DEPARTMENT OF
BUDGET & MANAGEMENT

MARTIN O'MALLEY
Governor

ANTHONY BROWN
Lieutenant Governor

T. ELOISE FOSTER
Secretary

DAVID C. ROMANS
Deputy Secretary

QUESTIONS AND RESPONSES # 2
Project No. F10B8200014
Dental Benefits Program
June 02, 2008

Ladies/Gentlemen**:**

This List of Questions and Responses #2, questions #36 through #85, is being issued to clarify certain information contained in the above named RFP. The statements and interpretations of contract requirements, which are stated in the following questions from 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.

36. *Please clarify the statement that was made in Attachment P-1. They are stating that they are looking for rates for a 5 year period, however reserve the right to renegotiate in order to reduce the premium each year.*

RESPONSE: The summary of the statement in Attachment P-1 is correct. Maximum rates for each year are to be proposed but the increase is not automatic each year. During rate negotiations, the contractor must explain and justify a rate increase based on utilization, trend, and other actuarial factors. If the financial experience for a given fiscal year indicates a renewal increase of less than the maximum bid by the Offeror for that fiscal year, the State reserves the right to negotiate to the lower, actuarially indicated renewal increase percentage.

37. *Is the deductible and annual max based on a plan year or a calendar year?*

RESPONSE: All deductibles and annual maximum amounts are calculated on a plan (fiscal) year basis. This is July 1 to June 30 of each year.

38. *On CC-27 of the DPPO Attachment O-1; what kind of services outside of the standard dental CDT procedure codes are they referring to?*

RESPONSE: The reference in CC-27 of DPPO Attachment O-6 means that any changes made to CDT codes will not negatively impact the definition of a covered service based on the State's plan design.

39. *Were there any plan changes with the current carrier in prior years?*

RESPONSE: There have been no substantive plan changes with the current carrier made during the experience time periods contained in the RFP. In the Dental HMO plans, the benefit for preventive examinations was changed from once every 6 months to twice every 12 months to provide flexibility in scheduling appointments.

40. *Attachment N-3: Please confirm that the UCCI DHMO Retirees Individual & Child and Family populations were transposed.*

RESPONSE: It is confirmed that the UCCI DHMO Retirees Individual & Child and Family populations in Attachment N-3 were transposed. Please see below and refer to Amendment # 4 for the correction.

	Active	Direct Pay	Satellite	Retirees	Total
UCCI DHMO Plan					
Individual	7,725	241	273	4,094	12,333
Individual & Spouse	3,720	67	124	2,584	6,495
Individual & Child	1,677	16	38	196	1,927
Family	6,369	60	143	621	7,193
Total	**19,491**	**384**	**578**	**7,495**	**27,948**

41. *Attachment N-4: The DBP DHMO Capitation amounts do not seem to match the enrollment. Please explain? For example, the number of members in September 2007 was 13,410 with a Capitation amount of $131,620. In October 2007, the number of members was 13,464 with a Capitation amount of $114,783. The 13% reduction doesn't seem representative of the member or member and dependent enrollments.*

RESPONSE: The data in Attachment N-4 is the most currently available data. Offerors are encouraged to use their best judgment in determining the risk profile of the group.

42. *Attachment N-6: The UCCI PPO Enrollment for June 2007 is inconsistent with the rest of the year. Why was there such a significant decrease in enrollment for just the one month?*

RESPONSE: The data in Attachment N-6 reflects the actual enrollment activity for the plan. Offerors are encouraged to use their best judgment in determining the risk profile of the group.

43. *Attachment N-6: Through what month were the incurred claims paid through? For example, are the claims represented in November 2007 paid and incurred in November 2007 or do they include claims that were incurred in November 2007 and paid in future months?*

RESPONSE: The incurred claims data in Attachment N-6 represent claims (by incurred date) paid as of 12/31/2007.

44. *Attachment N-7a-c: Why are the plan paid amounts (and possibly membership) different from the paid claims from Attachment N-4-6? For example, N-6 shows total claims from October 2005 – September 2007 as $34,366,438. N-7b reflects a Plan Paid amount for the same period of $19,067,297.48.*

RESPONSE: Please refer to Amendment #4: The titles for Attachments N-7b and N-7c have been changed to:

In & Out Of Network
Paid Claims 10-06 thru 9-07

The titles for Attachment N-4, N-5, and N-6 have been changed to "*Incurred* Claims & Enrollment."

