MARYLAND
DEPARTMENT OF
BUDGET & MANAGEMENT

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Q & A #3
TO
REQUEST FOR PROPOSALS (RFP)
DENTAL PLAN ADMINISTRATION AND INSURANCE SERVICES
SOLICITATION NUMBER F10B3400005
SEPTEMBER 24, 2013

Ladies and Gentlemen:

This List of Questions and Responses #3, questions #72 through #89, is being issued to clarify certain information contained in the above named RFP. The numerical sequencing begins with question #72 as questions #1 through #46 were answered in Q&A #1, issued on September 13, 2013 and questions #47 through #71 were answered in Q&A #2, issued on September 18, 2013.

In most instances the submitted questions and the Department's responses merely serve to clarify the existing requirements of the RFP. Sometimes, however, in submitting questions potential Offerors may make statements or express interpretations of contract requirements that may be inconsistent with the Department's intent. To the extent that the Department recognizes such an incorrect interpretation the provided answer will note that the interpretation is erroneous and either state that the question is moot once the correct interpretation is explained or provide the answer based upon the correct interpretation.

No provided answer to a question may in and of itself change any requirement of the RFP. If based upon a submitted question it is determined that any portion of the RFP should be changed, the actual change may only be implemented via a formal amendment to the RFP. In this situation the answer provided will reference the amendment which contains the RFP change.

The statements and interpretations of contract requirements which are stated in the following questions of potential Offerors are not binding on the State, unless the State expressly amends the RFP. Nothing in the State's responses to these questions is to be construed as agreement to or acceptance by the State of any statement or interpretation on the part of the vendor asking the question as to what the contract does or does not require.

72. ***Question:*** *In order to ensure we can accurately complete the disruption files, can you please provide the full Provider Tins within all three Disruption files?*

    Answer: The requested information is not available.

73. ***Question:*** *The census that was provided does not match the specific membership counts that were provide within the Technical Proposals FA1, FA2 and FA3 Attachment T-4. Can you confirm the membership counts within Attachment T-4 are accurate?*

    Answer: Attachment T-4 has been amended to include the same membership counts as the census. Please use the membership counts on T-4 and in the census when providing access information requested in FA1, FA2 and FA3 Attachment T-4. See also Amendment #4, Items 1, 2 and 3.

74. ***Question:*** *Within the document named FA3_Attachment_F_DPPO-SF_Financial_Proposal, the Average Reimbursement Tab, can you provide the percentage that you would like utilized to complete this chart i.e. 80th 85th or 90th percentile.*

    Answer: We are requesting average contracted reimbursement, as of July 1, 2013, for providers in your DPPO network. List the average amount, based on your current book of business.

75. ***Question:*** *Please provide the complete Tax ID Numbers for the 3 Disruption Analysis Reports provided with Attachment U (FA1, FA2, FA3 – Attachment T-10).*

    Answer: The requested information is not available.

76. ***Question:*** *What percentile is used for processing out-of-network claims in the PPO plan?*

    Answer: For out-of-network claims, allowed charges are based on a Maximum Allowable Charge schedule which is tied to reimbursement levels for in-network providers. No further information is available.

77. ***Question:*** *[A] Is there anything in the new Medical Exchange that will impact the dental offering? [B] To clarify, we are aware that the state has built the Maryland Health Benefit Exchange (MHBE) to respond to the Affordable Care Act. Though we believe that the exchange is only offered to employers with less than 50 employees, we were curious as to*

whether any state employees would be offered the exchange as an alternative source of coverage.

Answer: [A] There is nothing currently known in the new Medical Exchange that will impact the dental offering. [B] No, we will not be offering it as an alternative.

78. ***Question:*** *We previously asked for DPPO claims data through 2013 (YTD) but the State did not provide it. As the State is asking for fully insured quotes, we are concerned that the failure to provide this information gives the incumbent a competitive advantage as they are the only prospective bidder that has access to this information. That will allow the incumbent to have a more complete view of emerging experience and rely less on projections. Please reconsider your response so that the playing field for all bidders is level.*

Answer: The incumbent is relying on and utilizing the same information that is being provided to all Offerors during this procurement.

79. ***Question:*** *Are current non-network DPPO benefits based on the 90th percentile? If not, what percentile is used?*

Answer: For out-of-network claims, allowed charges are based on a Maximum Allowable Charge schedule which is tied to reimbursement levels for in-network providers. No further information is available.

80. ***Question:*** *On page 5 of the State of Maryland PPO Certificate, the Maximum Allowable Charge definition states that the "Maximum Allowable Charges for Covered Services rendered by Non-Participating Dentists may be the same or higher than such charges for Covered Services rendered by Participating Dentists." The Addendum at the end of the State of Maryland PPO Certificate states that "The Company uses Maximum Allowable Charge schedules to determine claim payments" that vary based on geographical area. Based on this we have the following questions:*

    a) *For Non-Participating dentists, are the in-network schedules used to set the reimbursement level for out of network claims? If not, is a schedule used to set the reimbursement level for out of network claims?*

    Answer: For out-of-network claims, allowed charges are based on a Maximum Allowable Charge schedule which is tied to reimbursement levels for in-network providers. No further information is available.

b) If a schedule other than the in network schedule is used for out of network claims, is there a relationship between the 2 schedules (eg in-network + 10%) and how often are they updated?

