what is the process?

D. What backup procedures exist in the system?

E. Describe your disaster recovery plan, specifically outlining continued service capabilities given a regional disaster.

F. Do you expect to make any system improvements or changes in the next few years?

G. Describe the steps taken to ensure that the client plan provisions match the plan provisions loaded in your claims systems.

IV. Customer Service

A. If a third party vendor is used, describe the integration of your customer service function and those of the third party.

B. When are customer service representatives available?

C. Describe the experience levels of customer service agents. Are any of these functions “off-shored”?

D. Describe the technology available for use by individual participants in the State of Idaho program.

E. What other technology tools do you anticipate introducing at a future date, if any?

F. How will the account be managed for the State? Will it be by you as a carrier or will a third party be involved? Please provide a description and a brief background on those involved.

G. Describe your dispute resolution process if there are issues on claims.

H. List any ancillary services you provide and the cost associated with them.

V. Clinical Services & Programs

A. To what extent do you provide clinical services to:
   1. Members
   2. Pharmacists
   3. Physicians

B. To what extent do you review prescriptions for appropriateness and/or interaction with other prescriptions filled for the same patient? If you use a third party to provide these services, to what extent will this data be integrated with your medical data? What benefit would this provide to the State?

C. Detail the specialized management services you provide. What costs are associated with these services? How do these programs provide information to the participant and the dispersing provider?

D. Describe any programs available to the State to control costs regarding their prescription program. Examples of this would be items such as pre-authorization, drug utilization review, step therapy, etc.

E. Are hard data reports available to the State which would detail results from these programs?

F. Can you integrate these reports with medical data to substantiate the validity of these programs?

VI. Formulary Development and Rebates

A. Who controls the formulary selection, you as a carrier, or a third party vendor?

B. Describe how formulary drugs are determined? How often are they reviewed?

C. Include a copy of your formulary by NDC and Drug Name in an Excel file.

D. Who performs the rebate contracting related to the formulary? If a third party vendor; how do you control this and to what extent is it audited? How frequently does a committee meet to review this?

E. Are there minimum rebate guarantees to the State? If not, how does the State benefit from the rebates? What formulas are used to credit the State with rebates and how are the rebates applied? If so, please provide their values and basis in the table in Section IX below? Is there a minimum percentage share of overall rebates associated with the drugs dispensed to plan participants that the State would receive? How are rebates defined? When will rebates be paid? If actual rebates are in excess of the guaranteed amounts, will the excess also be paid to the state?

F. Describe how these rebates are reported to the State, and the detail provided in any reports provided to the State detailing these rebates.

G. Are there any charges or fees for administration of the rebate program? If so, what are the charges and how are they made?

VII. Pharmacy Network

A. Who does contracting with the pharmacies on your behalf? How frequently are the contracts negotiated?

B. Is there more than one network available? If so, provide a brief description of each network including the number of pharmacies and major changes in Idaho. Confirm that the network is national in scope.

C. How do you audit these pharmacies, and what do you audit?

D. Based on the largest network available, what percentage of Idaho pharmacies are covered? (For consistency of response please count each pharmacy location as one, i.e., RiteAid would have a count for each location, not a count of one for the chain.)

E. Would you allow the plan to include or exclude certain stores or chains?

VIII. Management Reports

A. Describe the standard management reports typically available to plan sponsors comparable to the State. Do you have the ability to customize reports if needed by the State?

B. If the State opts for cost control activities such as pre-authorization, quantity limits or other cost management programs, can you provide reports to the State based on these activities?

C. Based on available data from your reporting system, do you have the ability to model the cost impact of potential plan design changes or proposed cost containment efforts?

D. If the State were to consider a value based design approach, describe your ability to extract pertinent data and make recommendations regarding this design approach.

IX. Discount & Fee Pricing

A. Please complete the following section with your fees and discounts based upon Post Roll-back AWP pricing. Please also state the AWP source and the frequency with which you update for changes in these reports. Assume a broad based retail network.

Will you use a Maximum Allowable Charge (MAC) list for multi-source drugs (e.g., multi-source brand and generic drugs)? If so, what is proportion of all multi-source drugs are typically on your MAC list? Also please provide a copy of your current MAC list and pricing.

