

## MEDICARE ADVANTAGE RFP—ANSWERS TO BIDDERS' QUESTIONS

**1. Q--**Given the State of CT's budget objectives, would the Comptroller's Office be willing to consider a program leveraging a POS platform that replicates the benefits and program attributes of the PPO platform. The POS plan would match the PPO in its flexibility to see a specialist without a referral and to use an out of network provider anywhere in the United States without a penalty. This platform would provide beneficiaries an identical care experience and has the potential to yield greater savings to the State of CT.

**A--Yes, we would consider a POS platform**

**2. Q--**Given the high number of CT based retirees, would the Comptroller's Office be willing to carve out the CT and NY/ Tri-State retirees to a carrier who is headquartered in the State of CT and has the highest market share of membership and the broadest MA network - including Yale – in the State?

**A--Even though we have a high number of CT-based retirees, it is our preference to deal with a carrier that can provide coverage for retirees throughout the US**

**3. Q--**Is the State Comptroller's Office RFP requirement for carriers having two Medicare Advantage Clients over 50k retirees, a firm, and non-negotiable criteria? Will you entertain bids from a carrier who can demonstrate their experience in handling very large Medicare Advantage clients, including significant municipalities, such as the City of New York as evidence of their successful experience with groups similar in size to the State of CT retirees?

**A--It is desired that carriers have experience with handling Medicare Advantage clients with at least 50,000 retirees. However we will consider responses from carriers that are able to demonstrate their ability to handle a population of this size.**

**4. Q--**How many carriers will be considered for this RFP?

**A--The State is willing to consider contracting with more than one MA carrier if it can be shown to be advantageous. However, our preference is for a single carrier solution if the decision is made to go to a Medicare Advantage plan.**

**5. Q--**The State Comptroller's office is explicit that the winning carrier must cover dependents as part of the RFP for the Medicare Advantage program. Given the fact that all MA members must be eligible for Medicare to gain access to the benefit, how does the State envision handling dependents that are non-Medicare eligible? Please confirm that this segment of the population is not part of this RFP offering?

**A--Dependents not eligible for Medicare would be offered coverage under one of the active employee plans. However, a process for implementing the enrollment of non-Medicare eligible dependents has not yet been developed; the State would appreciate hearing suggestions as to how this might be handled, especially in a PeopleSoft environment.**

**6. Q--**The RFP specifies that claims experience, demographic and actuarial factors including health care cost trends will be factored into subsequent annual premium rates. Will you also

## MEDICARE ADVANTAGE RFP—ANSWERS TO BIDDERS' QUESTIONS

consider CMS program changes that impact the product's pricing in subsequent annual rate negotiations?

**A-- The State is aware that these changes can impact pricing; it is up to each bidder to quantify that impact.**

**7. Q--**Our company has significant experience managing large Group Medicare cases, including several >50,000 members. Currently, we manage several cases >50,000 lives with Group Medicare Advantage only and we have a Public Sector Part D case with close to 50,000 members. With our Group Medicare Advantage cases, we integrate very closely with the employer's PBM and our clinical care management team integrates the Rx claims data to drive an integrated Medical/Rx care management approach. The result being that we have the experience to handle a case of your size which we believe is the primary purpose of your question. Your question is structured in a way which will result in just one bidder meeting the requirement of currently having two or more Group MA-PD cases. Is it your intent to specifically require a bidder to have two current Group MA-PD clients or are you willing to accept all bidders who have the demonstrated and referenced experience of handling Group MA cases with >50,000 members?

**A--We are willing to consider bids from carriers that have demonstrated experience handling Group MA cases with more than 50,000 members. We are not requiring that bidders have experience with two current Group MA-PD cases with >50,000 members**

**8. Q--**For the Health Enhancement Program identified in section 2.2, is there a particular format the requested detailed claim data will need to be forwarded to Conifer Health Solutions? If so, can you share the specifications of the format in which the data will be requested?

**A—See attached.**

**9. Q--** Will there be an opportunity to ask additional questions following the release of the Reference Documents, since they were not released prior to the bidder question due date?

**A--Yes, firms that have additional questions based on the Reference Documents should submit them by 2:30 p.m. Friday, February 17, 2017. Responses will be posted no later than Friday, February 24, 2017.**

**10. Q--**In order to duplicate and price premium for existing Part D EGWP formulary, please forward a copy of the filed Silverscript formulary in standard CMS format in Excel, .csv or .txt file.

