

REQUEST FOR PROPOSALS  
(RFP)

**ISSUE DATE:** September 6, 2005

**TITLE:** Administrative Services and Fully Insured HSA-Compliant High Deductible Health Plan

**Number:** OHB05-03

**ISSUING AGENCY:** Commonwealth of Virginia  
Department of Human Resource Management  
James Monroe Building, 13th Floor  
101 North 14th Street  
Richmond, Virginia 23219

**PERIOD OF CONTRACT:** From July 1, 2006 through June 30, 2008, with three one-year renewal options as described within.

Sealed proposals for furnishing services described herein will be received subject to the conditions cited herein until 2:00 p.m., October 4, 2005.

All Inquiries Must Be In Writing And Should Be Directed To:

William Gregory  
Department of Human Resource Management  
James Monroe Building, 13th Floor  
101 North 14th Street  
Richmond, Virginia 23219  
Fax Number: (804) 225-2790

SEND ALL PROPOSALS DIRECTLY TO THE ISSUING AGENCY ADDRESS SHOWN ABOVE.

**Note: This public body does not discriminate against faith-based organizations in accordance with the Code of Virginia, § 11-35.1 or against a bidder or offeror because of race, religion, color, sex, national origin, age, disability, or any other basis prohibited by state law relating to discrimination in employment.**

In compliance with this Request for Proposals, and to all the conditions imposed therein and hereby incorporated by reference, the undersigned offers and agrees to furnish materials and services in accordance with the attached signed proposal or as mutually agreed upon by subsequent negotiation.

Name and Address of Firm:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
Zip Code: \_\_\_\_\_

Fax Number: \_\_\_\_\_ ( ) \_\_\_\_\_

Date: \_\_\_\_\_

By: \_\_\_\_\_  
(PRINTED NAME)

\_\_\_\_\_  
(SIGNATURE IN INK)

Title: \_\_\_\_\_

Telephone: \_\_\_\_\_ ( ) \_\_\_\_\_

**PRE-PROPOSAL CONFERENCE:** A Mandatory pre-proposal conference will be held on Wednesday, September 21, 2005, at the James Monroe Building. (Reference Paragraph 5.9.)

## INTRODUCTION

### 1.1 Purpose

The purpose of this Request for Proposals (RFP) is to secure an administrator or insurance contractor for an HSA-Compliant high deductible health plan (HDHP) option to be included in the statewide health benefits program for employees (to include early retirees) of the Commonwealth of Virginia and The Local Choice (TLC) program. This will not include Medicare-eligible retirees of the Commonwealth of Virginia or The Local Choice. The TLC program is an optional health benefits program for political subdivisions of the Commonwealth. Please note that one statewide high deductible health benefit plan option must be offered. Less than statewide plans will not be offered under this RFP. The effective date of the HDHP option will be July 1, 2006 for the state employee plan and subsequent dates depending on renewal timing for the TLC program.

The objectives of the state employee and TLC programs are to provide better than average benefits administered in a very cost-effective manner with excellent service to enrollees, so that state agencies and participating local jurisdictions can recruit and retain high quality employees. Within this context, the employee health benefits program would like to offer choices among health benefit plans that address diverse needs.

### 1.2 Background

HB 1494, enacted during the 2005 legislative session, requires the health insurance plan for state employees to include as one of the health coverage options a high deductible health plan that would qualify for a health savings account.

The Department of Human Resource Management (the Department) is the authorized agent of the Governor in administering the state employee health benefits program. The program is delivered through approximately 298 state agencies to some 101,000 active, full-time employees, retirees not eligible for Medicare, and extended coverage (COBRA) enrollees, and to the dependents of these enrollees. Agencies distribute program materials, assist employees in applying for coverage or changes in coverage according to rules developed by the Department, payroll-deduct employee premiums, post eligibility information onto the Benefits Eligibility System (BES), and otherwise assist employees in accessing the program's benefits. To support employees and agencies' benefit personnel, the Department operates Employee Direct (E-Direct) which is a web-based system through which employees may make enrollment and coverage changes without the use of paper forms.

The Department also has the responsibility for administering a health benefits program, The Local Choice (TLC), which is offered to localities statewide. Any local government, school district, political subdivision, etc. may join this program. Presently there are 240 member groups covering approximately 29,000 employees. The Department offers a choice of plans to member groups in addition to plan(s) offered to state employees. Currently the choices of plans include PPO and HMO plans with some utilizing coinsurance rather than co-payments and deductibles.

The Department has developed plans and programs with the advice of consultants, vendors, employees and others, and has delivered benefits through Contractors, either insurers or third party administrators. The coverages currently available may be found on the state employees web site [www.dhrm.virginia.gov](http://www.dhrm.virginia.gov) and on the Local Choice web site: [www.thelocalchoice.virginia.gov](http://www.thelocalchoice.virginia.gov).

### 1.3 General Description

The Department currently offers one statewide self-funded plan, a PPO called COVA Care to state employees.

The Local Choice program currently offers four choices under the self-funded plan and is designed around a PPO called Key Advantage. It is anticipated that there will always be a degree of choice in TLC to better meet the needs of the different groups. Both programs also offer one regional HMO.

Incorporated within all of these plans are these separately procured benefit plans of: a medical surgical plan; a dental plan; a mental illness and substance abuse plan (MISA) including Employee Assistance Programs; and a prescription drug plan. This RFP # OHB05-3 provides offerors the opportunity to provide all these benefits and services under the HDHP on a statewide self-funded basis. One offeror will be selected using a competitive negotiation process.

The Department wishes to receive offers for the statewide HDHP plan on an Administrative Services Only (ASO), self-insured basis. The department is under no obligation to implement one form of funding versus the other.

This RFP is divided into sections, such as this numbered Section 1.0, Introduction. A section is one of the principal divisions of this RFP. Within these sections, numbered paragraphs are the second principal division and normally contain the number of the section in which they are located, such as this paragraph numbered 1.3.

**It is imperative that offerors respond to all applicable requirements and complete all applicable schedules and exhibits described in the Form of Response, Section 6.** Any offeror confusion about which sections and/or paragraphs may be applicable to a potential offeror should be clarified no later than the mandatory offerors' conference.

**This RFP does not address coverage for Medicare Retiree benefits.**

### 1.4 Policy Regarding Participation of Small, Women, and Minority Owned Businesses

It is the policy of the Commonwealth of Virginia to contribute to the establishment, preservation, and strengthening of small businesses and businesses owned by women and minorities and to encourage their participation in state procurement activities. The Commonwealth encourages Contractors to provide for the participation of small businesses and businesses owned by women and minorities through partnerships, joint ventures, subcontracts, and other contractual opportunities. Submission of a report of past efforts to utilize the goods and services of such businesses and plans for

involvement on this contract are required. By submitting a proposal, offerors certify that all information provided in response to this RFP is true and accurate. Failure to provide information required by this RFP will ultimately result in rejection of the proposal.

All information requested by this RFP on the ownership, utilization, and planned involvement of small businesses, women owned businesses, and minority owned businesses must be submitted. If an offeror fails to submit all information requested, the purchasing agency will require prompt submission of missing information after the receipt of vendor proposals in order for a non-compliance proposal to be considered. (See Exhibit TWO)

## 1.5 Appendices

Appendix 1 is the current standard contract. Appendix 2 contains selected enrollment, premium, demographic and claim data for state employees. Appendix 3 contains a description of the state employee billing system, and Appendix 4 contains the EDI payment procedures that are used for the state employee group.

## 1.6 Attachments

Attachment 1 contains the summary chart of benefits. Attachment 2 contains the cost schedules and technical questionnaire that must be submitted with a proposal. In electronic form (see 1.8 below) it also contains claim and eligibility data necessary to prepare a proposal. Attachment 3 provides report formats and Attachment 4 is the claims data tape specifications.

## 1.7 Exhibits

Exhibit **One** contains a sample HIPAA Privacy Business Associate Agreement (see paragraph 8.23). Exhibit **Two** contains the Small Business and Business Owned By Women and Minorities report that is required to be submitted under paragraph 6.6.

## 1.8 Electronic Data Files and Response Forms

Files containing claims, enrollment data and the Attachment 2 schedules you will need to prepare and submit a proposal are available in electronic form. To obtain the CD containing these MS Excel and Word files, you may pick them up at the **mandatory** pre-proposal conference. So that we may have an ample supply, contact William Gregory by e-mail ([bill.gregory@dhrm.virginia.gov](mailto:bill.gregory@dhrm.virginia.gov)) prior to the pre-proposal conference. Please note these files are proprietary and available only to vendors present at the pre-proposal conference.

## 2.0 HDHP BENEFIT SPECIFICATIONS, TASKS, AND MANDATORY QUALIFICATIONS

### 2.1 Statewide Medical Plans

The Department is required to offer at least one statewide benefit plan for the state employees program and for the TLC program. One contractor is used for both programs and the plan(s) are provided on a self-insured basis. The plans that are currently offered are described on the web sites provided in Section 1.2 above and encompass a variety of

PPO and HMO plan designs. The Department will continue the self-insured arrangements for the current programs. The HDHP will be offered as a new option to both programs.

2.1.1 One vendor will be selected to administer/insure the entire plan. The Contractor should describe in the proposal how EAP services are coordinated under the HDHP. It is the intent of the Department that EAP benefits mirror those of existing statewide plans as nearly as possible within the requirements of an HSA-compliant HDHP.

2.1.2. The HDHP plan will be offered July 1, 2006. An HSA component may be added July 2007. Offerer shall submit detailed information about its ability to administer a Health Savings Account for participants enrolled in the HDHP, including recordkeeping, fund management, investment options, claim reimbursement, etc.

2.1.3 One HDHP contractor will be selected for both the state employees and the TLC programs. The underwriting and actuarial characteristics of both groups are similar. For proposal efficiency, the claims and other data contained in this RFP, as well as the questionnaire and cost exhibits address the state employee program only. Fees and other contractual details for TLC will be addressed in negotiations.

## 2.2 Provider Networks

2.2.1 The Contractor must offer a statewide network of providers who are expert and practiced and appropriately credentialed in their respective fields. The number of providers should permit employees to access the network for services within the standards described in paragraph 2.3.

2.2.2 The Contractor must ensure that:

- a. providers continue to meet the Contractor's criteria,
- b. sufficient liability insurance is maintained,
- c. provider contracts continue to remain in force,
- d. referral patterns and utilization of services are monitored continually, and
- e. sufficient (in the Department's judgment) numbers of credentialed providers are available.

2.2.3 The Department will consider a vendor who subcontracts seamless local networks, if the networks are properly credentialed and offer the specified benefits at capitated rates deemed advantageous to the Department.

2.2.4. The Contractor must develop, maintain and publish an electronic directory of participating providers of services. Provider directories must be available to all

group administrators and must be easily accessible by enrollees on the contractor's web site (see paragraph 8.15). The Contractor shall have and execute a plan for updating provider lists and communicating changes to benefits administrators and enrollees.

2.2.5 The Contractor must develop and maintain channels of communications with providers adequate to maintain a high degree of participation and continuity in the provider base and to insure that providers are familiar with the program's requirements.

### 2.3 Mandatory Qualifications For Offerors

All network-based plans shall demonstrate that the following access is available to employees. **Alternatively**, if the plan has a Certificate of Quality Assurance from the Center for Quality Health Services and Consumer Protection, the plan shall be deemed to have met the access requirement. If such certificates have not been issued by Dec. 15, 2004, the Department may deem the Offeror's application for the Certificate to meet this requirement.

#### 2.3.1 Medical/Surgical Networks

Type of Provider	Percent of Employees	Distance
One acute care hospital	90% of employees	15 miles
Two acute care hospitals	90% of employees	60 miles
One primary care physician	90% of employees	5 miles
Three primary care physicians	90 % of employees	15 miles

#### 2.3.2 MISA Networks

The number of MISA providers should permit employees to access the network for outpatient MISA services within 30 miles from home for 90% of covered members or 60 miles for inpatient, where possible.

### 2.3.3 Prescription Drug Plan Pharmacy Network

- 2.3.3(a) The Contractor must develop a network of pharmacies which, by contract, agrees to submit claims for subscribers, agrees not to waive deductibles or coinsurance, and agrees to accept the Contractor's allowance (along with any patient deductible or coinsurance) as payment in full for covered services. Contractor will make negotiated discounts available on payments for drugs subject to the deductible.
- 2.3.3(b) Develop and execute a plan for conducting field audits of 5% of participating pharmacies each year.
- 2.3.3(c) Contract with a pharmacy to provide mail-order prescription drug services for large prescriptions.

### 2.3.4 Dental Plan Network

- 2.3.4(a) The Department will consider offers that structure plan reimbursements on either provider network basis or reasonable and customary allowances established by the offeror.
- 2.3.4(b) If the plan proposed is delivered through networks of professional providers who, by contract, agree to accept the Contractor's allowance (along with any patient co-payments) as payment in full for covered services, then the network, to the extent possible, should encompass at least 50% of the professional providers in active practice within each city and county of the Commonwealth. For cities or counties not meeting this standard, the Department shall determine if reasonable access to sufficient providers exists. The initial credentialing of providers, maintenance of the network and communications with providers shall be the exclusive responsibility of the Contractor.

## 2.4 Plan Claim Processing

### 2.4.1 General Processing Requirements

- 2.4.1(a) Process all claims incurred and fill all covered prescriptions during the life of this contract.
- 2.4.1(b) Receive, date and control claims and submitted prescriptions within 24 hours of the day received.
- 2.4.1(c) Verify eligibility of claimant and period of coverage for every claim processed. Pay no claims for TLC employees whose premiums are not currently paid. Eligibility file must include each dependent by name and

number together with the period during which coverage has been in force.

- 2.4.1(d) Examine the licensure and participation status of the provider of services.
- 2.4.1(e) Determine whether or not the services or drugs are covered.
- 2.4.1(f) Determine that the services provided were necessary.
- 2.4.1(g) Check claims history and prevent duplicate payments or payments that exceed contract limits
- 2.4.1(h) Deliver a summary paid claim listing to the Department in a form acceptable to the Department every week along with an invoice. Administrative costs are to be billed monthly.
- 2.4.1(i) Maintain a bank account for paying claims. Reconcile the account, and credit interest to the Department when interest on the float exceeds banking charges.
- 2.4.1(j) Maintain a history of all claims paid. Not less than 18 months of claims history prior to the current calendar year shall be maintained on line.
- 2.4.1(k) Provide within ten (10) days after the end of each month an electronic file of claims paid during the previous month to Department's Consultant in format provided under Attachment 4.