Confirm the following or explain how and why your approach would deviate from these requirements:

- The AWP applied at point of sale for claim adjudication and charge back will be the AWP based on the 11 digit NDC for the drug dispensed as of the date it was dispensed.
- The charge to the State will be the lowest of: (a) the Pharmacy's Usual & Customary charge; (b) the guaranteed discounted ingredient cost as listed below plus the dispensing fee listed below; or (c) the MAC (if applicable) plus the dispensing fee listed below.
- The participant will be charged the lowest of: (a) their copay as set forth in their benefit plan, (b) the Pharmacy's U&C; the guaranteed discounted ingredient cost as listed below plus the dispensing fee listed below; or (c) the MAC (if applicable) plus the dispensing fee listed below.
- The below discount guarantees are minimums, and discounts in excess of these amounts will accrue to the State.
- The below Dispensing fee Guarantees are maximums, and dispensing fees lower than these amounts will be changed when applied.

	Retail	Mail
Generic Pricing – Guaranteed	_____	_____
Brand Pricing – Guaranteed	_____	_____
Dispensing Fee:	_____	_____
Administrative Fees Per Member		

per Month (electronic): _____ _____

Administrative Fees Per Claim (manual): _____ _____

Specialty Pricing:
- AWP (discount) - Guaranteed _____
- Dispensing Fees _____
- Administrative Fee _____

Guaranteed Minimum Rebates (per brand script):
- Mail _____
- Retail _____
- Retail Maintenance Brand _____
- Rebate Share accruing to the State _____ %

B. Performance Guarantees

Please list any performance guarantees you are willing to provide with the proposed dollar amounts relating to these guaranteed standards.

Section 6: Financial

I. Financial Requirements

The purpose of this section is to apprise a prospective insurer of the State's major objectives in the design and operation of an effective insurance program and to set forth the State's requirement of an insurer.

A. The State's major objectives are:

1. Minimization of going-in-costs (premium). However, premium quotations should be consistent with realistic pricing assumptions.

2. High credibility and the short-term recognition of actual experience (measured under realistic assumptions) through experience rating or alternative funding mechanisms.

3. Minimization of long-term costs. Here "cost" means premiums less the related experience refunds, adjusted for timing differences, or a conceptually consistent definition for alternative funding arrangements.

4. Budgetary stability (predictability) in the funding levels for these benefits. It is recognized that this objective is inconsistent with item b. The State seeks proposals that outline mechanisms such as stabilization reserves that reconcile these objectives as best as possible. In this connection, please note that the State is legally enabled to establish such reserves and to assure an insurer's access to them.

B. Requirements of Proposers

In order to meet the State's objectives, it is expected that a proposer will conform to the following requirements (among others):

1. Employ realistic assumptions in setting premium rates, reporting experience, and developing experience refunds.

2. Explicitly state the actuarial and financial assumptions underlying premium rates, reserves, interest credits and charges (both as to the level and the base to which the rate is applied).

3. Charge competitive amounts for administrative services that are performed. Retention charges for claims administration should be consistent with thorough, professional performance.

4. Retention charges must not include any commissions or broker fees.

5. Be willing to vary risk and contingency charges according to the level of risk assumed by the insured. The presence of stabilization reserves should affect risk charge levels. The proposer must be willing to make explicit the level of risk

charges in its retention. In this connection, it should be noted that the State understands that an insurer deserves fair compensation for risks undertaken.

6. Be innovative in the financial structure of the plan so that the policyholder realizes the maximum effects of interest credits and the reduction or elimination of unnecessary expenses.

7. Be willing to provide detailed expense analyses as requested by the State.

II. Current Premium Rates

The State of Idaho currently pays the employer portion of the premium for active employees. Employees pay a premium for themselves and any dependents enrolled in the plan. Traditionally, the State has chosen to support a portion of both the cost of the employee and any dependent coverage.

Active employee monthly premium rates for the current fiscal year are available here:

http://ogi.idaho.gov/employees/premium_rates.html.

Retirees are responsible for the payment of the entire monthly premium for both themselves and their enrolled dependents. However, a portion of the actual cost of the retiree coverage is supported by the State Active rates without the retiree subsidy can be calculated by removing $18.84 from the active rate.

Retiree coverage is secondary to any Medicare benefits to which the retiree and/or his dependent(s) may be entitled. Reductions in premium are made as members become eligible for both parts A and B of Medicare.