**A--The Formulary and Performance Drug List were sent on 2/8/17 via Secure File Transfer to those Bidders that sent a signed NDA form.**

## MEDICARE ADVANTAGE RFP—ANSWERS TO BIDDERS' QUESTIONS

**11. Q--**In reference to 9.1 Proposed pricing offer- 3-year annual total premium guarantees: Is the intent of this provision for bidders to provide 3 year premium rates or are you open to bidders providing not to exceed rate caps in years two and three?

**A-- We are open to bidders providing not to exceed rate caps in years two and three.**

**12. Q--**For the Medicare eligible retirees, please confirm the current coordination of benefits methodology with Medicare that is used by the current carriers; COB (coordination of benefits, retiree comes out whole), MOB (maintenance of benefits, also called Carve-out and Non-duplication) or Government Exclusion (also called Medicare exclusion) basis:

- a. COB – Coordination of benefits/ retiree comes out whole - Calculates what the plan would have paid as sole provider and adds what Medicare pays. If the total is more than 100% of the bill, the plan pays only enough to total 100%. The retiree often pays no deductible or coinsurance.
- b. MOB - maintenance of benefits or also called Carve-out and Non-duplication - Calculates the plan's payment as if there were no Medicare coverage, applies the deductibles, coinsurance and other plan limits and pays the remaining amount minus what Medicare pays.
- c. Government Exclusion (also called Medicare exclusion) - Determines the total expenses covered under the plan, reduces them by Medicare benefits and then applies the deductibles, coinsurance and other plan limits.

**A--We use (b) the “maintenance of benefits” model above.**

**13. Q--**Will the employer contributions continue to be 100% of premiums going forward for all plans?

**A—There is no present plan to modify employer contributions.**

- a. Does the State of CT provide any contributions for members to enroll in the individual market? **A—No**
- b. Will contributions vary if the State of CT decides to offer multiple plans or multiple carriers? **A--It is unlikely that multiple plans will be offered or, if so, what impact that would have on contributions.**

**14. Q--**In reference to section 1 “OSC reserves the right to award any service in whole or in part” and 6a. full replacement vs. coexisting basis:

- a. Is the intent to award coverage to one Medicare Advantage carrier and potentially carve-out the Rx portion to another carrier? **A--If a single vendor is**

## MEDICARE ADVANTAGE RFP—ANSWERS TO BIDDERS' QUESTIONS

**not selected as the MA-PD carrier, it is anticipated that the selected MA carrier would work with our current PBM**

- b. Is it possible that Medicare Advantage Medical coverage will be awarded to multiple carriers and offered on a slice basis alongside one another? **A—If the decision is made to go to a MA plan we expect that a single carrier would be selected.**
- c. Is it possible that the current self-insured commercial medical will remain in place and offered alongside one or more Medicare Advantage medical plans? If so, will all current and future retirees be defaulted into the Medicare Advantage plan with the option to opt-out? **A—If the state elects to go to a MA plan for Medicare eligible retirees, we expect that all current and future retirees would be defaulted into the MA plan with an option to opt-out.**

**15. Q--**When did the State of CT move to a Self-Insured EGWP Rx plan? Who was the prior Rx carrier for Medicare eligible retirees prior to CVS Caremark?

**A--The State moved to an EGWP RX program in January 1, 2012. The EGWP RX carrier (SILVERSCRIPT) is a subsidiary of CVS Caremark, the state's PBM**

**16. Q--**Please confirm benefits requested in ICL, gap, and catastrophic phases.

- a. Are the copays for coverage in ICL for 30 day supply only? Please describe cost share for 30, 60, and 90 day supply in ICL for both retail and mail order.

**A--Please refer to page 6 of the Retirees Health Options Planner (Attachment A) in the RFP, which details copays for 30, 60 and 90-day supply for all retiree plans.**

- b. Part D coverage in gap and catastrophic phases are not described in the SPD. Please confirm.

**A-- There is full coverage for retirees in the gap and catastrophic phases of program. The member pays only applicable copay. Please refer to the Retirees Health Options Planner (Attachment A) in the RFP for additional detail.**

**17. Q--**The RFP states that members from the Connecticut Partnership Plan do not currently participate in the EGWP plan. Would the OSC like to offer the MAPD plan to partnership plan participants?