#### 2.4.2 Medical/Surgical, MISA and Dental Specific Processing Requirements

- 2.4.2(a) Price the services.
- 2.4.2(b) Meet the quality and service standards described in Attachment 2.
- 2.4.2(c) Generate and mail a check, as required, and an explanation of benefits (EOB) or denial notice. The forms of the EOB and denial notice are subject to the Department 's approval. Payments and denial notices must be mailed within five business days of the date on which the claim was processed.

#### 2.4.3 Prescription Drug Plan Specific Claim Processing Standards

The plan covers legend drugs with reimbursement limited to the cost of generic equivalents purchased in either a retail or mail order pharmacy.

- 2.4.3(a) Adjudicate all claims at point-of-service, whether at a community or mail order pharmacy, including correct application of deductible (combined medical, MISA and drug expenses) and coinsurance.

- 2.4.3(b) Maintain a consolidated history of claims paid for both community retail pharmacies and the mail order pharmacy.
- 2.4.3(c) Determine whether or not the drugs are covered. The system should have the capability to exclude certain drugs or classes of drugs.
- 2.4.3(d) Check consolidated community pharmacy and mail order pharmacy claims history to determine that the claim does not duplicate in whole or in part a previously paid claim or exceed contract limits.
- 2.4.3(e) Price mail order and community claims according to the contract terms. The system should have the ability to handle varying dispensing fees, multiple co-payments, incentives for dispensing generic drugs and limits on payments for drugs which have generic equivalents.
- 2.4.3(f) Conduct an ongoing program which reviews the utilization of services, patterns of prescribing, and the actual dispensing of legend drugs under the program.

#### 2.4.4 . Prescription Drug Plan Mail Service Pharmacy Dispensing Standards

- 2.4.4(a) Check patient history to determine the appropriateness of the prescription in terms of quantity, possible interactions and other related quality issues.
- 2.4.4(b) Employ a sufficient number of licensed pharmacists to fill prescriptions correctly and quickly, and to provide redundancy as a control over quality. Prior to mailing, a pharmacist other than the one who filled the prescription must check each prescription or, if the process is automated, a pharmacist must check the prescription.
- 2.4.4(c) Contact the patient or physician, as appropriate, to secure generic or therapeutic substitutes or to advise of potentially harmful drug interactions.
- 2.4.4(d) Dispense quickly and accurately, providing the patient with all important information about the drug dispensed and a kit for the next prescription.
- 2.4.4(e) Provide consolidated retail and mail order claims history files with each prescription interactions, and to provide consolidated billing to the Department.

- 2.4.4(f) Review paid claims files to locate and investigate cases of potential fraud and abuse. The Contractor is responsible for developing the criteria used to identify cases, for contacting the beneficiary, pharmacy or prescribing physician, and for all appropriate corrective actions, such as collecting erroneous payments and referring potential fraud cases to appropriate authorities.

## 2.5 Benefit Administration

- 2.5.1 The Department will determine eligibility in the plan. The Contractor shall check the eligibility of claimants against the eligibility file that will be supplied electronically by the Department (for State employees) and a central eligibility file (for enrollees of The Local Choice) before authorizing benefits.

Mail identification cards, if used, to enrollees within 7 days of receipt of the files from the Department or its designee indicating eligibility.

- 2.5.1(a) Issue one card for each single contract or two cards for each other contract for use by enrollees when obtaining medical surgical, MISA prescription drug or dental benefits. A single identification card is required for all coverages.
- 2.5.1(b) The card should include an alternate ID number (not a social security number) that will be provided to the Contractor by the Department.
- 2.5.1(c) The Contractor shall maintain a file of persons eligible. This file can be updated from files provided by the Department, or, in the case of TLC employees, from files provided by the Department's designee, which files identify the persons eligible for benefits.

- 2.5.2 The Contractor shall develop employee communication materials which fully and accurately describe:

- 2.5.2(a) specific provisions of an HDHP as it differs from a conventional health plan,
- 2.5.2(b) specific provisions of an HSA, including requirements for contributions and distributions from an HSA,
- 2.5.2(c) the benefits of the program,
- 2.5.2(d) how the program works,
- 2.5.2(e) where, how, and when additional information can be obtained,
- 2.5.2(f) how to access care,
- 2.5.2(g) what to do in an emergency,

- 2.5.2(h) how to appeal the determination of the Contractor with respect to a denial of benefits for any reason,
  - 2.5.2(i) employee assistance services available,
  - 2.5.2(j) such other information as would be required to meet the standards of a summary plan description as that term is defined in the Employee Retirement Income Security Act (ERISA), and
  - 2.5.2(k) develop 2 articles per year for use by the Department in employee communications about various aspects of the plan.
- 2.6 Provide a legal defense against all claims arising out of this contract.
- 2.7 Hold enrollees and covered dependents harmless with respect to services covered under this contract when such services are furnished by participating providers.
- 2.8 Mandatory Qualifications for Offerors of Medical, MISA, Prescription Drug and Dental Services
- 2.8.1 The plan shall demonstrate that the access to participating providers available to employees of the Commonwealth is acceptable to the Department.
  - 2.8.2 A network-based plan shall annually produce and submit an approved Member Satisfaction Survey.
  - 2.8.3 The plan must offer toll-free customer service telephone numbers at least three months before the effective date of the contract.
  - 2.8.4 The plan must provide a web site available to state and TLC employees, which includes access to decision support tools, including a provider directory which is updated no less frequently than monthly, that is available for use by April 1, 2006.
  - 2.8.5 The plan must submit a paid claims test tape containing at least 500 claims in the format defined in Attachment 4 by October 21, 2005. The Department must be able to read and approve the tape formats no later than November 22, 2005 or no contract will be finalized. PLEASE NOTE: Standard vendor tapes are not acceptable to fulfill this requirement.
  - 2.8.6 All network-based plans shall annually produce and submit a HEDIS (or department approved substitute), including the standard Member Satisfaction Survey, in accordance with the current requirements. At least 80% of the covered persons responding to the Contractor's annual surveys (Paragraph 4.1.9) must rate their overall experience with the program as "satisfactory" or better.
  - 2.8.7 All network-based plans shall apply for NCQA certification *before* responding to his RFP. If rejected, regardless of the reason, the plan(s) shall re-apply at the earliest time permitted by NCQA.

- 2.8.8 To be awarded a contract, all plans must demonstrate the capability to provide the claims and eligibility tapes described in paragraph 2.8.5 below. Such demonstration will consist of submission and approval of a test tape in the format described in Attachment 4. The timing and other logistics involved with this process will be determined during the proposal evaluation negotiations.
- 2.8.9 All plans must offer toll-free customer service telephone numbers at least three months before the effective date of the contract.
- 2.8.10 All plans must offer comprehensive, proven decision support and self-managed care tools.
- 2.8.11 The network for the plan shall provide access to participating providers outside of the Commonwealth of Virginia for enrollees who reside or travel outside the state.
- 2.8.12 Respond correctly and timely to inquiries received by telephone, by mail or in person.

### 3.0 STANDARDS OF PERFORMANCE

#### 3.1 General (Applies to all Benefits)

The Contractor shall be solely responsible to the Department and liable for any delay or non-performance of any portion of the contract which results from this RFP, and for erroneous payments. The Contractor shall not be responsible for delay or non-performance if the non-performance is caused by the failure of the Commonwealth, covered persons, or non-network providers to provide information necessary for the Contractor to meet its contractual obligations.

Certain performance obligations are of such importance that a Contractor's failure to achieve the requirements found herein jeopardizes the value which the Department expected of the contract. In acknowledgment of this, and in consideration of the extra expenses and other damages incurred by the Department should the Contractor fail to fulfill specified contractual obligations, both parties agree that the Contractor shall pay to the Department the amount contained in the appropriate schedule of liquidated damages (see paragraphs 3.3, 3.4, 3.5) when the Contractor's performance fails to meet the specified standards of performance.

**It is expressly agreed that, unless otherwise specified, the determination of liquidated damages, if any, shall be determined annually as described below and in Attachment 2, and as applicable, by comparing the system generated reports in Attachment 2 and 3 to the related Schedules submitted by the Contractor.**

##### 3.1.2 Claims Must Be Paid Correctly

The goal is 100% accuracy.

Below Standard:

Total payment error rate in excess of 1% of benefit payments, where total payment error rate is the dollar amount of erroneous payments, including payments to an incorrect payee (any reason) or paid in an incorrect amount (any overpayment plus any underpayment) or any other payment error (including both incorrect payee and incorrect amount), divided by the total dollar amount of claims paid during the audit period, **OR**

Total error rate in excess of 5% of claims processed, where total error rate is the number of claims with any kind of error (including payment errors) divided by the total number of claims processed during the audit period.

Compliance with this standard shall be determined by internal audit, and verified by external audit. Should the internal and external audits arrive at results which materially affect the amount of liquidated damages, the Contractor and the Department shall negotiate the actual amount of the damages. If these parties cannot reach an agreement through negotiation, they shall jointly pay for an independent audit whose determination shall be binding on both parties.

### 3.1.3 Coordination of Benefits Savings

The contractor shall coordinate benefits and produce an annual report reflecting COB savings achieved under the plan.

### 3.1.4 Access of Eligibility Files Updates

The Department will maintain current eligibility files for both the state employee group and the TLC program. Enrollee eligibility changes may be made electronically without restriction to time of day or day of week. The Department will move these changes automatically to an electronic file for pickup by the Contractors. It is expected that each Contractor pick up changes on a daily basis.

### 3.1.5 Reporting

Reports containing the requested true information shall be submitted timely. The submission of a materially inaccurate report does not constitute timely submission for the purposes of this section. NOTE: Timely reporting also includes the submission of accurate and readable weekly claims tapes, paid claims invoices, and monthly administration invoices.

The Department shall determine compliance with this standard by the date of receipt of reports.

### 3.1.6 Invoicing and Processing

The contractor shall, if required by the Department invoice each TLC group monthly for premiums related to their participation in the plan. Process 90% of TLC premium invoices within 3 business days of receipt of payment

and 100% of premium invoices within 5 days of receipt.

Compliance with this standard shall be determined by audit.

### 3.1.7 Premium Projections

Regardless of the plan funding method, it is important that premium projections be as accurate as possible and be determined solely by sound application of all applicable underwriting and actuarial methods. Specific standards applicable to this contract's rating methods and representations of network savings are addressed in Attachment 2.

3.1.8 Each month the Contractor will adjudicate (i.e., pay or deny) 90% of all submitted claims within 15 working days of receipt. All claims (100%) will be adjudicated (i.e., pay or deny) within 30 working days of month received.

### 3.1.9 General Phone Responses

Proposals should state the Contractor's willingness to accept these standards, and to install the necessary telephone, telecommunications or other systems necessary to ensure adherence to the standards without cost to the Commonwealth. The Contractor will need to be able to provide the Department with documentation of its performance.

For claims administration, utilization review and other Contractor services (for example, basic non-crisis related functions), adequate toll-free telephone lines must be available for access by covered persons during normal business hours. The following standards must be met each month:

3.1.9(a) Fewer than 2% of calls are abandoned.

3.1.9(b) Average waiting time is 30 seconds or less.

### 3.1.10 MISA Specific Telephone Standards

The Contractor must be able to meet the following standards for telephone services and access. These standards shall be measured and reported monthly.

3.1.10(a) There will be no busy signals for the MISA crisis telephone line. Any deviation from the 100% standard is below standard.

3.1.10(b) No caller to the MISA crisis telephone line will ever be put on hold or fail to reach a live individual within 10 seconds, regardless of day or time.

- 3.1.10(c) The Contractor shall maintain a toll free telephone crisis line for MISA services. The line shall be staffed at all times, 24 hours per day including weekends and holidays, by qualified personnel who can provide information to covered individuals and family members, and can provide assistance, assessment, and referrals for emergencies, if necessary. NOTE: Answering machines or tape-recorded messages are not acceptable.

3.1.11 Prescription Drug Specific Telephone Standards

Provide 24 hour per day pharmacy coverage to respond to emergency calls by enrollees regarding their prescriptions. The line shall be staffed at all times, 24 hours per day including weekends and holidays, by qualified personnel who can provide information to covered individuals and family members, and referrals for emergencies, if necessary. NOTE: Answering machines or tape-recorded messages are not acceptable.

3.1.12 Processing Time

These processing standards shall be measured and reported monthly.

- 3.1.12(a) The Contractor shall authorize/deny inpatient MISA treatment within 24 hours of the request.
- 3.1.12(b) The Contractor shall authorize/deny outpatient MISA treatment within five working days of the request.

3.2 Prescription Drug Specific Standards

3.2.1 Prescription Drug Claims Processing Timeliness

Contractor will provide point of service claims processing for all providers submitted and mail order processed claims. All properly completed manual claims must be processed within 30 calendar days, and 90% of all properly completed claims must be processed within 15 calendar days.

3.2.2 Prescription Drug Claims Processing

Claims must be paid correctly. The claims processing system must have an extensive series of prepayment edits. Claims payments are subject to audit. Erroneous payments must be corrected, overpayments recovered and problems with the claims processing system must be repaired when ordered.

3.2.3 Mail Service Pharmacy Timeliness of Dispensing

Mail order prescriptions must be dispensed within seven calendar days of receipt.

### 3.2.4 Mail Service Pharmacy Accuracy of Dispensing

- 3.2.4(a) Mail order drugs actually dispensed shall conform to the drugs actually prescribed in every respect. Substitution consistent with the Virginia Voluntary Formulary is permitted. (The data to be used to evaluate compliance with this standard includes all prescriptions for all programs filled at the facility which dispenses drugs covered under the State program.)
- 3.2.4(b) The facility must be open to announced and unannounced inspections by the Department and its agents.
- 3.2.4(c) The number of dispensing errors identified at the last quality control checkpoint must be recorded and reported immediately as requested. Also, any dispensing error discovered (by whatever means) after the drug has been mailed must be reported upon discovery in a special incident report to the Department.

### 3.3 Schedule of Liquidated Damages – General (Applies to all Benefits)

This schedule of liquidated damages is mutually agreed in view of the difficulty and the cost of measuring the actual damages incurred from complaints, lost productive time, intrusion into other business, etc., as a result of under-performance in the areas noted.

