

Questions Regarding NJSHBP Bid for April 1, 2008

PPO:

1. Q: (Section B, p3) What is the expected number of employees that will continue to be offered the Traditional and NJ Plus point of service plan? Will those employees also have the option of choosing the new PPO plan?

A. It is expected that the Traditional and NJ PLUS plans will not be available to any employees/retirees by the end of 2008. These employees will be eligible to participate in the new PPO plans when they are introduced.

2. Q: (Section B, p10) Will the evaluation committee be identified prior to proposals being submitted? When will this information be disclosed?

A. The Evaluation Committee will not be identified until the Committee's report becomes public information following its approval by the State Health Benefits Commission.

3. Q: (Section B, p10) What departments will comprise the evaluation committee?

A. The Evaluation Committee has not been identified at this time.

4. Q: (Section D, P18) Will the Questionnaire, Contractual Requirements and Financial Forms be supplied in a read/write format such as Word?

A. CDs will contain the RFP in Word format, and will be distributed at the Mandatory Pre-Bid conference.

5. Q: (Section D, p 25) Can you provide additional information around the Commission's goal for marketing of SHBP to non-participating Local Employers, such as proposed annual scope of project?

A. At the time the Commission makes such a request, the details of the marketing effort will be outlined.

6. Q: (Section D, p 30) Please advise what analysis, if any, will be performed to analyze and compare bidder's discounts in addition to the reimbursement schedules requested?

A. Since discount and similar analyses are a part of the evaluation process, they cannot be divulged at this time.

7. Q: (Section D, p 32) Will the Commission consider alternatives to the current retiree plan structure—eg., Group Medicare Supplemental Plans as an alternative to the current PPO/HMO structure?

A. At this time, there are no plans to do so. However, after implementation the Commission may consider cost-saving alternatives. The RFP asks for information regarding these issues as it applies to each vendor's products.

8. Q: (Section D, p32) If a Group Medicare Supplemental Plan is quoted, is the intent of the Commission to have said plan mirror the PPO plans as closely as possible or can vendors suggest reasonable proposal alternatives?

A. At this time, we are not asking for bid proposals on Group Medicare Supplemental Plans.

9. Q: (Section D, p32) Will the Commission have the ability to accommodate split eligibility (age 65+ / <65) for a Medicare Supplement plan design?

A. Not applicable at this time.

10. Q: (Section D, p36) Who is the current Disease Management Vendor for the Traditional and NJ Plus plan?

A. Horizon Blue Cross and Blue Shield of New Jersey provides a Disease Management Program for NJ PLUS. The Traditional Plan does not have a Disease Management Program.

11. Q: (Section D, p 36) What Disease Management programs are currently offered on the Traditional and NJ PLUS Plans?

A. As previously stated, the Traditional Plan does not have a Disease Management Program. The Disease Management Programs currently offered in NJ PLUS are: Diabetes, Coronary Artery Disease (CAD), Heart Failure, Chronic Obstructive Pulmonary Disease (COPD), Asthma, Chronic Kidney Disease (CKD), Obesity, Hepatitis C, and Multiple Sclerosis.

12. Q: (Section D, p44) How are employees covered under the SHBP Rx plans currently informed about MAC pricing programs and changes to such programs?

A. Whenever there are changes in the formulary for the SHBP prescription drug plans, members are informed by the vendor.

13. Q: (Section E-2, p73) Please confirm that item "cc" infers that the Commission does not want monthly premium bills to include capitations.

A. As a self-insured program, there are no premiums involved with the SHBP. The SHBP will pay claim costs and monthly ASO fees. The Commission does not want the monthly ASO fee to include capitation. However, it should be included on the claims billing as an identified line item.

14. Q: (Section E-2 , 74) Please advise what the current COB methodology is for the Traditional and NJ Plus plans.

A. The current methodology is pursue and pay. However, the RFP is requesting pay and pursue - Standard COB (i.e., when the SHBP is secondary, the plan will provide a reduced benefit amount which when added to the primary benefit paid will equal no more than 100% of eligible, allowable expenses).

15. Q: (Section F, Scope of Work for PPO) With respect to the Usual and Customary percentile for out of network reimbursement, please confirm what the current Usual and Customary level is for the NJ PLUS and Traditional plans as well as what the proposed level should be for PPO Plans A, B, and C.

A. It is currently the 90th percentile of PHCS and will continue at that level in the new PPO plan designs.

16. Q: (Section G, p 105) Will the commission allow for and consider additional tiering of administrative costs above 150,000 employees? (eg 150,000 to 200,000, 200,000 to 300,000 etc.)

A. At this time, vendors are being asked to complete the fee tiering tables as currently structured.

17. Q: (Section G, p 105) Will there be additional financial exhibits for bidders to complete with the proposal submission, or at any point following submission in the negotiation process?

A. Additional financial information will be distributed at the bidders' conference to those bidders submitting a confidentiality agreement.

18. Q: (Section K, p120) Please confirm the time frame to reconcile performance metric results for purposes of performance guarantee accounting.