**A--Carriers are welcome to submit a plan for providing such coverage, but it is not a requirement.**

## MEDICARE ADVANTAGE RFP—ANSWERS TO BIDDERS' QUESTIONS

**18. Q--**The RFP states that the OSC provides coverage for one hearing aid every 24 months. Would the OSC consider a dollar cap and allow for two hearing aids every 24 months?

**A--**Benefits in the retiree plan are intended to mirror those provided to active employees. Benefits for active employees are collectively bargained, and inclusion of certain benefits, such as coverage of hearing aids, is subject to state insurance mandates. Bidders may submit information or proposals for variations in coverage of hearing aids; however, it is unlikely that such changes could be implemented without consent of bargaining parties.

**19. Q--**What role will Care Management Solutions play in managing those retirees enrolling in the MA-PD?

**A--**Care Management Solutions is the vendor that monitors compliance with HEP requirements, provides condition related counseling for those with chronic conditions, and through its subcontractor receives and warehouses claims data for all healthcare related vendors (dental, pharmacy, medical). The contract for such services will go out for bids in the third quarter of 2017. It is expected that Care Management Solutions (or a successor firm) would play a similar role in connection with HEP coordination for Medicare-eligible retirees. It is our desire that Medicare claims data for retirees would be provided to the States' data warehouse to support HEP.

**20. Q--**Please confirm that the current contribution amounts will remain the same for retirees under an MAPD arrangement. Does the OSC anticipate a change in the current contribution structure?

**A--**At this time no change is contemplated to the current contribution structure.

**21. Q--** The RFP states that the OSC is soliciting offers for a fully insured national passive PPO plan that mirrors the benefits outlined in the attached summary of benefits section.

**Q--**Please confirm that the OSC does not want to offer an HMO/POS plan to mirror the benefit of the POE and POEG plans. Please confirm that bidders should provide three passive PPO plan designs for retiree populations - Group 1, 2 and 3.

**A--**Confirmed, we do not want to replicate POE or POE-G plans.

**22. Q--**Will OSC eventually change the MA-PD renewal date to July 1st to match the active's renewal date?

**A--**That decision has not yet been made; bidders are invited to detail the advantages or disadvantages of changing the renewal date to July 1<sup>st</sup>.

**23. Q--**Regarding the final price proposal due date – If CMS delays the release of the final call letter will the final price proposal due date be adjusted accordingly?

## **MEDICARE ADVANTAGE RFP—ANSWERS TO BIDDERS' QUESTIONS**

**A--Yes, if issuance of the CMS final call letter is delayed we will adjust the due date for submission of the final price proposal.**

**24. Q--**Will bidders have an opportunity to pose questions about the data and additional forms received? If so, what would be the due date for any questions?

**A-- Yes, firms that have additional questions based on the Reference Documents should submit them by 2:30 p.m. Friday, February 17, 2017. Responses will be posted no later than Friday, February 24, 2017.**

**25. Q--**In regard to redacted copies of bidders' RFP responses on a CD or DVD, please clarify what OSC means by "an original and one copy."

**A- Provide 2 redacted copies of your bid.**

**26 Q--**Please provide further detail or examples to help clarify the following component of the question:

"All transition-of-care-related issues and non-confinement provisions must be expressly waived for the initial enrollment for covered retirees and covered dependents that have already satisfied the limitations under the existing plan...."

**A-- - This language is intended to ensure that no covered Medicare-eligible retirees or covered Medicare-eligible dependents of a retiree will lose coverage if OSC switches to an MA-PD program, regardless of care they are currently receiving, including but not limited to hospital confinements.**

**27. Q--**Please confirm who would receive MMRs and MORs.

**A-- The MMRs and MORs should be sent to OSC and its data warehouse vendor.**

**28. Q--**Please confirm the OSC's understanding that the out-of-network provider must be recognized and participating under the federal Medicare program.

**A--Confirmed**

**29. Q--**Can the OSC provide more detail with regard to expectations of on-site staff; i.e., number of individuals, full or part-time? Will the staff be working within the retirement division?