<u>Brief Reference</u>	<u>Liquidated Damage Award</u>
99% of benefit \$ paid correctly	3% of administrative costs for each 1% or fraction below standard
95% of claims paid without error	1% of administrative costs for each 1% or fraction below standard
90% of claims adjudicated within 15 working days of receipt	\$2,500 for each working day after the 15 <sup>th</sup> necessary to achieve 90%
100% of claims adjudicated within 30 working days of month received	\$1,000 for each working day after the first of the month following month claim received

Eligibility Files not picked Up daily	\$100 per day, days 2-5, \$1,000 per day thereafter
2% abandoned calls	\$1,000 per each percent or fraction thereof above standard
30 second average wait time	\$1,000 for each second above standard
Late/Missing Reports	\$100 per day, days 1-5; \$1,000 per day thereafter
Invoice Processing	\$500 per invoice not meeting standard
Inaccurate projections	1% of contracted administrative fee for failure to meet the standards described in Attachment 2.
80% patient satisfaction	\$2,000 for each percent or fraction thereof below standard

### 3.4 MISA-SPECIFIC SCHEDULE OF LIQUIDATED DAMAGES

This schedule of liquidated damages is mutually agreed to in view of the difficulty and the cost of measuring the actual damages incurred from complaints, lost productive time, intrusion into other business, etc., as a result of under-performance in the areas noted.

<u>Brief Reference</u>	<u>Liquidated Damage Award</u>
no busy signal on crisis line	\$200 per occurrence of busy signal
10 second answer on crisis line	\$100 per occurrence of longer than 10 second wait
24 hour inpatient authorize/deny	\$1,000 per occurrence
5 day outpatient authorize/deny	\$100 per occurrence

### 3.5 PRESCRIPTION DRUG SCHEDULE OF LIQUIDATED DAMAGES

<u>Brief Reference</u>	<u>Liquidated Damage Award</u>
------------------------	--------------------------------

claims timeliness	\$1,000 for each 1% or fraction below standard
prescription timeliness	\$100 per day for each late prescription
prescription dispensing	\$1,000 for every instance in which scripts are not checked by a pharmacist other than the dispenser

#### 4.0 REPORTS AND DELIVERABLES

Generally, separate report sets are required for (1) TLC local governments, (2) TLC school jurisdictions, (3) TLC in total, (4) the state employee active employee group, (5) the state employee early retiree group, and (6) the state employee group in total. Attachments 2 and 3 also contain formats of some system-generated reports that will be used to assess Contractor performance and to determine the amount of liquidated damages due, if any. Report formats are generally contained in Attachments 2 and 3. Offerors are invited to suggest improvements or additional reports.

#### 4.1 REPORTS

##### 4.1.1 Rate and Administrative Expense Buildup Schedule

This form, which may be found in Attachment 2-1, must be submitted in accordance with paragraph 4.1.10 and 8.5.

##### 4.1.2 Weekly Claims Report

The Weekly Claims Report is to be prepared in MS Excel format and E-mailed on the third business day after the close of the week. The format is contained in Attachment 3.

##### 4.1.3 Weekly claims tape

The format for the tape may be found in Attachment 4. The tape shall be delivered weekly to the Department's designee.

##### 4.1.4 Administrative Fee Report

This report is used by all ASO plans to invoice administrative costs on a monthly basis. The format is contained in Attachment 3.

##### 4.1.5 Monthly Service Report

This report discloses Contractor's results in meeting customer service and claims processing goals. The format can be found in Attachment 3.

##### 4.1.6 TLC Monthly Income Report

The Monthly Income Report shows the premium income received from each local employer by plan and in total, with an indication of employer groups in default. The report is to be prepared in MS Excel format (see Attachment 3) and E-mailed on the 20<sup>th</sup> day after the close of the month.

#### 4.1.7 Extended Coverage (COBRA) Transactions and Enrollment File

The specifications for this electronic file are found in Attachment 3. The two purposes of the report are (1) to report all changes (adds, deletes) to the previous month's Extended Coverage enrollment, and (2) to provide a file denoting the current Extended Coverage enrollment.

#### 4.1.8 Monthly Utilization Management Report

This report discloses the contractor's assessment of its utilization management activities, including admission review, concurrent review and case management. The specifications for this electronic file are found in Attachment 3.

#### 4.1.9 Annual HEDIS

The Contractor shall submit the latest appropriate version of the HEDIS (or Department-approved equivalent), including the standard Member Satisfaction Survey for the most recent calendar year, by July 1 or with the contractor's renewal, as appropriate.

#### 4.1.10 Annual Accounting and Renewal

On or before September 15, after the completion of 12 months' operations under the contract, the Contractor shall submit specified IBNR lag triangle data in the required form to the Department Actuary.

On or before September 15, after the completion of 12 months' operations under the contract, the Contractor shall submit a complete accounting of its operations for the fiscal year ended the last June 30, and shall propose a rate, using the Rate Buildup Schedule, for the fiscal year beginning the next July 1. The accounting and rate analysis should treat separately each major class of benefits, medical-surgical, mental illness and substance abuse, prescription drug, and dental.

In addition, the Annual Report shall contain:

- costs by employee, spouse and dependents (separately for active employees, retirees, and extended coverage enrollees),
- a list of the fifty highest cost cases (enrollees) with relevant detail on admissions, diagnoses, etc.,
- amounts paid to hospitals (including inpatient surgical per diem, inpatient acute medical per diem, inpatient acute obstetrical case rate, inpatient outlier minimum charge per case and inpatient outlier rate, and outpatient case rates for those procedures which comprise 50% of outpatient hospital reimbursement, or for the 25 procedures which have the highest total dollar impact together with an indication of the percentage of total outpatient reimbursement these 25 procedures represent),
- show the fifty professional providers of services receiving the largest payments, and

- claims in excess of \$100,000, if not previously reported.

Finally, the Annual Report shall provide a frequency distribution of contracts, claims and dollars paid in total and by type of benefit.

4.1.11 Such other reports as may be necessary to document the performance of the Contractor and its adherence to the contracted standards.

4.2 All Contractors: Utilization of Small Businesses and Businesses Owned by Women and Minorities.

1. Periodic Progress Reports/Invoices. Within sixty days of each six months' operation under this contract, disclose the actual dollars contracted to be spent to-date with such businesses, and the total dollars planned to be contracted with such businesses on this contract. This information shall be provided separately for small businesses, women-owned businesses and minority-owned businesses.
2. Final Actual Involvement Report: The contractor will submit, prior to completion of the contract and prior to final payment, a report on the actual dollars spent with small businesses, women-owned and minority-owned businesses during the performance of this contract. At a minimum, this report shall include for each firm contracted with and for each such business class (i.e., comparison of the total actual dollars spent on this contract with the planned involvement of the firm and business class as specified in the proposal, and the actual percent of the total estimated contract value. A suggested format is as follows:

Business Class: Small, Women-Owned or Minority-Owned

<u>FIRM NAME, ADDRESS AND PHONE NUMBER</u>	<u>TYPE GOODS/ SERVICES</u>	<u>ACTUAL DOLLARS</u>	<u>PLANNED DOLLARS</u>	<u>%OF TOTAL CONTRACT</u>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
TOTALS FOR BUSINESS CLASS		_____	_____	_____

4.3 Other Deliverables

4.3.1 The Contractor agrees to furnish and warrants that the administrative charge quoted includes all enrollment materials, benefits booklets, and brochures

describing plan benefits, applications, notices, claims forms, checks, remittance advices, two articles for employee publications, administrative manuals, provider networks, directories, forecasts, invoices, identification cards, criteria sets and such services and materials stated or implied anywhere in this RFP or the Contractor's response thereto.

- 4.3.2 The contractor shall assist the Department with the ongoing operations of The Local Choice (TLC) program by working with the TLC administrator providing seamless marketing; communications; underwriting; renewal and proposal preparation and delivery; group billing and collections; and maintaining membership.

## 5.0 PROCUREMENT PROCEDURES

### 5.1 Method of Award

- 5.1.1 The Department shall select two or more Offerors deemed to be fully qualified and best suited among those Offerors submitting proposals, unless the Department has made a determination in writing that only one Offeror is fully qualified, or that one Offeror is clearly more highly qualified than the others under consideration. The selection of Offerors will be based on the evaluation factors included in this RFP. Negotiations shall be conducted with the selected Offeror(s). Price shall be considered when selecting finalists for negotiation, but shall not be the sole determining factor.
- 5.1.2 After negotiations have been conducted with each selected Offeror, the Department shall select the Offeror, which, in its opinion, has made the best proposal. The Department shall award the contract to that Offeror. The Department may cancel this RFP, or reject proposals at any time prior to an award. The Department is not required to furnish a statement of the reason why a particular Offeror was not deemed to have made the best proposal (Section 2.2-4359, Code of Virginia).
- 5.1.3. Should the Department determine in writing, and in its sole discretion, that only one Offeror is fully qualified, or that one Offeror is clearly more highly qualified than the others under consideration, a contract may be negotiated and awarded to that Offeror.
- 5.1.4 The contract will incorporate by reference all the requirements, terms and conditions of this RFP and the Contractor's proposal, except as either or both may be amended through negotiation. All statements and representations, written or verbal, relating to the award of this and renewal contracts must be construed to be consistent with the following submission instructions.

### 5.2 Submission of Written Proposals

- 5.2.1 All proposals must be in the form requested (See paragraph 6.0 and Attachment 2). The data required on the schedules submitted in response to this RFP are subject to verification. Material errors shall be a basis for rejecting such a

proposal. An original and six copies shall be delivered in a sealed container, and labeled as a proposal, with the words "**Do Not Open**" and **the type of benefit plan enclosed** prominently displayed on the outside. Proposals must be received no later than 2:00 p.m. on Tuesday, October 4, 2005, by:

William Gregory  
Department of Human Resource Management  
James Monroe Building, 13th Floor  
101 North 14th Street  
Richmond, Virginia 23219

Each copy of the proposal should be bound in a loose-leaf notebook. All documentation submitted with the proposal should be contained in that single volume. (If necessary, additional notebooks may be submitted in clearly marked and referenced sequence.) *Offerors are required to submit an electronic RFP response as directed by the Attachment 2 schedules, along with each copy of the proposal.*

5.2.2 Ownership of all data, materials and documentation originated and prepared for the Department pursuant to the RFP shall belong exclusively to the Department and be subject to public inspection in accordance with the Virginia Freedom of Information Act. Trade secrets or proprietary information submitted by an offeror shall not be subject to public disclosure under the Virginia Freedom of Information Act; however, the offeror must invoke the protections of Section 2.2-4342 of the Code of Virginia, in writing, at the time the data or other material is submitted. The written notice must specifically identify the data or materials to be protected and state the reasons why protection is necessary. The proprietary or trade secret material submitted must be identified as required and must indicate only the specific words, figures, or paragraphs that constitute trade secrets or proprietary information. The Department, in its sole discretion, may not consider proposals with unduly broad requests for protection against disclosure.

### 5.3 Modification of Proposals

Any changes, amendments or modifications of an offeror's proposal prior to the deadline for receipt of proposals must be in writing and submitted in the same manner as the original proposals. All modifications must be labeled conspicuously as a change, amendment, or modification of the previously submitted proposal. Changes, amendments, or modifications of proposals will not be considered after the deadline for receipt of proposals, except when the Department requests modifications.

### 5.4 Oral Presentation

Offerors who submit a proposal in response to this RFP may be required to give an oral presentation of their proposal to the Department. This provides an opportunity for the offeror to clarify or elaborate on the proposal. This is a fact finding and explanation session only and does not include negotiation. The Department will schedule the time and location of these presentations. Oral presentations are an option of the Department and may or may not be conducted.

## 5.5 Inquiries Concerning the RFP

Any communication concerning this RFP or any resulting contracts must be addressed in writing to:

William Gregory  
Department of Human Resource Management  
James Monroe Building, 13th Floor  
101 North 14th Street  
Richmond, Virginia 23219  
Fax Number: (804) 225-2790  
E-mail: bill.gregory@dhrm.virginia.gov

## 5.6 Public Inspection of Procurement Records

Proposals will be subject to public inspection only in accordance with Section 2.2-4342 of the Code of Virginia.

## 5.7 Clarification of Proposal Information

The Department reserves the right to request verification, validation or clarification of any information contained in any of the proposals. This clarification may include checking references and securing other data from outside sources, as well as from the offeror.

## 5.8 Reference To Other Materials

The offeror cannot compel the Department to consider any information except that which is contained in its proposal, or which is offered in response to a request from the Department. The offeror should rely solely on its proposal. The Department, however, reserves the right, in its sole discretion, to take into consideration its prior experience with offerors and information gained from other sources.

## 5.9 Mandatory Pre-Proposal Conference

A **mandatory** pre-proposal conference will be held at 10:00 a.m. on Wednesday, September 21, 2005, in the James Monroe Building, Conference Room B, 1<sup>st</sup> Floor, 101 North 14th Street, Richmond, Virginia. The purpose of this conference is to allow potential offerors an opportunity to present questions and to obtain clarification relative to any facet of this procurement.

Attendance at this conference is a prerequisite to submitting a proposal. Offerors who intend to submit a proposal are required to attend. Any changes resulting from this conference will be issued in a written addendum to the RFP. Attendance at the conference will be documented by the representative's signature on the attendance roster.

**It is requested that any known questions regarding the RFP be forwarded to William Gregory prior to date of conference to facilitate the conference. See Fax number and E-mail address in paragraph 5.5.**

Offerors should bring a copy of this RFP to the conference. Any changes, which result from this conference, will be issued in a written addendum to the RFP.

#### 5.10 Timetable

RFP Published	September 6, 2005
Mandatory Pre-Proposal Conference	September 21, 2005
Proposals Due, 2:00 P.M.	October 4, 2005
Notice of Intent to Award	November 8, 2005

#### 6.0 FORM OF RESPONSE AND CRITERIA

##### General

A proposal is required. Attachment 2 contains the schedules required to complete a proposal. Please review Attachment 2 carefully and complete those section(s) that apply to the plan being offered.

Each proposal shall be in the form of a loose-leaf binder (three inch maximum), tabbed to point to each section below. Before the first tab:

- Place the executed RFP Cover Sheet followed by a statement defining those sections of your proposal which may not be released because they are proprietary. Each page so designated shall also be marked "Confidential: Proprietary Information," and, if not so marked, shall not be protected.
- Following the executed Cover Sheet and statement of confidentiality, if any, place a properly completed Schedule 2-8, Proposal Checklist.

An original proposal and six copies are required. The original shall contain a Cover Sheet bearing an original signature signed in BLUE ink and be labeled on the cover as "Original".