45. *Please provide a 3 year rate history and/or the desired rate ratio for the 3 plans. For example, Individual = 1, Employee + 1 Child = 1.85, Employee + Spouse = 2, Family = 3.*

RESPONSE: Historical rate information may be gathered from review of the Department's health benefits website. Go to www.dbm.maryland.gov and follow the "State Employee," "Health Benefits" and "Archive" links to review the available data. In addition, the direct link below for rate history data should take you to the correct page. Rate ratios may be calculated from this data.

http://www.dbm.maryland.gov/portal/server.pt?open=514&objID=4007&parentname=CommunityPage&parentid=1&mode=2&in_hi_userid=1332&cached=true

46. *Section 3.6: Please confirm that claim payments will not be sent out until after the first payment is received in August from the State of Maryland.*

RESPONSE: Claim processing and premium payments will begin as of July 1, 2009. The Contractor, as a regulated insurer of dental health claims, is responsible for timely payment of claims as required by applicable law and its provider contracts.

47. *Attachment A, Section 4.2: Please explain the need for the Carrier's Tax ID number on every invoice. Can an alternate form of validation be provided (W-9, etc.)?*

RESPONSE: The Contractor's Federal tax identification number is required by law to be listed on every invoice. Please see State Finance & Procurement Article (Annotated Code) 15-102 and COMAR 21.07.01.03. An alternate form of validation will not be accepted.

48. *Attachment A, Section 4.3: Please provide a list of performance standards that might trigger refusal/limitation of payment.*

RESPONSE: Refusal or limitation of payment is justified and may occur in cases where performance is unsatisfactory or untimely. The procurement officer is authorized to do so as a remedy and to address performance issues.

49. *Attachment A, Section 5.1: Would ownership of all documents and materials include documents that are required for the Contractor's continued business administration?*

RESPONSE: Not necessarily. This provision permits the State to retain and use materials generated for performance under this contract, such as marketing materials

specific to the State plan, reports, and utilization/claims/enrollment records; several of these items are required to be produced to the State on a periodic basis. Materials, methodologies, administrative forms, marketing, methodologies, methods of analysis, ideas, know-how, methods, techniques and skills possessed prior by the contractor to the contract will not become the State's property. Further, data and records related to the receipt, processing and payment of claims, including claims histories, shall remain the property of the contractor but access to such information shall be provided to the State in accordance with Article 20 of this Contract.

50. *Attachment A, Section 5.2: Please provide examples of works or services that are not "works made for hire."*

RESPONSE: Please see Response to Question # 49.

51. *Attachment A, Section 16: In what instances would the Procurement Officer unilaterally order the Contractor to suspend, delay or interrupt its performance?*

RESPONSE: The clause in Section 16, of Attachment A is required by law. Please reference COMAR 21.07.01.16.

52. *Please confirm the staffing model for the 24 hour service line. Human staffing only or Human and Voice Response System.*

RESPONSE: The staffing model for the 24 hours service line is to include human staffing and a voice response system.

53. *What parameters/capabilities are required for the voice response system?*

RESPONSE: The voice response system requires that plan participants have access to all information necessary to effectively manage their benefits without the necessity of human intervention. Voice response functionality should include but not be limited to the following: locate a provider, inquire about claim status, transfer to a customer service representative, and inquire about eligibility.

54. *When you state that the GeoAccess Report must be supplied in electronic format that has read/write capabilities, what is your preferred format?*

RESPONSE: The preferred format for electronic GeoAccess Reports is either Microsoft Excel or Access.

55. *The member count for total members given in attachments O-4, is 119, 221 but the census contains 119,417 records. To what do we attribute the additional 196 records? Since the Charts are locked will we be sent new charts that we can change the counts or will the consultant change the charts and resubmit? When can we expect to see the new charts?*

RESPONSE: The member count number of 119,221 in Attachment O-4 is correct. Please refer to the note in the instructions on Attachment O-4 DPPO Provider

Network Access which identifies locations of employees/retirees that should be excluded from the exhibit. No revised charts will be sent.

56. *The member count for DPPO members given in attachment O-4 is 46,851 but the census contains 46,886 records with the DPPO designator. With the additional 33 records will we be sent new charts that we can change the count or will the consultant change the chart and resubmit? When can we expect to see the new charts?*

RESPONSE: The member count number of 46,851 in Attachment O-4 is correct. Please refer to the note in the instructions on Attachment O-4 DPPO Provider Network Access which identifies locations of employees/retirees that should be excluded from the exhibit. No revised charts will be sent.