## **MEDICARE ADVANTAGE RFP—ANSWERS TO BIDDERS' QUESTIONS**

**A- We want bidders to indicate their willingness to provide on-site staff, if it is determined to be necessary. However, at this time we have not determined whether it would be required, or, if so, the number of individuals needed or their probable schedules. Should on-site staff be required, they would likely be located within the Healthcare Policy & Benefit Services Division.**

**30. Q--Please confirm the online system referenced in this question refers to the CMS online system bidders utilize to confirm eligibility with CMS versus an online employer access system.**

**A- In question 7.9.7, the online system refers to the Bidder's online system**

**31. Q--Please confirm the OSC's understanding that the COB files supplied by CMS will be the final COB data used, and in some cases, may not be consistent with the data supplied by the OSC.**

**A—We do not understand the question being asked. Please restate it and resubmit no later than 2:30 p.m., Friday, February 17, 2017.**

**32. Q--Is this question specific to medical or pharmacy prior authorizations?**

**A-The reference is unclear. Please restate your question and resubmit no later than 2:30 p.m. Friday, February 17, 2017.**

**33. Q--Is it the OSC's intent that bidders match the current list of drugs on the current formulary? Since CMS has not approved the 2018 formularies, please confirm the OSC's understanding that the formulary used will be based on the 2017 formulary filed and approved by CMS.**

**A- Yes, it is the OSC's intent that bidders match the current list of drugs on the current formulary and Performance Drug List. It is understood there may be limitations on the current formulary, as defined by CMS regulations.**

**34. Q--The RFP indicates that the Price Proposal Worksheet was attached. Will the Price Proposal Worksheet be provided with the additional documents and data files?**

**A- The Price Proposal Worksheet has been posted on the Comptroller's as a separate document, which you may access online, by clicking the link beneath the RFP itself.**

**35. Q--Will bidders have the ability to make revisions and add language to the standard contract? Due to the fact that this is a fully insured MAPD plan, additional language will be required within the contract.**

## MEDICARE ADVANTAGE RFP—ANSWERS TO BIDDERS' QUESTIONS

**A- Bidders may propose revisions or additional language. However, certain provisions of the standard contract are not open for negotiation.**

**36. Q--**Please confirm that OSC understands our firm will adhere to the CMS 30-month coordination period. Medicare-eligible retirees, their Medicare-eligible dependents, and qualifying Medicare-eligible primary ESRD beneficiaries will automatically be enrolled in the commercial plan.

**A-- We confirm that OSC understands firms will adhere to the CMS 30-month coordination period rules for ESRD beneficiaries.**

**37. Q--**RFP Section 2.1 – Hearing Aids: Group currently covers one set (1 set) Hearing Aids Every 24 months. Please provide details such as any member cost sharing, number of hearing aids, time period and allowance. E.g., is there a Plan maximum coverage amount, for one set (1 set) Hearing Aids every 24 months.

**A- Current hearing aid coverage is as follows: There is no co-pay and a member can obtain a set of hearing aids every 24 months.**

**38. Q--**RFP Section 8.1.4 - Acupuncture: Group currently covers Acupuncture. Please provide benefit details such as member cost sharing, visit limits, etc. Additionally, please disclose what other non-Medicare covered benefits are currently covered but not reflected in the RFP or in the Pre/Post Retiree Healthcare Planners along with details of cost sharing, visit limits, etc.

**A- Details of benefit coverage, cost shares and applicable visit limits, if any, are currently included in the planners provided with the RFP. The plan document, which details coverage for acupuncture may be viewed at**

**<http://www.osc.ct.gov/benefits/docs/MedicalPlanDoceff1012016updt9132016.pdf>**

**39. Q--**Pre 2011 Retiree Healthcare Planner and Post 2011 Retiree Healthcare Planner – Medical Plans: Group currently offers both the Pre 2011 and Post 2011 Medical benefits with very slight differences. Are there any day limitations, e.g., for SNF or Inpatient Mental Health/Substance Abuse or any visit limitations, e.g., for Outpatient Therapies, etc.?