#### 6.1 Redline RFP noting demurrals (Tab 1)

Include a copy of the RFP. Using the *Track Changes* and *Highlight Changes* MS Word tools, annotate in redline **any and all** demurrals or deviations to the requirements of the RFP. You may also enter any substantive comments on the RFP provisions, but please restrict such to issues that are necessary to clearly understand your proposal. Information required in the tabs below need **NOT** be repeated in this tab. Also, affirmations or confirmations of compliance to RFP requirements are unnecessary in this tab and are **NOT** to be included.

#### 6.2 Legally Correct Description of Benefits (Tab 2)

For the HDHP statewide employees program, submit the HDHP benefits summary contained in Attachment 1, noting any changes by using the *Track Changes* and *Highlight Changes*

MS Word tools. The Contractor should indicate any demurrals in relation to benefits they can not match.

### 6.3 Benefits Brochure (Tab 3)

The offeror shall submit a model brochure containing supplemental information for employees to help them understand how the plan works.

6.3.1 The brochure shall consist of the information required by the monthly service report (see paragraph 4.1), and all of the following available or applicable to the type plan offered.

6.3.1(a) the plan's NCQA certification status,

6.3.1(b) selected HEDIS (or Department approved substitute) information on

- plan membership
- effectiveness of care
- Provider availability
- physician turnover
- disenrollment
- rate trends

6.3.1(c) highlights from the HEDIS (or Department approved substitute) Member Satisfaction Survey, including

- overall satisfaction
- overall quality of care and services
- access
- recommendation to family and friends

6.3.1(d) a brief summary of the report, which describes the plan's adherence to the access standards, found in paragraph 2.3.

6.3.1(e) a brief discussion of the criteria used to admit institutional and professional providers into the network and the bases on which the plan pays the providers.

6.3.1(f) optionally, the plan may include practice guidelines covering those outpatient procedures representing about one-half of outpatient

professional costs.

6.3.1(g) a brief discussion of the rate of usage of decision support tools and indicators of the effectiveness of the tools.

#### 6.4 Technical Questionnaire (Tab 4)

Attachment 2 contains the Technical Questionnaire, which constitutes the technical proposal. It must be completed in accordance with the instructions contained in the Questionnaire. In addition to the hard copy contained in this tab, the electronic file must be provided with your response as requested in the Questionnaire.

#### 6.5 Cost Proposal (Tab 5)

Attachment 2 contains the Cost Exhibits which, along with the offeror's latest certified audit report, constitute the cost proposal. Include in this tab, a copy of the audited report for the most recently completed fiscal year and a hard copy of the schedules. Also, the schedules must be submitted in Excel as directed in Attachment 2 instructions.

The attachment also contains schedules that provide the following cost proposal detail:

6.5.1 A detailed budget for start up costs, if any, for the period from the date of award through June 30, 2006. (The proposed budget, if accepted, will be treated as a firm, fixed price for the period in question. The contractor may bill the Department only after the completion of discrete, budgeted tasks, and will be reimbursed upon a finding by the Department that the work has been satisfactorily completed.)

6.5.2 A firm, fixed price per contract month for the first contract year.

6.5.3 A firm, fixed price per contract month for the second contract year. This price may not be indexed to the price of the first contract year.

6.5.4 A guaranteed interest rate for funds in the operating account or an index which will constitute a minimum guarantee.

6.5.5 A cost summary page.

#### 6.6 Participation of Small, Women, and Minority Owned Businesses (Tab 6)

Complete the information required on Exhibit TWO.

#### 6.7 Evaluation Criteria

Proposals will be evaluated on six criteria:

Offeror's organization and financial stability; and, HDHP and HSA expertise (10)  
Qualifications of staff (10)  
Network service and quality (20)  
Administrative and decision support tool capabilities (25)

Benefit cost management and administrative cost (30)  
Small, women owned and minority owned businesses (5).

## 7.0 GENERAL TERMS AND CONDITIONS

### 7.1 VENDOR'S MANUAL

This solicitation is subject to the provisions of the Commonwealth of Virginia Vendor's Manual and any revisions thereto, which are hereby incorporated into this contract in their entirety. A copy of the manual is normally available for review at the Department's office on the 13th floor of the James Monroe Building. In addition, a copy can be obtained from the Department of General Services' Division of Purchases and Supply by calling (804) 786-3842.

### 7.2 APPLICABLE LAWS AND COURTS

This solicitation and any resulting contract shall be governed in all respects by the laws of the Commonwealth of Virginia, and any litigation with respect thereto shall be brought in the courts of the Commonwealth. The Contractor shall comply with all applicable federal, state, and local laws, rules, and regulations.

### 7.3 ANTI-DISCRIMINATION

By submitting their proposals, Offerors certify to the Commonwealth that they will conform to the provisions of the Federal Civil Rights Act of 1964, as amended, as well as the Virginia Fair Employment Contracting Act of 1975, as amended, where applicable, the Virginians with Disabilities Act, the Americans with Disabilities Act, and Section 2.2-4311 of the Virginia Public Procurement Act.

In every contract over \$10,000 the provisions in 1 and 2 below apply:

1. During the performance of this contract, the Contractor agrees as follows:
  - a. The Contractor will not discriminate against any employee or applicant for employment because of race, religion, color, sex or national origin, or disabilities, except where religion, sex or national origin is a bona fide occupational qualification reasonably necessary to the normal operation of the Contractor. The Contractor agrees to post in conspicuous places, available to employees and applicants for employment, notices setting forth the provisions of this nondiscrimination clause.
  - b. The Contractor, in all solicitations or advertisements for employees placed by or on behalf of the Contractor, will state that such Contractor is an equal opportunity employer.
  - c. Notices, advertisements, and solicitations placed in accordance with federal law, rule, or regulation shall be deemed sufficient for the

purpose of meeting these requirements.

2. The Contractor will include the provisions of 1 above in every subcontract or purchase order over \$10,000, so that the provisions will be binding upon each sub contractor or vendor.

#### 7.4 ETHICS IN PUBLIC CONTRACTING

By submitting their proposals, Offerors certify (1) that their proposals are made without collusion or fraud and that they have not offered or received any kickbacks or inducements from any other Offeror, supplier, manufacturer, or sub contractor in connection with their proposal, and (2) that they have not conferred on or promised, any public employee having official responsibility for this procurement transaction, any payment, loan, subscription, advance, deposit of money, services, or anything of more than nominal value, unless consideration of substantially equal or greater value was exchanged.

#### 7.5 IMMIGRATION REFORM AND CONTROL ACT OF 1986

By submitting their proposals, Offerors certify that they do not and will not, during the performance of this contract, employ illegal alien workers or otherwise violate the provisions of the federal Immigration Reform and Control Act of 1986.

#### 7.6 DEBARMENT STATUS

By submitting their proposals, Offerors certify that they are not currently debarred by the Commonwealth of Virginia from submitting proposals for the type of goods or services covered by this solicitation, nor are they an agent of any person or entity that is currently so debarred.

#### 7.7 ANTITRUST

By entering into a contract, the Contractor conveys, sells, assigns, and transfers to the Commonwealth of Virginia all rights, title, and interest in and to all causes of the action it may now have or hereafter acquire under the antitrust laws of the United States and the Commonwealth of Virginia, relating to the particular goods or services purchased or acquired by the Commonwealth of Virginia under said contract.

#### 7.8 MANDATORY USE OF STATE FORM AND TERMS AND CONDITIONS

Failure to submit a proposal on the official state form provided for that purpose may be a cause for rejection of the proposal. Modification of or additions to the General Terms and Conditions of the solicitation may be cause for rejection of the proposal; however, the Commonwealth reserves the right to decide, on a case by case basis, in its sole discretion, whether to reject such a proposal.

#### 7.9 CLARIFICATION OF TERMS

If any prospective Offeror has questions about the specifications or other solicitation documents, the prospective Offeror should contact William G. Gregory in writing no later than five working days before the due date. Any revisions to the solicitation will be made only by addendum issued by the Department.

## 7.10 PAYMENT

### 1. To Prime Contractor:

- a. Invoices for items ordered, delivered and accepted shall be submitted by the Contractor directly to the payments address shown on the purchase order/contract. All invoices shall show the state contract number and/or purchase order number; social security number (for individual Contractors) or the federal employer identification number (for proprietorships, partnerships, and corporations).
- b. Any payment terms requiring payments in less than 30 days will be regarded as requiring payment 30 days after invoice or delivery, whichever occurs last. This shall not affect offers of discounts for payment in less than 30 days, however.
- c. All goods or services provided under this contract or purchase order, that are to be paid for with public funds, shall be billed by the Contractor at the contract price, regardless of which public agency is being billed.
- d. The following shall be deemed to be the date of payment: the date of postmark in all cases where payment is made by mail, or the date of offset when offset proceedings have been instituted as authorized under the Virginia Debt Collection Act.

### 2. To Subcontractors:

- a. A Contractor awarded a contract under this solicitation is hereby obligated:
  - (1) To pay the subcontractor(s) within seven (7) days of the Contractor's receipt of payment from the Commonwealth for the proportionate share of the payment received for work performed by the subcontractor(s) under the contract; or
  - (2) To notify the agency and the subcontractor(s) in writing, of the Contractor's intention to withhold payment and the reason.
- b. The Contractor is obligated to pay the subcontractor(s) interest at the rate of one percent per month (unless otherwise provided under the terms of the contract) on all amounts owed by the Contractor that remain unpaid seven (7) day following receipt of payment from the Commonwealth, except for amounts withheld as stated in (2) above.

The date of mailing of any payment by U.S. Mail is deemed to be payment to the addressee. These provisions apply to each sub-tier Contractor performing under the primary contract. A Contractor's obligation to pay an interest charge to a subcontractor may not be construed to be an obligation of the Commonwealth.

#### 7.11 PRECEDENCE OF TERMS

Paragraphs 7.1 - 7.10 of these General Terms and Conditions shall apply in all instances. In the event there is a conflict between any of the other General Terms and Conditions and any Special Terms and Conditions in this solicitation, the Special Terms and Conditions shall apply.

#### 7.12 QUALIFICATIONS OF OFFERORS

The Commonwealth may make such reasonable investigations as deemed proper and necessary to determine the ability of the Offeror to perform the services and the Offeror shall furnish to the Commonwealth all such information and data for this purpose as may be requested. The Commonwealth reserves the right to inspect Offeror's physical facilities prior to award to satisfy questions regarding the Offeror's capabilities. The Commonwealth further reserves the right to reject any proposal if the evidence submitted by, or investigations of, such Offeror fails to satisfy the Commonwealth that such Offeror is properly qualified to carry out the obligations of the contract and to provide the services contemplated therein.

#### 7.13 TESTING AND INSPECTION

The Commonwealth reserves the right to conduct any test/inspection it may deem advisable to assure supplies and services conform to the specification.

#### 7.14 ASSIGNMENT OF CONTRACT

A contract shall not be assignable by the Contractor in whole or in part without the written consent of the Commonwealth.

#### 7.15 CHANGES TO THE CONTRACT

Changes can be made to the Contract in any one of the following ways:

1. The parties may agree in writing to modify the scope of the contract. An increase or decrease in the price of the contract resulting from such modification shall be agreed to by the parties as a part of their written agreement to modify the scope of the contract.
2. The Department may order changes within the general scope of the contract at any time by written notice to the Contractor. Changes within the scope of the contract include, but are not limited to such things as services to be performed, the method of packing or shipment and the place of

delivery or installation. The Contractor shall comply with the notice upon receipt. The Contractor shall be compensated for any additional costs incurred as the result of such order and shall give the Department a credit for any savings. Said compensation shall be determined by one of the following methods:

- a. By mutual agreement between the parties in writing; or
- b. By agreeing upon a unit price or using a unit price set forth in the contract, if the work to be done can be expressed in units, and the Contractor accounts for the number of units of work performed, subject to the Department's right to audit the Contractor's records and/or to determine the correct number of units independently; or
- c. By ordering the Contractor to proceed with the work and to keep a record of all costs incurred and savings realized. A markup for overhead and profit may be allowed if provided by the contract. The same markup shall be used for determining a decrease in price as the result of savings realized. The Contractor shall present the Department with all vouchers and records of expenses incurred and savings realized. The Department shall have the right to audit the records of the Contractor as it deems necessary to determine costs or savings. Any claim for an adjustment in price under this provision must be asserted by written notice to the Department within thirty (30) days from the date of receipt of the written order from the Department. If the parties fail to agree on an amount of adjustment, the question of an increase or decrease in the contract price or time for performance shall resolve in accordance with the procedures for resolving disputes provided by the Disputes Clause (paragraph 8.12) of this contract and in accordance with the disputes provisions of the Commonwealth of Virginia's Vendor's Manual. Neither the existence of claim or a dispute resolution process, litigation or any other provision of this contract shall excuse the Contractor from promptly complying with the changes ordered by the Department or with the performance of the contract generally.

#### 7.16 DEFAULT

In case of failure to deliver goods or services in accordance with the contract terms and conditions, the Commonwealth, after due oral or written notice, may procure them from other sources and hold the Contractor responsible for any resulting additional purchase and administrative costs. This remedy shall be in addition to any other remedies which the Commonwealth may have.

#### 7.17 INSURANCE

By signing and submitting a bid or proposal under this solicitation, the bidder or offeror certifies that if awarded the contract, it will have the following insurance coverages at the time the contract is awarded. The bidder or offeror further

certifies that the contractor and any subcontractors will maintain these insurance coverages during the entire term of the contract and that all insurance coverages will be provided by insurance companies authorized to sell insurance in Virginia by the Virginia State Corporation Commission.

**INSURANCE COVERAGES AND LIMITS REQUIRED:**

1. Worker's Compensation - Statutory requirements and benefits.
2. Employee Liability - \$100,000
3. Commercial General Liability - \$500,000 combined single limit. Commercial General Liability is to include Premises/Operations Liability, Products and Completed Operations Coverage, and Independent Contractor's Liability or Owner's and Contractor's Protective Liability. The Commonwealth of Virginia must be named as an additional insured when requiring a Contractor to obtain Commercial General Liability coverage.

**7.18 ANNOUNCEMENT OF AWARD**

Upon the award or the announcement of the decision to award a contract as a result of this solicitation, the purchasing agency will publicly post such notice on the Agency's web site, [www.dhrm.virginia.gov.us/rfps/rfpmain.html](http://www.dhrm.virginia.gov.us/rfps/rfpmain.html) , for a minimum of 10 days.