57. *Can the State please clarify if it wants non-network claims processed at the 90th percentile of maximum allowable charges (MAC) or 90th percentile of Ingenix data? Would the State consider out-of-network reimbursement at the in-network allowances? At a lower percentile? (Attachment O-6 – Question CC-67 – Page 14)*

RESPONSE: The reimbursement levels are 90% of reasonable and customary charges. For purposes of this RFP, "Reasonable and Customary" is defined as a charge for a procedure or service that matches the general prevailing cost for that procedure or service within a given geographic region based on a three digit Zip code range. The charge should be based upon a consensus of what most other dental providers are charging for a similar procedure or service. The source of the charge information can be the Offeror's own claims data or the data of a credible and reliable supplier of such charge information or a combination of both. The source of the data must be clearly identified in the Offeror's proposal and the Offeror must commit to using the same source for the term of the Contract pending a written contract modification.

58. *Are there any other requirements, costs or fees associated with the marketing or enrollment of this product if we are selected? If so what are those requirements and approximately what were those costs last year?*

RESPONSE: The Contractor will be responsible for bearing its costs associated with marketing the plan to State members, including but not limited to attending open enrollment benefits fairs and marketing materials distributed there, member communications materials, provider directories, ID cards, etc. In addition to the Contractor's costs for development, printing and distribution of plan materials, the Contractor will be billed for a portion of the State's cost for printing and distribution of Open Enrollment materials as well as an annual customer satisfaction survey. Please refer to Attachments L-6 and O-6, CC-12 and CC-13. The average cost PER PLAN for the most recent survey (conducted in fall 2007) was $4,075. There were 14 plans.

59. *Looking at UCCI PPO allowances, the out of network benefits appears to be a fixed fee schedule that the coinsurance is then calculated off. Can you please verify for us what the out of network reimbursement level is based off? If a fee schedule, can the schedule be provided?*

RESPONSE: The out of network reimbursement level is not based on a fee schedule. Please see Response to Question # 57.

60. *Can a copy of the certificate with detailed plan design information, limitations and exclusions be provided?*

RESPONSE: Detailed plan information is available on the DBM/Health Benefits website at the link below:

http://www.dbm.maryland.gov/portal/server.pt?open=514&objID=3233&parentname=CommunityPage&parentid=6&mode=2&in_hi_userid=1332&cached=true

61. *Is there any data available on the in vs. out of network performance of the plan? How many claims in vs. out, how many claims dollars in vs. out?*

RESPONSE: The following tables list in vs. out of network performance. This data was taken from vendor-provided reports.

DPPO	10/01/05 - 09/30/06	10/01/06 - 09/30/07
In-Network Paid Claims	14,358,703.84	17,937,050.53
Out-of-Network Paid Claims	7,368,847.39	9,230,523.99
Total Paid Claims	21,727,551.23	27,167,574.52
% In-Network Paid Claims	66.09%	66.02%
% Out-of-Network Paid Claims	33.91%	33.98%
In-Network Number of Services	190,274	233,901
Out-of-Network Number of Services	82,145	99,047
Total Number of Services	272,419	332,948
% In-Network Services	69.85%	70.25%
% Out-of-Network Services	30.15%	29.75%

DHMO	10/01/05 - 09/30/06	10/01/06 - 09/30/07
In-Network Paid Claims	6,464,272.06	5,523,530.39
Out-of-Network Paid Claims	185,162.00	165,717.55
Total Paid Claims	6,649,434.06	5,689,247.94
% In-Network Paid Claims	97.22%	97.09%
% Out-of-Network Paid Claims	2.78%	2.91%
In-Network Number of Services	83,418	71,968
Out-of-Network Number of Services	870	953
Total Number of Services	84,288	72,921
% In-Network Services	98.97%	98.69%
% Out-of-Network Services	1.03%	1.31%

62. *We have had the opportunity review the census information and would just like to clarify the definition of "current enrollment" when reporting the Member Access information. The request is to provide two separate reports:*
1. Using current enrollment. Would you like us to use all dental enrollment (DBP and UCCI) for the DPPO and all the dental enrollment (DBP and UCCI) for the DHMO? or use only United Concordia DPPO enrollment for DPPO and United Concordia DHMO

for DHMO. We believe that you are looking for the first....all those currently enrolled in a dental plan vs. the entire population.

RESPONSE: Please see Response to Question # 16: Census data reflects current enrollment as of January 1, 2008.