**A- Please consult the Retiree Healthcare Planners and Medical Plan Document for specific guidance on visit limitations.**

**40. Q--**Pre 2011 Retiree Healthcare Planner and Post 2011 Retiree Healthcare Planner – Prescription Drugs:

- Are Specialty Drugs covered in all 3 Tiers? **A-- YES**
- Are Specialty Drugs available at all Network Retail and Mail Order providers? **A-- YES**



## MEDICARE ADVANTAGE RFP—ANSWERS TO BIDDERS' QUESTIONS

- What is the Day Supply for Retail? **A-- 30**
- Are covered drugs available in 90 Day Supply at Retail, and if so, what cost share applies? **A-- In addition to mail-order the state also has a Connecticut retail maintenance network of pharmacies at which a member can receive a 90-day supply.**
- What is the Day Supply for Mail Order? **A-- 90**
- Are Non-Maintenance Drugs covered at Mail Order with same cost sharing as Maintenance Drugs at Mail Order? **A-- No, Mail Order is 90-day supply only.**

**41. Q--**If necessary will bidders have opportunity to ask clarifying questions regarding the reference documents released post NDA submission (ex. Claims data)?

**A--** Yes, firms that have additional questions based on the Reference Documents should submit them by 2:30 p.m. Friday, February 17, 2017. Responses will be posted no later than Friday, February 24, 2017.

**42. Q—**With regard to 7.4.5 Are background checks based on the requirements set by OSC or by our firm

**A- -** They are set by OSC.

**43. Q—**With regard to 7.6.12 please confirm what types of legislative update does OSC require and the frequency of expected reports?

**A- The question seeks information about the carrier's practice of advising sponsors of legislative/regulatory changes that may affect administration or benefits of Medicare Advantage plans. To the extent such updates are provided, please indicate the frequency with which they occur.**

**44. Q—**With regard to 8.4.1. Split families – Please disclose how split families are managed today.

**A- There is a Medicare indicator on our eligibility files. Carriers use this data to split enrollment between Medicare and commercial coverage.**

**45. Q--**For both Pre-2011 and Post-2011 plans, please provide current medical and pharmacy equivalent rates broken out separately for Medicare retirees (total equivalent rate including state and retiree contribution)

Vendor	Plan Name	Date of Retirement	Calculation Code	Medical Premium	Pharmacy Premium	Total Premium
Anthem	Blue Cross Out of Area	After 7/1999	1 Person on Medicare	\$184.99	\$285.75	\$470.74

**MEDICARE ADVANTAGE RFP—ANSWERS TO BIDDERS' QUESTIONS**

<b>Vendor</b>	<b>Plan Name</b>	<b>Date of Retirement</b>	<b>Calculation Code</b>	<b>Medical Premium</b>	<b>Pharmacy Premium</b>	<b>Total Premium</b>
Anthem	Blue Cross Out of Area	After 7/1999	2 or More People on Medicare	\$369.98	\$571.50	\$941.48
Anthem	State Blue Cross Preferred	After 7/1999	1 Person on Medicare	\$183.55	\$285.75	\$469.30
Anthem	State Blue Cross Preferred	After 7/1999	2 or More People on Medicare	\$367.10	\$571.50	\$938.60
Anthem	State BlueCare POE	After 7/1999	1 Person on Medicare	\$184.52	\$285.75	\$470.27
Anthem	State BlueCare POE	After 7/1999	2 or More People on Medicare	\$369.04	\$571.50	\$940.54
Anthem	State BlueCare POE Plus Gatekeeper	After 7/1999	1 Person on Medicare	\$184.52	\$285.75	\$470.27
Anthem	State BlueCare POE Plus Gatekeeper	After 7/1999	2 or More People on Medicare	\$369.04	\$571.50	\$940.54
Anthem	State BlueCare POS	After 7/1999	1 Person on Medicare	\$183.55	\$285.75	\$469.30
Anthem	State BlueCare POS	After 7/1999	2 or More People on Medicare	\$367.10	\$571.50	\$938.60
Anthem	Blue Cross Out of Area	Prior to 7/1999	1 Person on Medicare	\$188.75	\$285.75	\$474.50
Anthem	Blue Cross Out of Area	Prior to 7/1999	2 or More People on Medicare	\$377.50	\$571.50	\$949.00
Anthem	State Blue Cross Preferred	Prior to 7/1999	1 Person on Medicare	\$188.75	\$285.75	\$474.50
Anthem	State Blue Cross Preferred	Prior to 7/1999	2 or More People on Medicare	\$377.50	\$571.50	\$949.00
Anthem	State BlueCare POE	Prior to 7/1999	1 Person on Medicare	\$187.82	\$285.75	\$473.57
Anthem	State BlueCare POE	Prior to 7/1999	2 or More People on Medicare	\$375.64	\$571.50	\$947.14