**7.19 DRUG-FREE WORKPLACE**

During the performance of this contract, the contractor agrees to (i) provide a drug-free workplace for the contractor's employees; (ii) post in conspicuous places, available to employees and applicants for employment, a statement notifying employees that the unlawful manufacture, sale, distribution, dispensation, possession, or use of controlled substance or marijuana is prohibited in the contractor's workplace and specifying the actions that will be taken against employees for violations of such prohibition; (iii) state in all solicitations or advertisements for employees placed by or on behalf of the contractor that the contractor maintains a drug-free workplace; and (iv) include the provisions of the foregoing clauses in every subcontract or purchase order of over \$10,000, so that provisions will be binding upon each subcontractor or vendor.

For the purposes of this section, "drug-free workplace" means a site for the performance of work done in connection with a specific contract awarded to a contractor, the employees of whom are prohibited from engaging in the unlawful manufacture, sale, distribution, dispensation, possession or use of any controlled substance or marijuana during the performance of the contract.

**7.20 NONDISCRIMINATION OF CONTRACTORS**

A bidder, offeror, or contractor shall not be discriminated against in the solicitation or award of this contract because of race, religion, color, sex, national origin, age, or disability or against faith-based organizations. If the award of this contract is

made to a faith-based organization and an individual, who applies for or received goods, services, or disbursements provided pursuant to this contract objects to the religious character of the faith-based organization from which the individual receives or would receive the goods, services, or disbursements, the public body shall offer the individual, within a reasonable period of time after the date of his objection, access to equivalent goods, services, or disbursements from an alternative provider.

## 7.21 eVA BUSINESS-TO-GOVERNMENT VENDOR REGISTRATION

The eVA Internet electronic procurement solution, web site portal [www.eva.state.va.us](http://www.eva.state.va.us), streamlines and automates government purchasing activities in the Commonwealth. The portal is the gateway for vendors to conduct business with state agencies and public bodies.

All vendors desiring to provide goods and/or services to the Commonwealth shall participate in the eVA Internet e-procurement solution either through the eVA Basic Vendor Registration Service or eVA Premium Vendor Registration Service, and complete the Ariba Commerce Services Network registration.

- a. eVA Basic Vendor Registration Service: \$25 Annual Fee plus a Transaction Fee of 1% per order received. The maximum transaction fee is \$500 per order. eVA Basic Vendor Registration Service includes electronic order receipt, vendor catalog posting, on-line registration, and electronic bidding, as they become available.
- b. eVA Premium Vendor Registration Service: \$200 Annual Fee plus a Transaction Fee of 1% per order received. The maximum transaction fee is \$500 per order. eVA Premium Vendor Registration Service includes all benefits of the eVA Basic Vendor Registration Service plus automatic email or fax notification of solicitations and amendments, and ability to research historical procurement data, as they become available.
- c. Ariba Commerce Services Network Registration. The Ariba Commerce Services Network (ACSN) registration is required and provides the tool used to transmit information electronically between state agencies and vendors. There is no additional fee for this service.

**Note: Vendors are strongly encouraged to register your company prior to submitting a bid or offer. Failure to register will result in your bid or offer being found non-responsive and rejected. All vendors must register in both the eVA and the Ariba Commerce Services Network Vendor Registration Systems.**

## 8.0 SPECIAL TERMS AND CONDITIONS

### 8.1 COST LIMITS

The Contractor is responsible for all the costs of implementing and administering the program. The Department is responsible for ensuring that the Contractor receives payment of all fees that are established pursuant to the contract which results from this RFP. Any cost incurred by the Contractor to address the tasks and responsibilities identified in this RFP which exceeds the contractually established fees is the risk of the Contractor.

## 8.2 RENEWAL OF CONTRACT

The term of this contract is two years with three one-year renewal options. For the one-year renewal options, the contract may renew annually subject to the following.

- 8.2.1 The Contractor shall advise the Department in writing no later than 2:00 PM on the last business day before September 16 that the insurer is willing to renew the contract on the same terms and conditions as currently in force or as modified pursuant to a request from the Department. This advice shall be in the form of a proposal which meets the requirements of Section 6, except that the submission of tabs 1 and 2 are necessary only to the extent that there are changes from the original proposal. Selected tab 5 detail is required with each renewal.
- 8.2.2 All Contractors require a finding by the Department that the Contractor's performance has been satisfactory. Such findings are within the sole discretion of the Department but will be based on materially important issues such as the plan's accreditation status (if applicable), employee satisfaction, and the amount of liquidated damages due the Department because of failure of the Contractor to meet standards.
- 8.2.3 If the Commonwealth elects to exercise the option to renew the contract for an additional one-year period, the contract price for the additional one year shall not exceed the contract price of the original increased/decreased by more than the percentage increase/decrease of the services category of the CPI-W section of the Consumer Price Index of the United States Bureau of Labor Statistics for the latest twelve months for which statistics are available.
- 8.2.4 If during any subsequent renewal periods, the Commonwealth elects to exercise the option to renew the contract, the contract price for the subsequent renewal period shall not exceed the contract price of the previous renewal period increased/decreased by more than the percentage increased/decreased of the services category of the CPI-W section of the Consumer Price Index of the United States Bureau of labor Statistics for the latest twelve months for which statistics are available.

## 8.3 Termination, Suspension and Cancellation of Contract

Either party may terminate this contract for its sole convenience effective July 1 of any year by delivery of written notice at least nine months prior to the effective date of cancellation, that is, by the previous September 1. Some school groups in the

Local Choice program have plan years ending on September 30<sup>th</sup>. Therefore, it is agreed that for any Contractor having enrollment in one or more of these school groups, the termination of this contract as applied to the particular school group will be effective September 30 following the July 1 termination date of the contract.

If the Department determines, in its sole discretion, that limiting additional enrollment would enhance the administration of this contract, the Department may limit enrollment or suspend entirely new enrollments by a written order to the Contractor.

Furthermore, in the event of emergency requirements or significant changes in the Contractor's financial or organizational status which could not have reasonably been foreseen, the Department reserves the right to cancel and terminate this contract, in part or in whole without penalty, upon 60 days written notice to the Contractor.

Any contract cancellation notice shall not relieve the Contractor of the obligation to deliver and/or perform on all outstanding orders issued prior to the effective date of cancellation.

#### 8.4 Payments and Interest

8.4.1 State Employee Program - The Department will send or make available (through the internet) to the Contractor an electronic file of changes in eligible enrollees and eligible dependents in a form to be mutually agreed upon on a daily or other basis as may be mutually agreeable. Contractor agrees that BES shall be the only official source for any eligibility file maintained by the Contractor for any claims payment made by the Contractor, unless the Department agrees to changes in writing.

8.4.2 The Local Choice Program - Bills for premiums shall be submitted to each local employer which has one or more enrollees in the plan by the twentieth day of the month prior to the month for which coverage is billed. Contractor agrees to submit bills in a form acceptable to the Department. Employers will reconcile bills and attach thereto applications effecting changes in coverage. Contractor will receive reconciled bills, applications and payments. Payments shall be made generally by the tenth of the month for which coverage is billed. Contractor agrees to reconcile bills timely, and update membership files and issue membership cards promptly. The plan will pay claims or provide services only for persons whose premiums are paid when due.

Note: The Contractor will provide the ability for large (as determined by the Department) TLC groups to pay their monthly premiums utilizing wire transfers or other electronic transfers of funds.

8.4.3 The Contractor will bill the Department for claims payments on a weekly basis and for administrative costs on a monthly basis. The Department will pay, subject to verification, the Contractor for services rendered. The form of the bills and the schedule of payments shall be acceptable to both parties. The

plan will pay claims or provide services only for persons determined to be eligible by the Department.

8.4.4 The standard form of payment utilized by the Commonwealth is by EDI (See Appendix 10 for description). Unless a different method is agreed upon through negotiations, each Contractor must complete the EDI agreements required by the Department of Accounts.

8.4.5 Retroactive Adjustments

Where the Department discovers an error in enrollment for which the Contractor has no responsibility, Contractor agrees to correct such an error retroactively up to a period of twelve months from the date on which the error is discovered.

8.4.6 COBRA Eligibles and Direct Bill Participants

For all state employee groups, contractor agrees to track eligibility and bill Extended Coverage (COBRA) enrollees and certain participants designated by the Department. Contractor shall submit a listing of any status changes to these enrollees during each month to the Department by the 15<sup>th</sup> of the following month reflecting changes by date and identified by social security number.

The above paragraph does not apply to Local Choice enrollees. Each TLC member groups is responsible for administering COBRA eligibility for their group and the collection of premiums for all of their enrollees, including COBRA and retirees.

8.4.7 Settlement and Payment of Liquidated Damages

There shall be an annual settlement between the Contractor and the Department on or before November 30<sup>th</sup>, unless both parties agree to an extension. The settlement agreement shall provide for the final settlement of contract expenses, including liquidated damages. It is mutually agreed that liquidated damages, if any, shall be determined by reference to claims incurred for the fiscal year in settlement and paid through the 30<sup>th</sup> of September following the close of that year. Amounts owed to either party shall be paid within 30 days of settlement. Late payments by either party are subject to interest at 1% per month on the unpaid balance, such that interest is due and payable on the 31<sup>st</sup> day following the date of settlement for the 30 days the balance would have remained unpaid. The settlement agreement shall specify the last business day on which timely payment may be made.

8.4.8 Interest

An ASO Contractor shall pay the Department interest on all funds held by the Contractor for the Department, including check float. The Department

will bargain in good faith with respect to the total structure of the financial arrangements such that the Contractor and the Department are both protected against the untimely payment of amounts due, including weekly claims reimbursements.

8.4.9 The Contractor shall deliver only those services actually ordered by the Department. The Department will accept and pay only for those services which have been fully rendered. The Contractor shall invoice the Department each month for services provided during the prior month. Payment will be made by the Department within 30 days of receipt of an approved invoice by the Commonwealth's EDI payment method. Refer to Attachment Three for EDI information.

## 8.5 Premiums

The Offerors shall propose premiums using the Premium Buildup form referenced in paragraphs 4.1. The Department retains the right to establish premiums for each ASO plan. In establishing such premiums, the Department will consider the Contractor's proposal, the costs of the Department in the administration of the employee health benefits program, and in the costs of activities which benefit the insureds of all plans, such as the annual enrollment and CommonHealth, the Department's work site health promotion program. All rate projections should include a surcharge of 2% to recognize these costs.

8.5.1 ASO plans shall propose premiums using the Premium Buildup form referenced in paragraph 4.1. The Department retains the right to establish premiums for each ASO plan. In establishing such premiums, the Department will consider the contractor's proposal, the age, gender, and, as may be feasible, the health risks of the enrolled population, the administrative costs of the Department, the relative efficiency of the plan's provider networks, the prices the plan pays for services, the plan's administrative costs, and such other factors as may be relevant.

### 8.5.2 Surcharges

All plans shall participate in the costs of the Department in the administration of the employee health benefits program, and in the costs of activities which benefit the insureds of all plans, such as the annual enrollment and CommonHealth, the Department's work site health promotion program. All rate projections should include a surcharge of 2% to recognize these costs.

## 8.6 AUDITS

Some standards of performance under this contract shall be measured by audits. Results of claims audits shall be extrapolated to the universe of claims being audited, and the Contractor's performance with respect to the universe of claims shall be deemed to be the same as the Contractor's performance on the sample of

claims, provided that the audit sample was randomly drawn and statistically valid (+/-3% error rate at 95% confidence level).

The Contractor shall assist the Department and the Department's auditors, who may be employees of the Department, employees of other Contractors, or agents of the Department, in the conduct of audits. This assistance shall include the provision of secure, quiet office space, including furnishings and telephones needed by the auditors.

The Contractor agrees to retain all books, records, and other documents relative to the contract which results from this RFP for five (5) years after final payment, or until the conclusion of any audit by the Commonwealth, whichever is sooner. The Department, its authorized agents, and State Auditors, shall have full access to, and the right to examine, any of the Contractor's materials relevant to the contract which results from this RFP.

## 8.7 CONTRACT REPRESENTATIVES

Both the Department and the Contractor shall appoint a contract representative who shall ensure that the provisions of this contract are adhered to. The Department hereby appoints the State Procurement Specialist Senior. Currently the position is held by Mr. William G. Gregory. His E-mail Address is Bill.Gregory@dhrm.virginia.gov

The Contractor shall provide the full name and address of their contract representative including telephone and fax number. In the event of a change in contract representatives, an official written notice shall be provided within 15 days of the change.

## 8.8 CERTIFIED CORPORATE ANNUAL REPORTS

Within 120 days of the close of its fiscal year, the Contractor shall furnish to the Department an annual report of its consolidated operations. This report shall be certified by an independent auditor.

## 8.9 CONFIDENTIALITY OF INFORMATION

The Contractor shall treat all information utilized in its performance of the contract as confidential, personal information. The Contractor shall handle all confidential information in accordance with the Virginia Privacy Protection Act, Virginia Code Section 2.1-377 et seq.. All files, computer data bases and other records developed or maintained pursuant to the execution of the contract are the property of the Department, and shall be delivered to the Department upon demand. The Contractor merely serves as the custodian of the files, and acts as agent for the Department in the payment for services and the performance of other assigned tasks, including assisting the Department with requests under the Virginia Freedom of Information Act.

## 8.10 COMMISSIONS AND BROKERAGE FEES

The Contractor agrees that, in the performance of this contract, no payments shall be made to brokers or sales persons who are not employees of the Contractor.

#### 8.11 SEVERABILITY

In the event any portion of the contract shall be determined by a court of competent jurisdiction to be invalid or unenforceable, such provision shall be deemed void and the remainder of the contract shall continue in full force and effect.

#### 8.12 ELIGIBILITY

The Department shall determine who is eligible for the employee Health Benefits program.

#### 8.13 EMPLOYER CONTRIBUTIONS TOWARDS PREMIUMS

The Department shall set the employer contribution for all plans.

#### 8.14 FORCE MAJEURE

Neither party shall be deemed to be in default of any of its obligations hereunder, if, and so long as, it is prevented from performing such obligations by an act of war, hostile foreign action, nuclear explosion, earthquake, hurricane, tornado, or other catastrophic natural event or act of God.

#### 8.15 INTERNET SITE

Contractor agrees to maintain an Internet site with a section or page devoted to enrollees covered under the employee health benefits program or TLC. As a minimum, the site shall contain the following:

8.15.1 a link to the Contractor's current provider directory with a capability to locate providers by geographic locations and type of practice.

8.15.2 the data specified in paragraph 6.3.