For the GeoAccess reports, please review the instructions on Attachment L-4 (DHMO) and Attachment O-4 (DPPO). Access is to be provided two ways: 1) all employees and retirees currently enrolled in the DHMO or DPPO plan (as applicable); 2) all employees and retirees (entire census population). For DHMO proposals, Offerors are instructed to combine DBP and UCCI DHMO enrollment. For DPPO proposals, Offerors are to use the UUCI DPPO enrollment.

63. *To help us better understand the current plan, please provide a PPO booklet certificate or contract that contains a complete list of covered services, exclusions and limitations.*

RESPONSE: Please see Response to Question # 60: Plan information is available on the DBM/Health Benefits website at the link below:

http://www.dbm.maryland.gov/portal/server.pt?open=514&objID=3233&parentname=CommunityPage&parentid=6&mode=2&in_hi_userid=1332&cached=true

64. *How long has UCCI provided PPO dental benefits to State of Maryland?*

RESPONSE: The current contract with UCCI began January 1, 2005 and continued through December 31, 2007 with two one year renewal options. The contract ends on June 30, 2009. UCCI was awarded its first contract to provide dental benefits coverage as part of the State program effective January 1, 1994.

65. *What is the in-network utilization for the PPO program?*

RESPONSE: Please see Response to Question # 61 and the in-network utilization data provided in that response.

66. *What is the current out-of-network reimbursement for the PPO program?*

RESPONSE: The current out-of-network reimbursement for the PPO program is detailed in Attachment O-3: DPPO Plan Design.

67. *What is the expected lag time from invoice receipt to payment remittance?*

RESPONSE: Please refer to the payment schedule in RFP Section 3.6.2: Payment Procedures to determine time from invoice receipt to payment remittance of premiums from the State.

68. *Please provide the total claim dollars submitted, and total claim dollars allowed.*

RESPONSE: Information of total claim dollars submitted and total claim dollars allowed is not available.

69. *Please provide the number of claims by month.*

RESPONSE: The following chart shows the number of encounters by fiscal year for each plan and vendor.

Fiscal Year	DBP DHMO	UCCI DHMO[2]	UCCI DPPO
2006	17,669	39,358	117,827
2007	24,901	33,591	145,026
2008 [1]	11,398	16,280	79,638

[1] 7/1/2007 – 12/31/2007

[2] UCCI DHMO data excludes capitated claim encounters

70. *Can the anticipated cost of $15,000 to print the State of Maryland's open enrollment booklet be applied to the MBE requirement?*

RESPONSE: No, the anticipated cost of $15,000 to print the State of Maryland's open enrollment booklet cannot be applied to the MBE requirement. The State prints these booklets and allocates a proportion of the cost to each vendor. However, each Contractor is expected to have other printed materials that may provide an opportunity for MBE participation: membership cards, provider directories, member handbooks, etc.

71. *Are you currently conducting participant satisfaction surveys? If so, please provide the results for the last three years.*

RESPONSE: Yes, the State conducts an employee satisfaction survey independent of vendor provided surveys. The first independent survey was conducted in 2007. For all dental plans combined, 78.5% of respondents indicated that they were either Satisfied or Very Satisfied with their dental plan.

72. *Question 27 of Attachment O-6, stipulates that "all services included in the State's benefit program will be covered regardless of CDT procedure code changes." Is this requirement for the initial contract period? If not, will this stipulation be ongoing?*

RESPONSE: Please see Response to Question # 38: The reference in CC-27 of DPPO Attachment O-6 means that any changes made to CDT codes will not negatively impact the definition of a covered service based on the State's plan design. This requirement is for the initial contract period and is ongoing.

73. *Can you please confirm that Attachments N-1a, N-1b, and N-1c have been provided for information purposes only and are not to be completed and submitted with the RFP?*

RESPONSE: It is confirmed that Attachments N-1a, N-1b, and N-1c have been provided for informational purposes only and are not to be completed and submitted with a proposal.