# **MEDICARE ADVANTAGE RFP—ANSWERS TO BIDDERS’ QUESTIONS**

Vendor	Plan Name	Date of Retirement	Calculation Code	Medical Premium	Pharmacy Premium	Total Premium
Anthem	State BlueCare POE Plus Gatekeeper	Prior to 7/1999	1 Person on Medicare	\$187.82	\$285.75	\$473.57
Anthem	State BlueCare POE Plus Gatekeeper	Prior to 7/1999	2 or More People on Medicare	\$375.64	\$571.50	\$947.14
Anthem	State BlueCare POS	Prior to 7/1999	1 Person on Medicare	\$188.75	\$285.75	\$474.50
Anthem	State BlueCare POS	Prior to 7/1999	2 or More People on Medicare	\$377.50	\$571.50	\$949.00
Oxford	Oxford Freedom Select POS	All	1 Person on Medicare	\$237.99	\$285.75	\$523.74
Oxford	Oxford Freedom Select POS	All	2 or More People on Medicare	\$475.98	\$571.50	\$1,047.48
Oxford	Oxford HMO POE-G	All	1 Person on Medicare	\$215.55	\$285.75	\$501.30
Oxford	Oxford HMO POE-G	All	2 or More People on Medicare	\$431.10	\$571.50	\$1,002.60
Oxford	Oxford HMO Select POE	All	1 Person on Medicare	\$226.96	\$285.75	\$512.71
Oxford	Oxford HMO Select POE	All	2 or More People on Medicare	\$453.92	\$571.50	\$1,025.42
Oxford	Oxford Out of Area	All	1 Person on Medicare	\$179.47	\$285.75	\$465.22
Oxford	Oxford Out of Area	All	2 or More People on Medicare	\$358.94	\$571.50	\$930.44

**46. Q--**For both Pre-2011 and Post-2011 plans, please provide most recent 24 months of medical claims experience on a month by month basis for Medicare retirees containing the following information:

- Medicare allowed amount
- Medicare paid amount
- Plan paid claims
- Retiree cost share (copays, deductibles)

## MEDICARE ADVANTAGE RFP—ANSWERS TO BIDDERS' QUESTIONS

**A- Such information is included in the Reference Documents.**

**47. Q--**For both Pre-2011 and Post-2011 plans, please provide most recent 24 months of monthly membership counts for Medicare retirees that correspond with medical claims experience

**A- Such information is included in the Reference Documents.**

**48. Q--**For both Pre-2011 and Post-2011 plans, please provide most recent 24 months of prescription drug claim experience on a month by month basis for Medicare retirees containing the following information:

- Medicare allowed amount
- Medicare paid amount
- Plan paid claims
- Retiree cost share (copays, deductibles)

**A- Such information is included in the Reference Documents.**

**49. Q--**For both Pre-2011 and Post-2011 plans, please provide most recent 24 months of monthly membership counts for Medicare retirees that corresponds with prescription drug claims experience

**A- Such information is included in the Reference Documents.**

**50. Q--**For both Pre-2011 and Post-2011 plans: Pharmacy formulary data request in excel- see below. We are requesting data that includes the following:

- A field with a unique member ID (if spouses have the same id as the member, need a spouse or relationship indicator)
- NDC (9 or 11 digit version)
- Effective/Fill dates for most recent 12 months
- Retail/Mail indicator
- Quantity or Day Supply counts

Rx Data Elements		
Field	Example	Description
Benefit Plan Identifier	Plan ABC	Benefit Plan Identifier
Member ID	123456789	Individual Member Identification Number
Scripts	1	Script Count
Days Supply	31	Days Supply

## MEDICARE ADVANTAGE RFP—ANSWERS TO BIDDERS' QUESTIONS

NDC Code	406048410	Nation Drug Code
Formulary Tier	1	Tier that was used to determine co-pay
RX Filled Date	4/15/2009	Prescription Filled Date
Generic/Brand Indicator	G	Indicator identifying whether the drug is Generic or Brand
Retail/Mail Order Indicator	R	Indicator identifying whether the drug is Retail or Mail Order
Quantity Dispensed	60	Number of Pills in the same single Script