8.15.3 an outline of coverage.

8.15.4 other information about the plan.

#### 8.16 SUBCONTRACTING

The Contractor is fully responsible for all work performed under the contract. The Contractor may not assign, transfer, or subcontract any interest in the contract, without prior written approval of the Department. The Contractor shall require all subcontractors to comply with all provisions of this RFP. The Contractor will be

held liable for contract compliance for all duties and functions whether performed by the Contractor or any subcontractor.

#### 8.17 DISPUTES

In accordance with section 2.2-4363 of the Code of Virginia, disputes arising out of the contract, whether for money or other relief, may be submitted by the Contractor for consideration by the Department. Disputes must be submitted in writing, with all necessary data and information, to the Director of the Department of Human Resource Management at the James Monroe Building, 12<sup>th</sup> Floor, 101 North 14<sup>th</sup> Street, Richmond, Virginia 23219. Disputes will not be considered if submitted later than sixty (60) days after the final payment is made by the Department under the contract. Further, no claim may be submitted unless written notice of the Contractor's intention to file the dispute has been submitted at the time of the occurrence or at the beginning of the work upon which the dispute is based. The Department shall render a final written decision regarding the dispute not more than ninety (90) days after the dispute is submitted, unless the parties agree to an extension of time. If the Department does not render its decision within 90 days, the Contractor's sole remedy will be to institute legal action, pursuant to section 2.2-436411-70 of the Code of Virginia. The Contractor shall not be granted relief as a result of any delay in the Department's decision.

During the time that the parties are attempting to resolve any dispute, each party shall proceed diligently to perform its duties.

#### 8.18 CONTRACTOR AFFILIATION

If an affiliate (as defined below in this paragraph) of the Contractor takes any action which, if taken by the Contractor, would constitute a breach of the contract, the action taken by the affiliate shall be deemed a breach by the Contractor. "Affiliate" shall mean a "parent," subsidiary or other company controlling, controlled by, or in common control with the Contractor, sub Contractor or agents of the Contractor.

#### 8.19 TRANSFER OF FILES

If for any reason the Department decides to no longer contract with the Contractor, the Contractor agrees to transfer to the party designated by the Department, at no cost, all data, records, computer files, other files, and materials of any sort that were maintained for the Commonwealth. The Contractor agrees to assist the Department in understanding, using, and transferring all files and records, including those maintained in computer language.

#### 8.20 ADVERTISING

In the event a contract is awarded as a result of this RFP, the Contractor shall not advertise that the Commonwealth of Virginia, or any agency or institution of the Commonwealth, has purchased, or uses its products or services.

#### 8.21 INDEMNIFICATION

The Contractor agrees to indemnify, defend, and hold harmless the Commonwealth of Virginia, its officers, agents, and employees from any claims, damages, and actions of any kind or nature, whether at law or in equity, arising from or caused by the use of any services of any kind or nature furnished by the Contractor, provided that such liability is not attributable to the sole negligence of the Department.

## 8.22 ANNUAL ENROLLMENT

The Department will provide employees an annual opportunity to change health benefits plans or types of membership. Contractor agrees to follow all instructions of the Department with respect to the conduct of the annual enrollment, including and especially the form and content of information supplied to eligible persons. The Contractor agrees to supply to agencies and TLC employers sufficient quantities of benefits booklets and brochures for the orderly conduct of annual enrollment activities. Annual enrollment expenses are the responsibility of the Contractor and are to be absorbed in its administrative costs. There will be no special recognition of annual enrollment expenses without the prior agreement of the Department.

Enrollment and changes in the state employee group is currently accomplished online by the state employees through the Department's Web based enrollment and change system which is referred to as Employee Direct or E-Direct. Changes through E-Direct are updated live time to the Department's Benefits Eligibility System (BES) which serves as the sole source of all enrollment information to Contractors, except for those enrollees (COBRA and retirees whose premiums cannot be deducted from annuities). See Appendix 8 for more detail. Agency benefit administrators may key changes directly to BES, however the spring 2005 enrollment reflected over a 50% usage of E-Direct by employees making changes. The Department is contemplating changes to this system with respect to input forms, but no changes are contemplated which will impact the manner in which Contractors receive enrollment information or the general format of the record Contractors will receive. The Department creates alternate identification numbers through its Benefit Eligibility System. Any vendor awarded this contract must be able to accept such alternative identification number, and use it on all written correspondence identifying the member, including the member's I.D. card. Furthermore, the vender must be able to track all members using the member's Social Security number.

The local employers currently conduct enrollment in the Local Choice program each May prior to the new fiscal year (July 1). The plans offered by each employer are group specific to that employer with the completed forms returned to the medical/surgical carriers by early June to allow for delivery of ID cards by the July 1 effective date. The TLC procedures are discussed in greater detail in Appendix 9.

## 8.23 HIPAA PRIVACY BUSINESS ASSOCIATES AGREEMENT

The Contractor agrees to be bound by the HIPAA Privacy Business Associates Agreement. This agreement must be executed prior to any contract award. See Exhibit ONE.

## 8.24 CHANGES IN PARTICIPATING PROVIDERS

The Plan shall require, among other things, that the provider will abide by the provisions of the agreement with the Plan for a full contract year with respect to State and TLC employees, except for such changes as retirement, abandonment of practice, etc. As an alternative, the Plan may represent that enrollees through any provider participating on July 1 of any contract year for a period of 12 months, regardless of any subsequent change in the participating status of the provider during that time. This provision does not apply to staff/group type HMOs. Note well that the end of the contract year for many, but not most, TLC groups is September 30, not June 30.

## 8.25 MAILINGS AND NOTICES

Contractor agrees to notify retirees and extended coverage enrollees annually in a form acceptable to the Department of changes in premiums and benefits or other contract amendments in a form acceptable to the Department. All notices shall be mailed first class. Contractor agrees to supply group administrators with all necessary forms and supplies.

Contractor will strictly limit the content and form of mailings and notices, other than premium bills and claims related transactions, to the benefits booklet and brochure cited in paragraphs 6.2 and 6.3 and an approved cover letter. Benefits booklets and brochures shall be printed in black ink on plain white paper, grade number 3, 50 pound offset, without any illustrations except graphs to illustrate HEDIS data. Under no circumstances will any communication of the contractor, written or verbal, compare its cost, benefits, or performance with that of another plan in the employee health benefits program. The logo of the Department and the title of the document shall be the most prominent features on the first page of each document.

Office of State Health Benefits Programs  
of the  
Department of Human Resource  
Management

H I P A A Privacy/Security  
Business Associate  
Agreement  
With  
(Insert Company Name)

Effective Date:  
(Insert Date)

## 1. PREAMBLE

**Pursuant** to the Health Insurance Portability and Accountability Act ("HIPAA") of 1996, and its implementing regulation, the Standards for Privacy of Individually Identifiable Health Information, 65 Fed. Reg. Section 84,462 et seq. (Dec. 28, 2000) and all subsequent provisions and Federal guidance ("HIPAA Privacy Rule"), the Commonwealth of Virginia's Office of Health Benefits Programs ("Covered Entity"), and **(name of the Business Associate)**, a **(state)** corporation, ("Business Associate"), (jointly "the Parties"), wish to enter into this Business Associate Agreement ("Agreement") that addresses the requirements of the HIPAA Privacy Rule with respect to "business associates" as that term is defined in that Rule.

This Agreement is intended to ensure that the Business Associate will establish and implement appropriate safeguards (including certain administrative requirements) for "Protected Health Information" (as defined in the HIPAA Privacy Rule and copied below) that the Business Associate may create, receive, use, or disclose in connection with certain functions, activities, or services (collectively "Services") to be provided by Business Associate to Covered Entity. These Services are identified in a separate agreement between the Parties entitled **(RFP# OHBXX-XX)** and dated **(Insert date)** ("Service Agreement").

The Parties acknowledge and agree that in providing Services, Business Associate will create, receive, use, or disclose Protected Health Information. In connection with Business Associate's creation, receipt, use, or disclosure of Protected Health Information, Business Associate, and Covered Entity hereby agree as follows:

## II. DEFINITIONS

- (a) *General definitions.* All capitalized terms used but not otherwise defined in this Agreement shall have the same meaning as those terms in 45 CFR §§ 160.103 and 164.501.
- (b) *Specific definitions.*
- (i) *Individual.* "Individual" shall have the same meaning as the term "individual" in 45 CFR § 164.501 and shall include a person who qualifies as a personal representative in accordance with 45 CFR § 164.502(g).
  - (ii) *Privacy Rule.* "Privacy Rule" shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 CFR Part 160 and Part 164, Subparts A and E.
  - (iii) *Protected Health Information.* "Protected Health Information" ("PHI") shall mean individually identifiable health information maintained and transmitted in any form or medium, including, without limitation, all information (including demographic, medical, and financial information), data, documentation, and materials that is created or received by a health care provider, health plan, employer, or health care clearinghouse, and relates to: (A) the past, present, or future physical or mental health or condition of an individual; (B) the provision of health care to an individual; or (C) the past, present, or future payment for the provision of health care to an individual, and that identifies or could reasonably be used to identify an individual. Protected Health Information does not include health information that has been de-identified in accordance with the standards for de-identification provided for in the Privacy Rule.
  - (iv) *Designated Record Set.* "Designated Record Set" shall mean a group of records maintained by or for the Covered Entity that is:
    - (A) The enrollment, payment, claims adjudication, and case or medical management record systems maintained by or for a health plan; or
    - (B) Used, in whole and in part, by or for the Covered Entity to make decisions about individuals.

For purposes of this paragraph, the term record means any item, collection, or grouping of information that includes Protected Health Information and is maintained, collected, used, or disseminated by or for the Covered Entity.

(v) *Data Aggregation*. "Data Aggregation" shall mean, with respect to Protected Health Information created or received by the Business Associate in its capacity as the Business Associate of the Covered Entity, the combining of such Protected Health Information by the Business Associate with the Protected Health Information received by the Business Associate in its capacity as business associate of another entity to permit data analyses that relate to the health care operations of the respective entities.

(vi) *Required By Law*. "Required By Law" shall have the same meaning as the term "required by law" in 45 CFR § 164.501.

(vii) *Secretary*. "Secretary" shall mean the Secretary of the Department of Health and Human Services ("HHS") or his designee.

### **III. OBLIGATIONS AND ACTIVITIES OF BUSINESS ASSOCIATE**

- (a) Business Associate agrees to not use or further disclose Protected Health Information other than as permitted or required by the Agreement or as Required By Law.
- (b) Business Associate agrees to use appropriate safeguards to prevent use or disclosure of the Protected Health Information other than as provided for by this Agreement.
- (c) Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to the Business Associate of a use or disclosure of Protected Health Information by Business Associate in violation of the requirements of this Agreement.
- (d) Business Associate agrees to report to Covered Entity any use or disclosure of the Protected Health Information not provided for by this Agreement.
- (e) Business Associate agrees to ensure that any agent, including a subcontractor, to whom it provides Protected Health Information received from, or created or received by Business Associate on behalf of, Covered Entity agrees to the same restrictions and conditions that apply through this Agreement to Business Associate with respect to such information.
- (f) Business Associate agrees to provide access, at the request of Covered Entity, and in the time and manner designated by Covered Entity, to Protected Health Information in a Designated Record Set, to Covered Entity or, as directed by Covered Entity, to an Individual in order to meet the requirements under 45 CFR § 164.524.
- (g) Business Associate agrees to make any amendment(s) to Protected Health Information in a Designated Record Set that the Covered Entity directs or agrees to pursuant to 45 CFR § 164.526 at the request of Covered Entity or an Individual, and in the time and manner designated by Covered Entity.
- (h) Business Associate agrees to make internal practices, books, and records relating to the use and disclosure of Protected Health Information received from, or created or received by Business Associate on behalf of, Covered Entity available to the Covered Entity, or at the request of the Covered Entity to the Secretary, in a time and manner designated by the Covered Entity or the Secretary, for purposes of the Secretary determining Covered Entity's compliance with the Privacy Rule.
- (i) Business Associate agrees to document such disclosures of Protected Health Information and information related to such disclosures as would be required for Covered Entity to respond to a request by an Individual for an accounting of disclosures of Protected Health Information in accordance with 45 CFR § 164.528.

- (j) Business Associate agrees to provide to Covered Entity or an Individual, in the time and manner designated by Covered Entity, information collected in accordance with Section III (i) of this Agreement, to permit Covered Entity to respond to a request by an individual for an accounting of disclosures of Protected Health Information in accordance with 45 CFR § 164.528.
- (k) Business Associate agrees to: (i) implement the administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic Protected Health Information that it creates, receives, maintains, or transmits on Covered Entity's behalf; (ii) Ensure that any agent, including a subcontractor, to whom it provides such information agrees to implement reasonable and appropriate standards to protect the information; and (iii) agrees to report to Covered Entity any security incident of which it becomes aware that involves the information. Business Associate agrees that that the obligations set forth in Section III (k) shall be implemented by the final compliance date for the Security Standards to the extent required by law.

#### **IV. PERMITTED USES AND DISCLOSURES BY BUSINESS ASSOCIATE**

- (a) *General Uses and Disclosures.* Business Associate agrees to create, receive, use, or disclose Protected Health Information only in a manner that is consistent with this Agreement or the Privacy Rule and only in connection with providing Services to the Covered Entity identified in the Service Agreement, provided that such use or disclosure would not violate the Privacy Rule if done by Covered Entity. In providing Services, Business Associate, for example, will be permitted to use and disclose Protected Health Information for "treatment, payment and health care operations" in accordance with the Privacy Rule.
- (b) *Other Uses and Disclosures:*
  - (i) Except as otherwise limited in this Agreement, Business Associate may use Protected Health Information for the proper management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate.
  - (ii) Except as otherwise limited in this Agreement, Business Associate may disclose Protected Health Information for the proper management and administration of the Business Associate, provided the disclosures are Required By Law or the Business Associate obtains reasonable assurances from the person to whom the information is disclosed that it will remain confidential and used or further disclosed only as required by law or for the purpose for which it was disclosed to the person, and the person notifies the Business Associate of any instances of which it is aware in which the confidentiality of the information has been breached.
  - (iii) Except as otherwise limited in this Agreement, Business Associate may use Protected Health Information to provide Data Aggregation services to Covered Entity as permitted by 42 CFR § 164.504(e)(2)(i)(B).