74. *Sections 4.3.3 - 4.3.8. Can the State please confirm that the "detailed response to Section 3.4 Description of General Requirements" is a separate narrative from the Executive Summary referenced in 4.3.3? Can the State also confirm that the "detailed response" should be the first item in the Technical Proposal, as listed in 4.3.4, followed by the various attachments, then the subcontractors (4.3.5), economic benefit factors (4.3.6), responsibility (4.3.7) and additional required submissions (4.3.9)?*

RESPONSE: It is confirmed that the "detailed response to Section 3.4-Description of General Requirements" (as detailed in Section 4.3.4.A.) is a separate narrative from the Executive Summary referenced in 4.3.3. The Executive Summary is to be more of a brief narrative, while the response to 4.3.4 is to be a complete, detailed synopsis, demonstrating "a comprehensive understanding of the requirements" of the RFP and how the offeror proposes to meet those requirements if awarded the contract. Elements of the Technical Proposal should follow the same order as the subsections of RFP Section 4.3: 4.3.1 Transmittal Letter, 4.3.2 Title and Table of Contents, 4.3.3 Executive Summary, etc.

75. *Attachment M-4- Fully Insured Maximum Premium Rates (DHMO): The calculation in cell G31 is not correct - the cumulative cost will be overstated using this formula.*

RESPONSE: The State requires a fixed premium rate for contract years one and two, a fixed premium rate for contract years three and four, and a fixed premium rate for contract year five. The exhibit contained in Attachment M-4 will correctly calculate all costs associated with the Offeror's proposal.

76. *Attachment M-5 - Offerer Premium Analysis (DHMO): Please clarify if rates are to be provided on a per employee per month (PEPM) basis or on a per member per month (PMPM) basis as instruction at top of page indicates PEPM and #7 Total Composite Premium Cost indicates PMPM.*

RESPONSE: Rates are to be provided on a per employee per month (PEPM) basis. Please note the State's definition of "Member" in section 1.2 of the RFP. The acronyms "PEPM" and "PMPM" are used interchangeably.

77. *Attachment P-5 - Fully Insured Maximum Premium Rates (PPO): The calculation in cell G31 is not correct - the cumulative cost will be overstated using this formula.*

RESPONSE: Please see Response to Question # 75: The State requires a fixed premium rate for contract years one and two, a fixed premium rate for contract years three and four, and a fixed premium rate for contract year five. The exhibit contained in Attachment P-4 will correctly calculate all costs associated with the Offeror's proposal.

78. *Attachment P-5 - Offerer Premium Analysis (PPO): Please clarify if rates are to be provided on a per employee per month (PEPM) basis or on a per member per month (PMPM) basis as instruction at top of page indicates PEPM and #7 Total Composite Premium Cost indicates PMPM.*

RESPONSE: Please see Response to Question # 76: Rates are to be provided on a per employee per month (PEPM) basis. Please see the State's definition of "Member" in section 1.2 of the RFP. The acronyms "PEPM" and "PMPM" are used interchangeably.

79. *We have reviewed the 2008 – 2009 Maryland State Employees Open Enrollment Brochure on the state's web site. We have followed the link provided in the enrollment guide to the current PPO carrier's web site. We have learned from that public information that a new PPO network is being offered to state employee's effective July 1, 2008. This discovery now prompts the following questions:*
-Prior to July 1, 2008, what is the name of the PPO network being used to process dental benefit claims?
-Prior to July 1, 2008, what percentile was being used to process out-of-network claims; 80th, 85th, 90th, etc?
-Has there been any change in the out-of-network percentile level since the beginning of the current contract period? If so, please provide a history of those changes.
-For the calendar year 2006, what percentage of claims was paid to in-network providers?
-For the calendar year 2007, what percentage of claims was paid to in-network providers?
-For the period Jan 2008 thru April 2008, what percentage of claims was paid to in-network providers?
-What has prompted the state in move to the Advantage Plus PPO network from the Advantage PPO network?
-After July 1, 2008 what percentile will be used to process out-of-network claims; 80th, 85th, 90th, etc?
-What set of circumstances arose that necessitated the introduction of this new network configuration for state employees?
-What enhancements will the state expect to realize once this change is implemented?
-Is there any geographic segment of the state employee population that is perceived as being under-served due to lack of PPO network provider access from either the Advantage or Advantage Plus networks?

RESPONSE: The "new" network was simply an upgrade by the current contractor from the Concordia Advantage to the Concordia Advantage Plus network to provide expanded coverage at no additional cost. There will be no changes in reimbursement levels, claims processing, coverage, plan design, etc. Available claims and utilization information from the dental plans has already been provided as confidential information in Attachment N and no additional claims information is available. Offerors are asked to respond to the RFP with their best proposal to meet the State's needs as articulated in the RFP.

