April 27, 2020

Amendment II
FY2021 Government of Guam Group Health Insurance Program
Request for Proposal DOA/HRD/EB-RFP-GHI-21-001

This is in reference to Government of Guam's Request for Proposal DOA/HRD/EB-RFP-GHI-21-001 issued on April 2, 2020 for the Government of Guam Group Health Insurance Program. The Government of Guam is in receipt of inquiries posed pursuant to the above mentioned RFP. The Government provides the following responses:

1. Given the public health emergency currently in place, what is the timeframe for negotiations, award of contract, open enrollment etc. once the RFP has been submitted by bidders?

   RESPONSE: As advised on page 1 of the RFP, negotiations are tentatively scheduled for June 15 – 26, 2020. Open Enrollment is tentatively scheduled early September. The government will adjust these dates accordingly in response to the public health emergency and inform all carriers who are invited to negotiations.

2. In light of the current circumstances and the work from home/social distancing requirement, will GovGuam consider extending the deadline for the submission of the proposal?

   RESPONSE: This is not being considered at this time.

3. Given current restrictions in place around the globe to avoid the spread of COVID-19 and keeping with general health guidance and regulation, many organizations have transferred employees to work at home. In an effort to keep individuals assembling hard copy proposal binders as well as the individuals that will receive them safe, will GovGuam be considering any enhancements to the RFP submission process? Specifically, will electronic submission of RFP responses be considered a valid submission until such time social distancing restrictions are lifted creating a safer environment for all parties involved in the process to create the necessary hard copy binders for distribution?

   RESPONSE: The Government of Guam will be requiring prospective carriers to submit thumb drives in lieu of copies at this time. Files must be password protected and saved as a read only file. The original requirement of two (2) thumb drives in excel file is still required. Please refer to Amendment III.

4. RFP due date is set for May 5th, which coincides with the last day of the currently mandated locked down due to Coronavirus. Has GovGuam made any considerations to change the due date? Is it possible to expand on question #2 and ask if they do not intend on extending the deadline, then to revise the submission requirements? Also preparing 13 binders will require staff resources, which is not quite following social distancing. Some alternatives that DOA may consider could allow for the following options:

   Submitting only 1 original binder with thumb drives enclosed
   
   RESPONSE: Please see response to number 3.

   Complete electronic submission via the AON secured site
   
   RESPONSE: Please see response to number 3.
Waive the requirement for the affidavits to be notarized
RESPONSE: Offerors must comply with submission of original notarized affidavits outlined in the RFP. Many states and territories are temporarily allowing notary services via video.

5. Assuming the Coronavirus lockdowns continue and air traffic is limited, will GovGuam consider the possibility of virtual meetings for the negotiations?
RESPONSE: The government of Guam will take this suggestion under advisement and assess when negotiations are scheduled.

6. Page 18 of the RFP states, “Offerors shall be available for negotiations commencing in the month of June 2019.” Please confirm that this is intended to read June 2020.
RESPONSE: Correct, June 15-26, 2020 are the currently scheduled dates for negotiations

7. In last year’s RFP, it stated that bidders must provide a network that includes all public and private hospitals on Guam pursuant to P.L. 35-2. This year’s RFP does not allude or mention this requirement based on the Public Law. Can GovGuam confirm that bidders are not required to contract with both or either public and/or private hospitals on Guam under this new RFP?
RESPONSE: Bidders must abide by all applicable Federal and Government of Guam laws.

8. The Foster claims triangle was not populated for the current Contract Year. Would it be possible to obtain claims triangle data for the Foster Children Program for the October-December 2019 period?
RESPONSE: Updated Exhibit C (dated 4.15.2020) includes this data.

9. Regarding Exhibit C, [Claim Lag Foster], why is there no claims data provided for after June 2019? Can you please provide any more recent months’ data that may be available?
RESPONSE: Funding for the foster program ran out in May 2019 for the remainder of FY2019. The program was funded again in October 2019 for FY20. Additional claims information for October 2019 to now is included in the revised Exhibit C.

10. While the RFP includes information on subscriber counts, would it be possible to also get information on enrollee or dependent counts? (Definition in RFP: “enrollee” means a subscriber or a dependent of a subscriber who is entitled to receive health services under a health insurance contract.)
RESPONSE: That level of enrollment detail has not been made readily available to the Department of Administration, but please assume approximate member to subscriber ratios of 2.6 for the PPO Active Plan, 2.3 for the Active HSA plan, 1.80 for the PPO and HSA Retiree Plans, and 2.5 for Dental.

11. On “Exhibit C-FY21-Enrollment-and-Claims-Final-4.1/20.xls”, can you please provide monthly enrollment and claims experience data for the period 10-1/17 through 9/2019 separately for Plan Y and Plan X?
RESPONSE: Data is intentionally aggregated to protect carrier confidentiality.