#### **V. OBLIGATIONS OF THE COVERED ENTITY**

- (a) *Provisions for Covered Entity to Inform Business Associate of Privacy Practices and Restrictions:*
  - (i) Covered Entity shall provide Business Associate with the notice of privacy practices that Covered Entity produces in accordance with 45 CFR § 164.520, as well as any changes to such notice.
  - (ii) Covered Entity shall provide Business Associate with any changes in, or revocation of, permission by Individual to use or disclose Protected Health Information, if such changes affect Business Associate's permitted or required uses and disclosures.

(iii) Covered Entity shall notify Business Associate of any restriction to the use or disclosure of Protected Health Information that Covered Entity has agreed to in accordance with 45 CFR § 164.522.

(b) *Permissible Requests by Covered Entity.* Covered Entity shall not request Business Associate to use or disclose Protected Health Information in any manner that would not be permissible under the Privacy Rule if done by Covered Entity, except Protected Health Information for those activities performed by the Business Associate in accordance with the provisions of the Service Agreement between the parties.

## VI. TERM AND TERMINATION

(a) *Term.* The Term of this Agreement shall be effective as of April 1, 2003, and shall terminate when all of the Protected Health Information provided by Covered Entity to Business Associate, or created or received by Business Associate on behalf of Covered Entity, is destroyed or returned to Covered Entity, or, if it is infeasible to return or destroy Protected Health Information, protections are extended to such information, in accordance with the Termination provisions in this Section.

(b) *Termination for Cause.* Upon Covered Entity's knowledge of a material breach by Business Associate, Covered Entity shall provide an opportunity for Business Associate to cure the breach or end the violation. If Business Associate does not cure the breach or end the violation within the time agreed to by the Parties, or if Business Associate has breached a material term of this Agreement and cure is not possible, Covered Entity may terminate this Agreement [and the applicable Sections of the Service Agreement] upon written notice to Business Associate.

(c) *Effect of Termination:*

(i) Except as provided in paragraph (c)(ii) of this Section IV, upon Termination of this Agreement for any reason, Business Associate shall return or destroy all Protected Health Information received from Covered Entity, or created or received by Business Associate on behalf of Covered Entity. This provision shall apply to Protected Health Information that is in the possession of subcontractors or agents of Business Associate. Business Associate shall retain no copies of the Protected Health Information.

(ii) In the event that Business Associate determines that returning or destroying the Protected Health Information is infeasible, Business Associate shall provide to Covered Entity notification of the conditions that make return or destruction infeasible. Upon mutual agreement of the Parties that return or destruction of Protected Health Information is infeasible, Business Associate shall extend the protections of this Agreement to such Protected Health Information and limit further uses and disclosures of such Protected Health Information to those purposes that make the return or destruction infeasible, for as long as the Business Associate maintains such Protected Health Information.

## VII. MISCELLANEOUS

(a) *Regulatory References.* A reference in this Agreement to a section in the Privacy Rule means the section as in effect or as amended and for which compliance is required.

(b) *Amendment.* The Parties agree to take such action as is necessary to amend this Agreement from time to time as is necessary for Covered Entity to comply with the requirements of the Privacy Rule and the Health Insurance Portability and Accountability Act, Public Law 104-191.

(c) *Survival.* The respective rights and obligations of Business Associate under Section VI(c)(i)&(ii) of this Agreement shall survive the termination of this Agreement.

(d) *Interpretation:*

(i) Any ambiguity in this Agreement shall be resolved in favor of a meaning that permits Covered Entity to comply with the Privacy Rule.

- (ii) In the event of an inconsistency between the provisions of this Agreement and the Privacy Rule, as may be amended from time to time, as a result of interpretations by HHS, a court, or another regulatory agency with authority over the Parties, the interpretation of HHS, such other court or regulatory agency shall prevail.
- (iii) In the event provisions of this Agreement differ from those mandated by the Privacy Rule but are nonetheless permitted by the Rule, the provisions of this Agreement shall control.
- (e) *Complete Integration.* This Agreement constitutes the entire agreement between the parties and supersedes all prior negotiations, discussions, representations, or proposals, whether oral or written, unless expressly incorporated herein, related to the subject matter of the Agreement. Unless expressly provided otherwise herein, this Agreement may not be modified unless in writing signed by the duly authorized representatives of both parties. If any provision or part thereof is found to be invalid, the remaining provisions shall remain in full force and effect.
- (f) *Successors and Assigns.* This Agreement will inure to the benefit of and be binding upon the successors and assigns of Covered Entity and Business Associate. However, this Agreement is not assignable by either party without the prior written consent of the other party, except that Business Associate may assign or transfer this Agreement to any entity owned or under common control with Business Associate.
- (g) *Limitation of Liability.* Except as otherwise provided for in the Privacy Rule, neither party shall be liable for other party's loss of profits, attorney's fees or interest, or for any incidental, indirect, special, or consequential damages as a result of this Agreement.
- (h) *No Third Party Beneficiaries.* Except as expressly provided for in the Privacy Rule, there are no third party beneficiaries to this Agreement. Business Associate's obligations are to Covered Entity only.
- (i) *Confidentiality.* Except as otherwise provided for in the Privacy Rule or this Agreement, neither party will disclose the terms of this Agreement to any third party without the other party's written consent.
- (j) *Counterparts.* This Agreement may be executed in two or more counterparts, each of which may be deemed an original.

**VIII. ACKNOWLEDGEMENT AND SIGNATURES**

THE PARTIES ACKNOWLEDGE THAT THEY HAVE READ THIS AGREEMENT,  
UNDERSTAND IT, AND AGREE TO BE BOUND BY ITS TERMS.

For : For Department of Human Resource  
Management

By: By:  
Print Name: Print Name: Sara Redding Wilson

Title: Title: Director

Date: Date:

**PARTICIPATION IN STATE PROCUREMENT TRANSACTIONS**

**BY**

**SMALL BUSINESSES AND BUSINESSES OWNED BY WOMEN AND MINORITIES**

The following definitions will be used in completing the information required by one or more of the three categories of businesses contained in this Appendix as applicable to your firm: (1) Participation by Small Businesses; (2) Participation by Businesses Owned by Women; and (3) Participation by Businesses Owned by Minorities.

**DEFINITIONS**

**Period** is the specified 12-month period for which the information provided in this list is applicable and valid. The period will be specified as month and year.

**Firm Name, Address and Phone Number** is the name, address and business phone number of the small business, women-owned business or minority-owned business with which the offeror has contracted or done business over the specified period or plans to involve on this contract, as applicable.

**Contact Person** is the name of the individual in the specified small business, women owned business or minority-owned business who would have knowledge of the specified contracting and would be able to validate the information provided in this list.

**Type Goods or Services** is the specific goods or services the offeror has contracted for from the specified small, women-owned or minority-owned business over the specified period of time or plans to use in the performance of this contract, as applicable. The offeror will asterisk (\*) those goods and services that are in the offeror's primary business or industry.

**Dollar Amount** is the total dollar amount (in thousands of dollars) the offeror has contracted for or has done business with the listed firm during the specified period or plans to use on this contract, as applicable.

**% Total Company Expenditures for Goods and Services** is calculated by dividing the dollar amount of business conducted or contracted for with the indicated firm over the specified period by the total expenditure of the offeror over the specified period for goods and services.

**% of Total Contract** is calculated by dividing the estimated dollars planned for the indicated firm on this contract by the total offeror estimated price of this contract.











**3. PARTICIPATION BY BUSINESSES OWNED BY MINORITIES**

(Continued)

C. Describe offeror's plans to involve minority businesses in the performance of this contract either as part of a joint venture, as a partnership, as subcontractors or as suppliers. Offerors are encouraged to provide additional information and expand upon the following format:

<b>FIRM NAME, ADDRESS &amp; PHONE NUMBER</b>	<b>CONTACT PERSON</b>	<b>TYPE GOODS/ SERVICES</b>	<b>DOLLAR AMOUNTS</b>	<b>% OF TOTAL CONTACT</b>

**APPENDIX 1**

**DEPARTMENT OF HUMAN RESOURCE MANAGEMENT**

**STANDARD CONTRACT**

This contract is entered into this \_\_\_\_\_, 2005, by \_\_\_\_\_, hereinafter called "Contractor" and the Commonwealth of Virginia, Department of Human Resource Management, hereinafter called "Purchasing Agency".

WITNESSETH that the Contractor and the Purchasing Agency, in consideration of the mutual covenants, promises and agreements herein contained, agree as follows:

**SCOPE OF SERVICES:** The Contractor shall provide the services to the Purchasing Agency as set forth in the Contract Documents.

**PERIOD OF CONTRACT:**

**COMPENSATION AND METHOD OF PAYMENT:** The Contractor shall be paid monthly according to the terms of its accepted proposal.

**CONTRACT DOCUMENTS:** The Contract Documents shall consist of this signed Contract; the Request for Proposals: proposal submitted by the Contractor dated \_\_\_\_\_, \_\_\_\_\_; the general conditions, special conditions, specifications, and other data contained in the Request for Proposals.

Any contractual claims shall be submitted in accordance with the contractual dispute procedures set forth in the Request for Proposals.

In witness whereof, the parties have caused this Contract to be duly executed intending to be bound thereby.

**CONTRACTOR:**

**PURCHASING AGENCY:**

By: \_\_\_\_\_

By: \_\_\_\_\_

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Print Name

Title: \_\_\_\_\_

Title: \_\_\_\_\_

Date: \_\_\_\_\_

Date: \_\_\_\_\_

Approved as to Form: \_\_\_\_\_

Office of the Attorney General

## APPENDIX 2

### Enrollment, Premium, Claim and Demographic Data

#### 8.11.1 COVA Care Enrollment effective 6/30/05

	Single	Dual	Family	Total
Active Employees	34,250	20,319	26,082	80,651
COBRA	374	60	45	479
Non-Medicare Retirees	6,580	2,125	348	9,053
Total	41,201	22,504	26,475	90,183

#### 9.11.1

#### 10.11.1 COVA Care Premium effective 7/1/05

	Employee Contribution	State Contribution	Total Premium*
COVA Care Basic (includes basic dental)			
• Single	\$36	\$340	\$376
• Dual	\$90	\$606	\$696
• Family	\$127	\$889	\$1,016
COVA Care plus Out-of-Network			
• Single	\$45	\$340	\$387
• Dual	\$102	\$606	\$718
• Family	\$143	\$889	\$1,050
COVA Care plus Expanded Dental			
• Single	\$47	\$340	\$387
• Dual	\$112	\$606	\$718
• Family	\$161	\$889	\$1,068
COVA Care plus Out-of-Network and Expanded Dental			
• Single	\$56	\$340	\$396
• Dual	\$124	\$606	\$730
• Family	\$177	\$889	\$1,066

\*Non-Medicare retirees pay total premium; COBRA participants pay total premium plus 2%

#### 11.11.1

#### 12.11.1 COVA Care Claims Paid July 2004 through June 2005

(claims shown are after network discounts)

Medical	\$ 421,463,110
Prescription Drug	\$ 118,169,414
Behavioral Health	\$ 8,036,339
Dental	<u>\$ 40,458,318</u>
 Total	 \$ 588,127,181

### Active Employees As of July 31, 2005

Age	Total	Female	Male	Age	Total	Female	Male
18	24	14	10	57	2665	1344	1321
19	86	52	34	58	2741	1394	1347
20	156	85	71	59	1834	910	924
21	266	157	109	60	1678	820	858
22	474	268	206	61	1547	719	828
23	745	430	315	62	1284	576	708
24	954	543	411	63	907	406	501
25	1053	610	443	64	777	346	431
26	1194	650	544	65	522	237	285
27	1200	653	547	66	385	143	242
28	1256	695	561	67	295	122	173
29	1302	686	616	68	240	83	157
30	1378	705	673	69	186	77	109
31	1449	761	688	70	121	49	72
32	1476	748	728	71	89	27	62
33	1752	898	854	72	61	18	43
34	1996	972	1024	73	58	17	41
35	1955	964	991	74	41	11	30
36	1985	1034	951	75	23	8	15
37	1965	1003	962	76	15	6	9
38	2024	1032	992	77	18	2	16
39	2179	1109	1070	78	12	4	8
40	2304	1232	1072	79	9	3	6
41	2511	1361	1150	80	9	5	4
42	2561	1396	1165	81	3	2	1
43	2592	1399	1193	82	3	1	2
44	2801	1568	1233	83	7	1	6
45	2849	1610	1239	84	3	2	1
46	2907	1587	1320	85	2	1	1
47	2931	1655	1276	86	2	1	1
48	3196	1791	1405	87	2	2	
49	3215	1769	1446				
50	3242	1818	1424	Totals	91548	48117	43431
51	3303	1787	1516				
52	3143	1705	1438				
53	3176	1691	1485				
54	2972	1556	1416				
55	2796	1475	1321				
56	2641	1311	1330				

**State Retirees As Of July 31, 2005**

Age	Total	Female	Male	Age	Total	Female	Male
30	6	4	2	71	1287	693	594
31	6	2	4	72	1284	690	594
32	8	4	4	73	1190	636	554
33	7	3	4	74	1136	661	475
34	15	10	5	75	1133	631	502
35	9	6	3	76	1027	561	466
36	16	11	5	77	1026	555	471
37	13	7	6	78	924	548	376
38	24	16	8	79	828	508	320
39	26	14	12	80	794	469	325
40	25	14	11	81	747	448	299
41	38	18	20	82	634	354	280
42	50	25	25	83	577	372	205
43	48	28	20	84	480	301	179
44	40	27	13	85	423	273	150
45	57	40	17	86	313	212	101
46	85	45	40	87	301	211	90
47	84	50	34	88	240	156	84
48	93	56	37	89	203	132	71
49	116	61	55	90	150	94	56
50	193	105	88	91	122	90	32
51	221	121	100	92	83	62	21
52	338	179	159	93	50	34	16
53	405	213	192	94	51	38	13
54	430	247	183	95	37	25	12
55	537	289	248	96	26	22	4
56	630	354	276	97	14	8	6
57	717	375	342	98	7	6	1
58	961	517	444	99	6	5	1
59	726	399	327	100	2	2	
60	806	411	395	101	3	3	
61	1029	548	481	102	3	2	1
62	1324	710	614	103	1	1	
63	1241	713	528	104	4	3	1
64	1319	740	579	105	3	2	1
65	1443	811	632				
66	1531	853	678	Totals	35634	20086	15548
67	1597	902	695				
68	1466	806	660				
69	1411	779	632				
70	1434	765	669				

### State Employee Membership and Billing System

#### A. Benefits Eligibility System

The Department maintains a central membership system that contains the records of all employees, retirees, other eligibles, and their dependents that have coverage under the state employee health benefits program. The system is a live time system known as the Benefits Eligibility System (BES). BES is used to receive enrollment changes, provide enrollment updates to all carriers, and is the official eligibility source for all programs, in addition to providing the self billing information used to transfer premiums to fully insured carriers on a monthly basis. All eligibles, including both the enrollee and their dependents, are required to carry an identification number that currently is their social security number. Eligibility updates, including the identification number, are made available to carriers electronically as frequently as daily

It is requested that carriers also carry the dependent identification on their claims files. Enrollment to the state program is largely done through the Office of Health Benefits (OHB)'s web based enrollment system that is called Employee Direct (E-Direct). Eligible persons may go to the E-Direct site to enroll, change membership types, change dependent information, or receive general information on the state's programs, along with other functions. E-Direct has a live time interface with BES and a change is updated while the caller is on line and a confirmation is provided. The state enrollee has the option of completing a manual enrollment/waiver form and giving it to their agency benefits administrator for keying directly to BES, but E-Direct is well accepted at this time and most employees use the web based system.