Retiree monthly premium rates for the current fiscal year are available here:

ogi.idaho.gov/retirees/premium_rates.html.

A. Is there any additional charge for the conversion policy which is made available?

B. Does your cost quote provide for all of the administrative services discussed in the Questionnaire? If not, please detail the services that are additional and the extra cost required.

C. Do your charges vary with the number of benefit revisions requested?

E. Are additional (one time) charges required for reprinting forms, reformatting certificates, etc.? If so, please spell out how these charges are made.

III. Rate Quotations

A. Quotations should be developed based on the presumption that *the existing insurer will assume the claims run out on the current contract*. Please express premiums for the following:

1. Active/Retired Employee Comprehensive Major Medical Plan

    a. Employee

    b. Employee and One Dependent

    c. Employee and Two or More Dependents

    d. Single Retiree Without Medicare

    (Proposed rate structure should provide the same relationships and slope reflected in current rates.)

B. If there are conditions on the rate quotations, please indicate.

C. Will you provide a multi-year rate guarantee?

IV. Traditional Insurance Arrangements

It is expected that all proposers will complete this section.

A. Current Practices

The State's group insurance coverages are fully insured. The existing contracts are experience rated. Surpluses or deficits are transferred on a monthly basis. The State holds substantial stabilization reserves for these coverages. The insurer maintains a maximum cash flow balance of $100,000. IBNR reserves are calculated monthly by the insurer and interest is paid to the state on these reserves at a rate equal to the 26-week Treasury Bill rate, plus one percent (1%). Would you agree to continue this arrangement?

B. What credibility for rating purposes would you give to the Medical Expense plan?

C. If you employ pooling of claims on individuals above a certain amount, please indicate the pooling level and the charges for such pooling.

D. Accounting and Actuarial Practices

Please indicate in detail the accounting and actuarial assumptions and methodology that you would employ in the following areas:

1. Definition of "paid claims".

2. Methods and actuarial basis (interest rates, termination tables, etc.) in determining liabilities and reserves.

a. Due and unpaid claims.

b. Incurred but not reported claims.

c. Basis of interest credits in experience reporting and the determination of dividends. Your answer should speak to both the level of interest and the base to which interest rates would be applied (e.g., mean reserves, mean liabilities, actual plan assets).

E. Rate Analysis and Retention Exhibit

On the basis of the rates quoted in IX.C., please distribute the rate to the following components. The retention is expected to be guaranteed.

Retention Illustration	**7/1/2013 - 6/30/2014**		**7/1/2014 - 6/30/2015**	
	Medical	Combined	Medical	Combined
Expected Paid Claims	_____	_____	_____	_____
Retention (Gross - no interest credit applied)	_____	_____	_____	_____
Components				
Premium Tax	_____	_____	_____	_____
Commissions (if any)	_____	_____	_____	_____
Claims Administration	_____	_____	_____	_____
Other Administration and Profit	_____	_____	_____	_____
Risk and Contingency	_____	_____	_____	_____
Premium Margin	_____	_____	_____	_____
Incurred But Not Reported Claim Reserve	_____	_____	_____	_____
Expected Total Premium	_____	_____	_____	_____
Interest Credits (if any)	_____	_____	_____	_____
Estimated Net Cost	_____	_____	_____	_____

State your gross retention charges per employee on a flat dollar amount per capita cost basis.

Active Employees	Medical	Combined
Per capita per employee	_____	_____

Retirees	Medical
Per capita per retiree	_____

F. How would the premium rate, the premium margin, and the risk and contingency charge in the retention be affected by the presence of a stabilization reserve equal to 5%?

G. Would retention levels be expected to change in renewal years? If so, for what reason, and by what amounts? Would you guarantee the retention for more than one year?

H. Describe specifically your practices relating to the determination of experience refunds. Include discussion of:

   1. Time at which the determination is made.

   2. What interest credits are allowed between the time the refund is actually earned (develops from experience) and the time it is paid.

I. Describe your practices under contract terminations including fees for adjudicating run-out claims. Include a discussion of reserve levels and the timing of experience refunds.

J. Are there any other requirements you impose or other considerations you want to discuss here?

K. Please identify additional fees for services available but not included in the above pricing proposal.