12. Can you please provide “run-out” (claims paid on or after 10/1/2019) claims by month separately for Plan Y and Plan X?
RESPONSE: Data is intentionally aggregated to protect carrier confidentiality.

13. The monthly enrollment provided in Exhibit C for Oct-18 through Feb-19 does not reconcile with monthly enrollment number provided in Exhibit C of last year’s RFP.

a. Please confirm that the monthly enrollment numbers provided in the RFP are accurate.
RESPONSE: Aon received updated files from the carriers. It appears that there were late enrollments submitted by a few departments that resulted in adjusted enrollment numbers when pulling data at a later time.

b. Please explain the reason for the increase in enrollment of over 1,000 subscribers from Sept-19 to Oct-19?
RESPONSE: There was an extended open-enrollment period for FY20 which included an active campaign to enroll. These steps may have contributed to the rise in enrollment.
14. Exhibit C provided claims lags data incurred and paid through December 2019 (except for Foster), monthly premiums through December 2019, and monthly enrollment through January 2020. Can you please provide any more recent months’ data that may be available (January 2020 through March 2020)?

RESPONSE: The timeframe (claims through December 2019) represents the data available upon implementation of the GHI overall timeline for the RFP to meet scheduled implementation dates. This is subject to review only if the overall timeline is amended.

15. Please confirm that the Gross Receipts Tax (GRT), Patient-Centered Outcomes Research Institute (PCORI) Fee, and other items allowed under the current agreement will be excluded from the premium amount for the purposes of calculating the experience participation ratio.

RESPONSE: The intent of the Experience Participation Ratio is for the carrier to pay out at least 86% of premiums out in claims. There is no intent to exclude certain costs as not applicable to the 14% or less of premiums that may be used to pay expenses.

16. In the Experience Participation Ratio, Premiums are calculated by multiplying the monthly enrollment with the rates. Since premiums are paid on a bi-weekly or bi-monthly basis, the monthly enrollment may not reflect actual enrollment movements during the bi-weekly or bi-monthly period. (i) Should the Premiums be calculated instead based on actual premiums earned? (ii) For FY 2019, what is the actual combined carriers’ premiums earned?

RESPONSE: GovGuam requires monthly invoices for premiums to be submitted.

17. The RFP is for a self-funded dental plan. Please clarify the Experience Participation Ratio that includes dental.

RESPONSE: The Participating Contract Refund is only intended to apply to fully-insured coverages. Self-funded Dental should be excluded.

18. We understand that the current GovGuam dental benefit is a self-insured program. Are dental claims included in the claims data?

RESPONSE: The dental claims lag triangle was provided on a separate tab in Exhibit C in order to separate out this data for bidders.

19. Is there a required ASO agreement format for the self-funded dental coverage?

RESPONSE: We will consider the prospective offeror’s sample ASO agreement.

20. Please clarify if there are requirements for the Pharmacy Rebates.

RESPONSE: There are no explicit requirements for Pharmacy Rebates, but bidders’ premium rates should reflect the best available arrangement. An outline of your pharmacy rebate provisions should be included with your proposal so the Government may accurately compare bidders’ premiums.

21. We noticed that the total incurred claims in the H.S.A Retiree claim lag more than double in the first few months of FY20 while enrollment only increased by 5% in FY20. Is there a reason for this anomaly?

RESPONSE: There was an extended Open Enrollment Period (OE) for FY20 which included an active campaign to attend the presentations and enroll. The OE communications were aggressive which may have led to a better understanding of their benefits and resulted in a higher utilization.

22. What measures has GovGuam taken to validate claims, premium, and enrollment data provided (financial statements, experience refund submissions, loss ratios, other sources, etc.)?

RESPONSE: Aon has audited claims payment for GG. Office of Public Accountability has conducted audits as well on enrollment and experience refunds.

23. Based on prior records, the experience refund letter from TakeCare, which showed MLRs in excess of 120%, and our records, the Loss ratio for FY2019 was greater 97%, but this does not seem to reconcile the information or data provided in Exhibit C. Please clarify the discrepancy with the amounts.

RESPONSE: The experience refund letters are under review and your responses should be based on the claims data.
24. Exhibit E, “Gym Tab” requests that we include a separate identifiable cost to provide members with a gym membership. Can you provide the eligibility provision (i.e., all members, subscriber and spouse only, only members over a specific age 16, 18? etc.) that would determine who is eligible for the benefit should you wish to continue providing that benefit?

   RESPONSE: Eligibility will include all members enrolled. Membership will have age limitations for members age 16 and above.