80. *We have been working on our responses and are having some problems on some of the spreadsheets where the "Offeror Name" is a protected field. We tried disabling the Macro security settings, however we are still finding that the field is protected and is requesting a password.*

RESPONSE: The "Offeror Name" fields will auto populate based on the initial entry by the Offeror in each of the Excel attachments. All Excel attachments use this same methodology.

81. *We noticed on the Financial Proposal for both the Dental DHMO and PPO Attachment M-5 and Attachment P-5 number 1 asks for costs to be broken out by PEPM but the detail below asks for PMPM, how should we report it - PE or PMPM?*

RESPONSE: Please see Response to Question # 76: Rates are to be provided on a per employee per month (PEPM) basis. Please see the State's definition of "Member" in section 1.2 of the RFP. The acronyms "PEPM" and "PMPM" are used interchangeably.

82. *It is our understanding that the three (3) attached documents will be used in lieu of Delta Dental's standard contract document (should we be selected as one of the state's dental benefit carriers). We have also noted that these documents must be signed and returned within 5 days of notification of contract award.*

Our legal staff has asked if these three documents are approved for use by the Maryland Insurance Administration; we can only sign contract documents that have been approved by the MIA. If the forms are approved, can you please provide us some type of documentation confirming this fact? We would not want to enter into an agreement using documents not approved for use by the MIA. If the forms are not approved, and Delta Dental was awarded the dental benefit contract, the forms would need to be filed and approved by the MIA before we could sign them. Filing and approving these forms can sometimes be a lengthy process, and if they are not filed and approved, we may not be able to meet the 5-day submission timeline.

RESPONSE: Each Offeror may seek MIA approval of the contract documents identified in the RFP; the Department has not solicited such approvals. These contract documents will govern the relationship between the parties and the scope of the group dental health insurance coverage sought by the State. If an additional insurance policy duplicating or matching insurance coverage detailed in the contract documents is necessary, the Offeror should identify that need in its Technical Proposal, along with any approvals and time frames for approval of such policies. If an Offeror proposes an insurance product that has been approved by the MIA, but deviates from the RFP requirements, such deviations should be noted in the Technical Proposal with the appropriate explanations.

83. *When completing D1 and D2 for minority business enterprise (MBE) participation is the percentage requested in D1 the total MBE participation for the contract? Additionally, when completing D2 "percentage of Total Contract", is the percentage [identified the percetange] of business the named MBE will perform[] as a part of the entire contract amount?*

RESPONSE: Yes, the D-1 figure must be the percentage of the Contract, as a whole, which the Offeror commits to provide as MBE participation. The figure on D-2 identified for each MBE must reflect the percentage of the Contract that the Offeror

commits to that MBE, taking into consideration how the payments will be counted in light of RFP §1.10.

When completing D-1, the percentage that the Offeror is committing to must be the amount of the total percentages filled out on the D-2 attachment. Example: on the D-2, company A is getting 0.1% of total contract dollars, company B is getting 0.2% of total contract dollars and company C is getting 0.2% of total contract dollars. The 0.5% total is to be placed on D-1 as what the Offeror is committing to MBEs to fulfill the MBE participation goal. If the amount adds up to less than 0.5%, the Offeror must ask for a waiver of the difference between the commitment and the goal identified in the RFP §1.10.

84. *Can you please provide a schedule of open enrollment meetings from the past enrollment period? Please include the meeting location if at all possible. Can you tell us, approximately how much time was allocated for each meeting and was a presentation required at each site? We are trying to determine the staffing needs to support the meeting requirements and this information is important to our planning.*

RESPONSE: Formal presentations are not required at enrollment fairs but contractors are required to provide sufficient staffing to present information about provider networks and coverage available to employees and answer any related questions. Further information regarding past open enrollment fairs will be posted on the DBM Health/Dental website as soon as possible

85. *On an annual basis, what is the anticipated movement/fluctuation in enrollment for the PPO and DHMO programs? We are trying to determine the number of EOC documents and ID cards to be generated as a result of enrollment changes submitted during the annual open enrollment cycle.*

RESPONSE: The State cannot predict enrollment for the various plans in the future. The RFP contains historical enrollment data for both the DPPO and DHMO plans. Offerors are encouraged to use those data in making their own assumptions with respect to future enrollment.

Please remember that offers are due on June 18, 2008, no later than 2:00 p.m. If there are additional questions concerning this solicitation, please contact me via e-mail at ggnall@dbm.state.md.us or by phone at (410) 260-7338 as soon as possible.

Date Issued: 06/02/2008

By: Gabriel Gnall
Procurement Officer