A. Metrics are to be reported quarterly by month and are to be reconciled annually.

19. Q: (Section K, p 120) Please confirm that the intent of the performance guarantees is to have different time to process metrics for PPO and HMO.

A. There is an error on page 120 A.1. The paragraph should read in part, "... for claims will not exceed fourteen (14) days for 90.0%..." The chart on Page 131 labeled I. Claim Administration/Customer Service under the chart heading "Standard" should read "90.0% processed within 14 Calendar Days"..

20. Q: (Section K, p122) Please provide additional clarification around the performance metric for Written Complaints.

A. A written concern or complaint is any inquiry for which the carrier must provide a written response.

21. Q: (Section K, p126) What is the definition of "sustain or grow" the network of providers. Will there be a distinct definition supplied for "grow"?

A. See questions #88 and #89 for an explanation of the Commission's expectations regarding network coverage for SHBP subscribers.

22. Q: (Section K, p127) With respect to the medical trend guarantee, there is a request to provide a guaranteed annual increase to claim costs as measured on a per member per month basis. Given the likelihood that there will be significant enrollment shift between plans due to changes in plan design, contributions, and potential vendor consolidation, please clarify how the baseline will be determined against which the increase in costs will be measured.

A. Plan Year 2007 costs, normalized/adjusted for Plan Year 2008 changes, will be the baseline for the trend guarantees.

23. Q: (Section K, P 127) What is the current in network utilization under the Traditional and NJ Plus plans excluding Medicare participants, capitation charges, and out of hospital prescription drugs?

A. As an indemnity plan, network utilization is not an issue for the Traditional Plan. During Plan Year 2006, in-network utilization for NJ PLUS was approximately 90%.

HMO:

24. Q: (Section B, p6): Has a determination been made regarding the number of HMO's that will be offered on April 1 2008 or does the Commission intend to make this information available at any point during the bid process?

A. No.

25. Q: (Section B, p10) Will the evaluation committee be identified prior to proposals being submitted? When will this information be disclosed?

A. The Evaluation Committee will not be identified until the Committee's report becomes public information following its approval by the State Health Benefits Commission.

26. Q: (Section B, p10) What departments will comprise the evaluation committee?

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31. Q: (Section E-2, p73) Please confirm that item "cc" infers that the Commission does not want monthly premium bills to include capitations.

A. As a self-insured program, there are no premiums involved with the SHBP. The SHBP will pay claim costs and monthly ASO fees. The Commission does not want the monthly ASO fee to include capitation. However, it should be included on the claims billing as an identified line item.

32. Q: (Section E2 p85) Is it requirement for the HMO plan to remain "gatekeepered" or can members have direct access to a specialist without referral?

A. While not necessarily a requirement, it is anticipated that SHBP HMOs will remain traditionally "gatekeepered". If you offer an open access plan, provide the cost differential/savings between this arrangement and a gatekeepered one.

33. Q: (Section G, p 105) Will the commission allow for and consider additional tiering of administrative costs above 150,000 employees? (eg 150,000 to 200,000, 200,000 to 300,000 etc)

A. At this time, vendors are being asked to complete the fee tiering tables as currently structured.

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A. Additional financial information will be distributed at the bidders' conference to those bidders submitting a confidentiality agreement.

35. Q: (Section K, p120) Please confirm all performance guarantees will be accounted for on an annual basis.

A. Metrics are to be reported quarterly by month and are to be reconciled annually.

36. Q: (Section K, p127) With respect to the medical trend guarantee, there is a request to provide a guaranteed annual increase to claim costs as measured on a per member per month basis. Given the likelihood that there will be significant enrollment shift between plans due to changes in plan design, contributions, and potential vendor consolidation, please clarify how the baseline will be determined against which the increase in costs will be measured.

A. Plan Year 2007 costs, normalized/adjusted for Plan Year 2008 changes, will be the baseline for the trend guarantees.

37. Q: (Section K, p 134) Please confirm that the intent of the performance guarantees is to have different time to process metrics for PPO and HMO.

A. There is an error on page 120 A.1. The paragraph should read in part, "... for claims will not exceed fourteen (14) days for 90.0%..." The chart on Page 131 labeled I. Claim Administration/Customer Service under the chart heading "Standard" should read "90.0% processed within 14 Calendar Days"..

38. Q: (Section K, p126) What is the definition of "sustain or grow" the network of providers. Will there be a distinct definition supplied for "grow"?

A. See questions #88 and #89 for an explanation of the Commission's expectations regarding network coverage for SHBP subscribers.

BIDDER'S CONFERENCE:

39. Q: (Overall) Will the one week postponement of the Mandatory Pre-Bid Conference have an impact on the RFP timeline?

A. No. The deadline for the RFP submission remains August 16, 2007 at 2 pm. The deadline for submitting any and all questions related to the RFP is July 13, 2007. Questions submitted after that date will not be considered.

40. Q: (Section D, p 19) Can you please clarify question 6. It appears to relate to references. How many references is the SHBP looking for the bidder to provide? If the question does not relate to references can you please provide further explanation?