**A- Such information is included in the Reference Documents.**

**51. Q--**For both Pre-2011 and Post-2011 plans, please provide most recent 24 months- please include medical plan design changes and dates of plan design changes for Medicare retiree plans

**A- Such information is included in the Reference Documents.**

**52. Q--**For both Pre-2011 and Post-2011 plans, please provide most recent 24 months- please include prescription drug plan design changes and dates of plan design changes for Medicare retiree plans

**A- Such information is included in the Reference Documents.**

**53. Q--**For both Pre-2011 and Post-2011 plans, please provide current medical detailed plan designs and benefit summaries for all plans offered to Medicare retirees

**A--See Retiree Healthcare Planners and medical plan document referenced above.**

**54. Q--**For both Pre-2011 and Post-2011 plans, please provide current prescription drug plan designs and benefit summaries for all plans offered to Medicare retirees

**A. See the Retiree Planners, medical and pharmacy plan documents available at <http://www.osc.ct.gov/benefits/docs/StatePharmacyPlanDocument1012016final.pdf>**

**55. Q--**For both Pre-2011 and Post-2011 plans, please confirm Medicare COB methodology based on the following examples:

We have provided a claim example of each Medicare Coordination of Benefits methodology:

- Come out whole (regular COB),
- Government Exclusion (expense care out)
- Non-Duplication (benefit carve out).

**MEDICARE ADVANTAGE RFP—ANSWERS TO BIDDERS’ QUESTIONS**

<b>Come Out Whole (a.k.a. Med 6, Regular COB)</b>		
Claim example (\$1,000 outpatient surgery bill)		
<b>Primary Plan: Medicare</b>	<b>Secondary Plan: ABC Company plan</b>	<b>Member Liability</b>
\$1,000 (allowable expense) - <u>\$200 (deductible)</u> \$800 <u>80% coinsurance</u> \$640 (primary plan benefit)	\$1,000 <u>-\$200 (deductible)</u> \$800 (balance) <u>80% (coinsurance)</u> \$640 (normal plan benefit)  \$360 balance is less than \$640 2 <sup>nd</sup> plan pays \$360	\$1,000 (allowable expense) - \$640 (primary benefit) <u>- \$360 (2<sup>nd</sup> plan benefit)</u> \$0 Member liability
<b>Government Exclusion (a.k.a. – Med 2, Expense Carve Out)</b>		
Claim example (\$1,000 outpatient surgery bill)		
<b>Primary Plan: Medicare</b>	<b>Secondary Plan: ABC Company plan</b>	<b>Member Liability</b>
\$1,000 (allowable expense) - <u>\$200 (deductible)</u> \$800 <u>80% coinsurance</u> \$640 (primary plan benefit)	\$1,000 <u>-\$640 (primary plan benefit)</u> \$360 (balance) <u>- \$200 (2<sup>nd</sup> plan deductible)</u> \$160 <u>80% (coinsurance)</u> \$128 (2 <sup>nd</sup> plan benefit)	\$1,000 (allowable expense) - \$640 (primary plan benefit) <u>- \$128 (2<sup>nd</sup> plan benefit)</u> \$232 Member liability
<b>Non-Duplication (a.k.a. Med 5, Benefit Carve Out, Maintenance of Benefits)</b>		
Claim example (\$1,000 outpatient surgery bill)		
<b>Primary Plan: Medicare</b>	<b>Secondary Plan: ABC Company plan</b>	<b>Member Liability</b>
\$1,000 (allowable expense) - <u>\$200 (deductible)</u> \$800 <u>80% coinsurance</u> \$640 (primary plan benefit)	\$1,000 <u>-\$200 (deductible)</u> \$800 (balance) <u>80% (coinsurance)</u> \$640 (normal plan benefit)  \$640 (normal plan benefit) minus \$640 (primary plan benefit) = \$0	\$1,000 (allowable expense) - \$640 (primary plan benefit) <u>- \$0 (2<sup>nd</sup> plan benefit)</u> \$360 Member liability

**A--We use the “non-duplication: benefit carve-out, maintenance of benefits” method.**