Answer: For out-of-network claims, allowed charges are based on a Maximum Allowable Charge schedule which is tied to reimbursement levels for in-network providers. No further information is available.

c) If schedules are not used for out of network claims, how is the out of network reimbursement calculated? Is the reimbursement based on Reasonable and Customary? If so what percentile is used (eg the 80th percentile)?

Answer: For out-of-network claims, allowed charges are based on a Maximum Allowable Charge schedule which is tied to reimbursement levels for in-network providers. No further information is available.

d) Are the State of Maryland insured premiums subject to state premium tax?

Answer: Premium rates are to include all claims and expenses the Offeror expects to incur during the applicable term.

e) Will the State of Maryland insured premiums be subject to PPACA assessments?

Answer: Premium rates are to include all claims and expenses the Offeror expects to incur during the applicable term.

f) What are the 2014 rates?

Answer: Rates are publicly available at the following web address;
http://dbm.maryland.gov/benefits/Pages/PremiumRates.aspx.

g) Is experience available going back to July 2009?

Answer: The requested information is not available.

h) What is the percentage of claims paid in network by experience year?

Answer: The requested information is not available.

i) Please provide EOB or claim counts per month for the experience periods provided.

Answer: The requested information is not available.

j) Please confirm no plan changes took place during the claims experience period provided.

Answer: As stated in response to #15 of Q&A #1 (9/13/13), the only plan change in the last 3 years has been an increase to the age of dependents to age 26. There have been no additional plan design changes.

81. ***Question:*** *What fraud prevention and detection program does the Department currently have in place?*

    Answer: The Department conducts various audits for our vendors and enrollees.

82. ***Question:*** *When is the typical annual enrollment period? What is the anticipated start/end date for the enrollment period?*

    Answer: The typical annual enrollment period is during the fall of each year; i.e. October of each year with trainings and health fairs in August and September.

83. ***Question:*** *Could you please provide us a copy of the current year's benefit fairs schedule (including date, location, number of attendees, etc.)?*

    Answer: Please see the following web address;
    http://dbm.maryland.gov/benefits/Documents/OpenEnrollmentFairs.pdf

84. ***Question:*** *From past experience, how many benefit fairs/meetings on average will be held at the same location on the same day?*

    Answer: The number of benefit fairs/meetings held at the same location on the same day varies from year to year.

85. ***Question:*** *Do you expect to have multiple benefits fairs held on the same day? If so, approximately how many different locations do you expect to have on the same day?*

    Answer: Yes, it is anticipated that multiple benefits fairs will be held on the same day; approximately 4-5.

86. ***Question:*** *Other than the 150+ benefit fairs during the annual enrollment period, will there be any other activity the carrier must/should attend (e.g. quarterly health fairs)?*

Answer: Yes. The Contractor shall be required to attend other meetings including but not limited to Agency Coordinator trainings and quarterly meetings with the DBM Contract Monitor/Manager.

87. ***Question [Formerly Question #65 from Q&A #2]:*** *Is there an MBE company currently working on the existing contract? If yes, please provide the name of that company and the types of services provided.*

    Answer: The MBE company currently working on the existing contract is Janice K. Stetz, LLC.

    Revised Answer: The Department's response to the above-referenced question is incomplete. There are multiple MBEs working under UCCI's current contract. The current contract was modified to substitute the previous MBE subcontractor with Janice K. Stetz, LLC; please see Modification #2 on the following DBM website; http://dbm.maryland.gov/contractors/contractlibrary/Pages/DentalBenefitsProgram.aspx
    As the remaining information being requested has been deemed confidential and proprietary by the Contractor, no further information is available. However, potential subcontractable areas include, but are not limited to: staffing enrollment, printing, benefit fair give-aways and customer service surveys.

88. ***Question:*** *The State's response to question 28, from the "Questions and Responses #1" document distributed on September 13, states that the current carrier "has their own proprietary fee schedule." Is this fee schedule currently used for both in-network and out-of-network claims? If the current carrier's fee schedule is not used for out-of-network claims, please provide the current reimbursement level (e.g., 90th percentile, 80th percentile, etc.) used to process out-of-network claims*

    Answer: For out-of-network claims, allowed charges are based on a Maximum Allowable Charge schedule which is tied to reimbursement levels for in-network providers. No further information is available.

89. ***Question:*** *Please provide clarification on exactly how out-of-network claims are being adjudicated for the current DPPO dental plan. We understand that in-network providers are reimbursed using the negotiated contract allowances. However, we are still unclear about how out-of-network claims are paid. Is the same contract allowance used to pay in-network and out-of-network claims? Or, is some other allowance applied to out-of-network claims?*

Answer: For out-of-network claims, allowed charges are based on a Maximum Allowable Charge schedule which is tied to reimbursement levels for in-network providers. No further information is available.

Should you require clarification of the information provided, please contact me at (410) 260-7374 as soon as possible.

Date Issued: **September 24, 2013**

Authorized By: Andrea R. Lockett
<signed>
Procurement Officer