A. Three references are required.

41. Q: (Section D, p44) Can you please clarify question 221 and the intended definition of "mail at retail" program?

A. The intent is to have vendors describe programs they have in place where many / all of the financial and administrative components of a mail order drug program are available on a retail basis.

42. Q: (Section E2, p82) With respect to item 16A will the SHBP accept two responses, one of which meets the contractual requirements of the RFP and a second which could be more financially attractive in providing additional savings to the SHBP, but would not meet all requirements outlined. What guidance could the SHBP provide to us in formatting a response?

A. No. Only responses meeting all of the contractual requirements will be considered and evaluated.

43. Q: (Section E2, p 84) Please provide clarification to requirement 18B. Is the intent to have separate annual out of pocket maximums for copayments under retail versus mail order or one combined out of pocket maximum?

A. While it is the SHBP's current intent to have the out of pocket maximums combined, it is possible that this will change in the future.

44. Q: (Addendum 3) Please clarify requested structure for banking (cleared check data). Is the intent to report as follows:

State Active, State Early Retiree, State Retiree 65+, Education Active, Education Early Retiree, Education 65+ , Other Local Employer Active, Other Local Employer Early Retiree, Other Local Employer 65+ Or is there another requested format or additional breakdowns required?

A. Addendum III requires the retiree population be split between Early and Medicare Eligible (includes 65+ and disability). Otherwise, this is correct.

45. Q: (Addendum 5) Please provide clarification as to how bidders should respond. Should this be Section 9 of the RFP response?

A. This should be included in Section 9 of your proposal and labeled as response to Addendum V.

46. Q: (Addendum 5) Is the intent to offer this to pre and post 65 retirees or only one population? What is the expectation of the commission around financial design of the program—a charge to the SHBP per participant or is there a specified budget that vendors need to accommodate?

A. This program will initially be offered to future State retirees, both Early and Medicare. The vendor should propose a voluntary program geared to retirees that have the most favorable expected return on investment. Vendors should quote the additional fees that would apply to this program.

Documents Supplied at the Pre Bid Conference:

47. Q. Census: Is it possible to receive the census data with current carrier and plan (Traditional versus NJ PLUS as well as specific HMO vendor) identified?

A. No additional census data will be provided. Addendum I - Section 11 includes census data as of May 2005 and May 2006 split by: NJ PLUS, Traditional Plan, and HMO. Since Indemnity and POS represent the majority of the covered population with the SHBP, the data supplied is a credible representative of the overall claims experience. Additionally, these reports split enrollment by location listing each NJ 3-digit ZIP code, as well as some broader area groupings for locations outside NJ. This files splits enrollment by Active, Early Retiree, and Medicare-Eligible Retiree and by State, Local Government, and Local Education.

48. Q. Claims Data: Is it possible to see claims data, at least on an annual basis, by carrier and plan, including HMO claim data by specific vendor?

A. No additional claims data will be provided. The claims data provided is for NJ PLUS and Traditional Plan combined and then split by the same location, employee status, and employer group as the census data (see response immediately above).

49. Q. Forms: Are the forms that need to be completed as part of the RFP available in Word or some other read/write format? The current PDF's available on the website cannot be completed in an electronic format.

A. No, the documents are in PDF format to protect their integrity. You may download and submit a hard copy, which will be sufficient for filing of these forms with the Division.

50. Q. Disruption Reports: Is this information available with a "Y/N" participation indicator for the current vendor?

A. No. Bidders are asked to indicate if specific providers (physicians, facilities, pharmacies, etc.) are in their proposed network.

51. Q. Attachment 13 Financial Summary: Can you please provide clarification as to how the SHBP defines "Care Management Savings"?

A. Care Management Savings are savings resulting from a vendor's various medical management programs and should be calculated by assessing what the projected cost of the medical services would have been without care management.

Addendum VIII:

52. Q. Please clarify item 5 of the benefit differences legislated under Chapter 103 for the SEHBP. Is it the intent of the SEHBP to have the network status of the dispensing physician dictate the benefit levels of the prescription reimbursement rather than the pharmacy's network status? Can additional clarification be provided as to how the SEHBP wants this benefit to be handled? If the intent is that this benefit is to be truly considered under medical is it also the intent of the SEHBP to forgo pharmacy discounts?

A. The network status of the prescribing physician will determine the percentage of coinsurance to be paid on the prescription drug claim (i.e. 90% in-network, and either 80% or 70% out-of network, depending on PPO plan). The percentage to be paid will always be based on the discounted amount negotiated with the pharmacy.

53. Q. Is it the intent of the SHBP commission to receive fees with and without pharmacy administration on all members at all requested membership tier levels? Please confirm our pricing should be reflective of the vendor being awarded a PBM contract as well as a medical contract on members

A. Yes, your pricing should be with and without drugs, at all requested membership tiers. Please note that groups such as Local Government, and Education sub-groups, and retirees may be offered plans that include or do not include prescription drug coverage. Be aware that any one sub-group could change in the future, ie., one group goes to a separate, stand-alone PBM while other groups do not.

We are not awarding separate, stand-alone PBM contracts through this RFP. For certain groups in this RFP, the medical vendor will also administer the drug program.