As stated above, eligibility updates will be made available to all contractors through a FTP process on a daily basis. It is expected that contractors maintain their eligibility files on a current basis to provide for accurate claims processing.

#### B. Billing for Self Funded Plans

The services billed under the self-funded plans fall into two categories. These are billing for claims payments and billing for administrative fees (Section 4.0) as records accumulated, and invoiced in total to the Department on a weekly basis. The OHB staff reviews the invoice and the Contractor is reimbursed through a electronic transfer of funds within 48 hours of the receipt of the billing documentation. The billing documentation will at a minimum consist of: a cover invoice which provides the net claim dollars to be paid broken between the state employee and the TLC program, and support documentation for each program that provides the claims dollars paid for each benefit category during the period covered by the invoice and year to date. This procedure will be finalized with each contractor as part of the negotiation process and the cycle may be varied based upon compelling reasons, such as claim volume and dollars.

15th of the following month. In this process, the OHB will review the invoice and authorize reimbursement through the EDI process. Again the billing documentation will consist a cover invoice providing the administrative dollars in total for each program with a summary for all programs, and documentation which supports the summary invoice. This support will at minimum consist of a breakdown by each program of billing units by price per unit, shown for the current period and year to date. The number of billing units for each employer under the TLC program will also be required. The monthly administrative invoice may also be used as the financial transfer document for miscellaneous non-claim items that are either due from or to the Department when supported by clear documentation. This procedure will also be finalized during final negotiations.

## Appendix 4

### ELECTRONIC DATA EXCHANGE (EDI)

All payments to Contractors will be made by EDI. The Financial Handbook and forms to be completed are found on Web location below.

<http://www.doa.state.va.us/procedures/GeneralAccounting/EDI/tradingpartnerguide.pdf>

## ATTACHMENT 1 - SUMMARY CHART OF BENEFITS - COVA CARE AND PROPOSED HDHP

COVA CARE HDHP PLAN DESIGN	COVA CARE BENEFITS				HDHP DIFFERENCES	COMMENTS
Calendar Year Deductible:	Individual \$200	Family \$400			\$1200 single; \$2400 family \$5000 single; \$10,000 family \$1,500,000	
Annual Out-of-Pocket Limits	\$1,500	\$3,000				
Lifetime Maximum ( <i>Other Covered Services</i> )	\$1,500,000					
Basic Benefits	Co-Payment	Deductible Applies?	In-network coinsurance	Comments:	HDHP DIFFERENCES	HDHP DIFFERENCES
<b>Accidental Dental Injuries</b>	\$0	Yes	20%		AFTER DEDUCTIBLE MEMBER PAYS 20% COINSURANCE UNTIL MAXIMUM OUT OF POCKET REACHED. No separate inpatient or outpatient facility copayments	
<b>Ambulance Travel</b>	\$0	Yes	20%	No Calendar Year Limit		
<b>Diagnostic test and x-rays</b>						
• Inpatient	\$0	No	0%			
• Outpatient, including Office	\$0	Yes	10%			
<b>Doctor's Visits</b>						
Inpatient						
• Primary Care Physician (PCP)	\$0	No	0%			
• Specialist	\$0	No	0%			
Outpatient /Office						
Primary Care Physician (PCP)	\$25	No	0%			
Specialist	\$35	No	0%			
<b>Home Health Care</b>	\$0	No	0%	90-visit Calendar Year Limit		
<b>Hospice Care Services</b>	\$0	No	0%			
<b>Hospital Services</b>						
Inpatient Facility	\$300 per stay	No	0%			
Outpatient Facility,incl.ER visits	\$100 per visit	No	0%	Waived if admitted		
<b>Mental Health or Substance Abuse Treatment</b>						
Inpatient Treatment						

Facility	\$300 per stay	No	0%		
Professional Provider Services	\$0	No	0%		
Partial Day Program	\$300 per stay	No	0%		
Outpatient Treatment					
Facility Services	\$100	No	0%		
Specialist	\$35	No	0%		
Employee Assistance Program	\$0	No	0%	Four visits per incident	define how EAP works; intent is to provide 4 free visits per incident
<b>Medical Equipment, appliances and supplies</b>	\$0	Yes	20%	Includes Diabetic Supplies	
<b>Nursing Services – Private Duty</b>	\$0	Yes	20%	Home Services only	
<b>Oral Surgery</b>	\$35	No	0%		
<b>Skilled Nursing Facility</b>					
Facility	\$0 per stay	No	0%	180 day per stay limit	
Professional Provider Services	\$0	No	0%		

Basic Benefits	Co-Payment	Deductible Applies?	In-network coinsurance	Comments:	HDHP DIFFERENCES	COMMENTS
Inpatient						
PCP/Specialist	\$0	No	0%			
Assistant Surgeon	\$0	No	0%	Medical Necessity Review		
Anesthesiologist	\$0	No	0%	Medical Necessity Review	AFTER DEDUCTIBLE MEMBER PAYS 20% COINSURANCE UNTIL MAXIMUM OUT OF POCKET REACHED	
Outpatient						
PCP	\$25	No	0%			
Specialist	\$35	No	0%			
Anesthesiologist	\$35	No	0%	Medical Necessity Review		

<b>Wellness Services</b>						Covers all wellness benefits allowed under Sec. 223
<b>Well child - Office Visits at specified intervals through age 6</b> (Includes all immunizations given at the time of the Office Visit)					Deductible does not apply. Same benefits as COVA Care. Coinsurance 20% where it applies	
• PCP	\$25	No	0%			For RFP, mirror COVA Care benefit
• Specialist	\$35	No	0%			Prior to implementation review to determine if need plan design changes to incent preventive care
Screening Tests	\$0	No	10%			
<b>Routine Wellness/Preventative care (Age 7 and older)</b>					Deductible does not apply. Same benefits as COVA Care. Coinsurance 20% where it applies	
Annual check-up						
• PCP	\$25	No	0%			For RFP, vendor define preventive vs. diagnostic for purposes of Sec. 223. Explain how handled for claim processing purposes
• Specialist	\$35	No	0%			
Immunizations	\$0	No	10%	Plan pays 90% coinsurance up to a \$200 CY maximum.		
Lab and x-ray services	\$0	No	10%			
Preventative Care						
Annual gynecological exam						
• PCP	\$25	No	0%			
• Specialist	\$35	No	0%			
Annual Pap test	\$0	No	10%			
Annual mammography screening, beginning at age 35	\$0	No	10%			
Annual Prostate exam (digital rectal exam), beginning at age 40						
• PCP	\$25	No	0%			
• Specialist	\$35	No	0%			
Annual Prostate specific antigen test, beginning at age 40	\$0	No	10%			

Colorectal cancer screening	\$0	No	10%				
<b>Prescription Drugs</b>							
Retail pharmacy (per 34 day supply)						Vendor must be able to adjudicate drug claims at point of service, applying appropriate deductible and coinsurance	
• First Tier	\$15	No	0%	Typically generic drugs	AFTER DEDUCTIBLE MEMBER PAYS 20% COINSURANCE UNTIL MAXIMUM OUT OF POCKET REACHED	Member should have access to PBM discounts for brand, generic and specialty drugs	
• Second Tier	\$20	No	0%	Lower cost brand-name drugs			
• Third Tier	\$35	No	0%	Higher cost brand-name drugs			
Mail Order (up to 90 day supply)							
• First Tier	\$30	No	0%	Typically generic drugs			
• Second Tier	\$40	No	0%	Lower cost brand-name drugs			
• Third Tier	\$70	No	0%	Higher cost brand-name drugs			
<b>Dental Services – The Basic Plan includes most services except prosthetic, complex restorative and orthodontic. Covered expenses are not subject to a deductible and limited to a \$1200 calendar year maximum</b>							
• Diagnostic/Preventative Services	\$0	No	0%			Does not apply to HDHP deductible. Coverage same as COVA Care.	RFP request pricing with and without dental benefits
• Primary Services	\$0	No	20%	\$1,200 annual maximum			Pricing for basic dental (diagn/preventative and primary) and expanded dental
<b>Out-of Network Option</b>	25% penalty applied to the eligible benefit.				No out of network coverage		
<b>Basic Benefits</b>	<b>Co-Payment</b>	<b>Deductible Applies?</b>	<b>In-network coinsurance</b>	<b>Comments:</b>	<b>HDHP DIFFERENCES</b>		
<b>Expanded Dental</b>	The annual Dental maximum increases from \$1200 to \$1500 with this option				Does not apply to		

• Prosthetic and Complex Restorative	\$0	No	50%		HDHP deductible. Coverage same as COVA Care.
• Orthodontic	\$0	No	50%	Lifetime maximum \$1200	
<b>Vision/Hearing/Expanded Dental</b>					not covered

August 31, 2005

## Attachment 3

### Report Formats

The general form and contents of each contractor submitted report are outlined below. It is not the intent of the Department to require special designed reports if the Contractor has a standard report format that will satisfy the Department's needs for oversight of the various programs. However, the Department reserves the right to require a special report design if the standard reports are not satisfactory, in the Department's opinion. Offeror shall submit a sample report with the final format and details to be determined during the negotiation process. The primary reports are addressed below, however the Offeror should submit a sample of any requested report, whether identified below or not.

#### 1. Weekly Claims Report

A. Cover Letter – Each report provides Cover Charges broken by the following categories: (a) State Employees, (b) State Medicare for Drug Only, (c) TLC Government, (d) TLC Schools, and (e) Total column. Each column will reflect any applicable discounts on a separate line and show net charges by category. This will serve as the Contractor's invoice and the total of the net charges will be the amount due the Contractor.

B. An Excel spread sheet for each category will provide a detail of covered charges broken by type of charge. Examples can be: Inpatient, Hospital, Vision, EAP, Mail order, etc. The spreadsheet shall provide a Plan Year-To-Date column followed by month-to-date column and a separate column or each week of the current month.

#### 2. Administrative Fee Report – Monthly Invoice

A. Cover Letter – Each report provides Monthly Administrative Fees broken by the following categories: (a) State Employees, (b) State Medicare for Drug Only, (c) TLC Government, (d) TLC Schools, and (e) Total column. Any pre-approved charges or credits will be shown under each category and added to or subtracted from the categories fees. This will serve as the Contractor's invoice and the total of the net charges will be the amount due the Contractor.

#### B. Support Documentation

- a. Enrollment summary – For each category in A, the enrollment by plan within that category will be provided along with the applicable fee singularly and in total for all units within the plan. A Y-T-D column shall also be provided for each enrollment line. The total for all units within a category shall be the amount invoiced in A above.

**NOTE: THE DEPARTMENT WILL AUDIT EACH MONTH'S REPORTED ENROLLMENT BY THE CONTRACTOR. A VARIANCE IN EXCESS OF 0.5% (1/2 OF A PERCENT) FROM THE ENROLLMENT SHOWN ON BES MAY RESULT IN A DELAY IN PAYMENT OF**

**THE INVOICE UNTIL THE DISCREPENCY IS RESOLVED. SEE LIQUIDATED DAMAGES SCHEDULE AS PERTAINS TO ELIGIBILITY FILES NOT PICKED UP TIMELY.**

- b. Pre Approved Charges or Credits – A schedule of any charges or credits will be included by category as provided in A above. Support documentation for such charges/credits must be provided.

**3. TLC Monthly Income Report**

This shows the premium income received from each local employer by plan and in total, with an indication of employer groups in default. The report is to be prepared in MS Excel format and E-mailed on the 8th day after the close of the month.

**4. Monthly Service Report**

This report shall be in Excel format and submitted electronically to the Department within 15 days of the end of each month. The report shall be contained one page, if possible, and address all Standards of Performance, Section 3.0, except for the annual premium projections due by September 15th. The first column on the spreadsheet shall identify the items being reported and have headings with specific detail line items. Examples of headings, if applicable, would be: network, participants, customer service call statistics, claims activities, cycle time, inventory, accuracy rates, COB savings, claims dollars paid (by plan and by enrollee), EAP services, and pharmacy scripts by tier. Additional columns should show standards, if applicable, YTD statistics, and most recent two quarters of activity broken by month.

**5. Monthly/Quarterly Utilization Management Report**

This report shall be in Excel format and submitted electronically to the Department within 15 days of the end of each month/quarter. The report shall be contained one page, if possible. The purpose of this report is to disclose the Contractor's assessment of its utilization management activities, including admission review, concurrent review and case management.

The first column on the spreadsheet shall identify the items being reported and have headings with specific detail line items. The additional columns should show the activity YTD, the current month, average of the past 3 months, and average of past 12 months.

In addition to the utilization report described above, the Contractor shall submit support reports that allow the Department to monitor utilization by the specific product covered. Examples of, but not limited to, such reports are:

- a. Medical and MISA - Large inpatient claims expected to exceed \$100,000 with amount paid to date and expected total
- b. Pharmacy – Top 10 drugs processed by quantity and doll

volume.

- c. EAP – Services requested and provided by type.
- d. Interventions provided – Type and quantity for disease and pharmacy management.

#### 6. Extended Coverage (COBRA) Transactions and Enrollment File

This report shall be in Excel format and submitted electronically to the Department within 10 days of the end of each month. The primary purposes of the report are (1) to report all changes (adds, change in membership, and terminations) to the previous month's Extended Coverage enrollment, and (2) to provide a file denoting the current Extended Coverage enrollment.

The file shall at a minimum contain the enrollee's name, identification number; type, reason, and date of change; and current status.