25. Please provide specifics of the current GovGuam gym benefits. Does it cover all members, i.e., actives, retirees and their dependents, or is there a cap of 10,000 members only?

   RESPONSE: Coverage will be extended to all members up to a 10,000 member cap.

26. Until a final decision is made on whether or not to include the Gym Membership as a FY21 benefit, for RFP response purposes, can you confirm that the proposed medical rates requested in Exhibit E should be exclusive of the cost of gym memberships?

   RESPONSE: Exhibit E includes a separate tab for the additional Gym Membership cost. All other tabs (1500, 2000, and RSP should reflect rates exclusive of the Gym Membership, but inclusive of the other wellness requirements under Guam law.

27. Does GovGuam anticipate any material modifications in its medical/dental contribution strategy in FY21?

   RESPONSE: GovGuam does not yet know or anticipate what the contributions will be in FY21. They are sensitive to overall cost.

28. In Exhibit J, there are references in section II. Membership and section III. Voting, to “representative from the Judicial Branch appointed by the Chief Justice of the Supreme Court of Guam”. Should we assume that some consideration is being given to including the Judiciary of Guam, (currently covered under a separate program) in GovGuam’s current plan? If so, can you please provide the following additional data:
   a. Separate Judiciary of Guam plan enrollment and claims experience by month for the most recent 12-month period
   b. Individual high dollar ($50,000+) claimants in the most recent 12 month period
   c. Judiciary of Guam census including age/gender/coverage status (single, member/spouse, member/child(ren) and family)
   d. Plan document (plan overview, SPD etc.) that describes the current level of benefits provided to Judiciary of Guam members

   RESPONSE: The Judiciary of Guam had a separate health insurance contract for FY19 as authorized in 4 GCA §4301(c), and therefore, we do not have the requested data. The Judiciary of Guam has advised the Department of Administration of its intent to continue with a separate contract for FY21, and thus will not be relevant to the GovGuam plan.

29. Referencing Exhibit-D-FY21-Plan-Design-and-Network-Final-4.1.20.xls, can you please confirm the following:
   a. Does GovGuam intend to include a $90,000 Family Out-of-Pocket Maximum for Out-of-Network, Non-Participating Providers for the PPO1500 and HSA2000 plans in FY21?

      RESPONSE: The intent is $30,000 per individual member for OON with a maximum of $90,000 for family. Please enter this maximum in your response in Exhibit D.

   b. For purposes of administering the Out-of-Pocket Maximum for the PPO1500 and HSA200 plans, can you please confirm that if an individual member of a family satisfies their individual Out-of-Pocket maximum, they will have met their overall Out-of-Pocket obligation and the plan will begin to pay 100% of the eligible charge for covered services for the remainder of the plan year for that person?

      RESPONSE: That is correct.

   c. Can you please confirm that deductibles and out-of-pocket maximums are integrated between In-Network and Out-of-Network for the PPO1500 and HSA2000 plans?

      RESPONSE: Yes, Deductibles In and Out-of-Network are integrated and Out-of-Pocket Maximums In and Out-of-Network are also integrated.

30. Does the current GovGuam benefit plan cover incentives for health improvement and preventive screenings?

   RESPONSE: Yes.
31. Please confirm that the current dental plan is self-funded. Please provide specifics on the process when the carrier receives a claim from a provider.

**RESPONSE:** Yes, the current dental plan is self-funded. GovGuam agencies pay a premium equivalent into a fund to pay claims. When the administrator receives a claim, it is processed and adjudicated. Once per week, the administrator requests a payment wire for the claims paid from the fund.

32. There are several references to “broad network” in the RFP, yet there is no definition of an alternative to this network nor is there an option provided in Exhibit E to show different pricing for a plan using such a network. If such an option is being requested, please provide a definition of the alternative network and where the pricing for such should be indicated.

**RESPONSE:** No alternative networks are being requested for FY21. GovGuam is requesting a carrier’s most broad and inclusive network.

33. Exhibit A Phase 1 # 31 refers to a “broad provider network”. Can you please clarify what this refers to.

**RESPONSE:** No alternative networks are being requested for FY21. GovGuam is requesting a carrier’s most broad and inclusive network.

34. Exhibit A Phase 1 #22 – Does the coverage of a child under legal guardianship of the subscriber end when the child reaches age 18 and is no longer a minor?

**RESPONSE:** Coverage for court issued legal guardianship will end when the child reaches age 18 unless otherwise indicated on the guardianship document.

35. Exhibit A, Phase I, Question 4 references the consultant’s MFT site. Will information about this site, and how to access it, be provided at a later date?

**RESPONSE:** Exhibit A, Phase I, Question 4 says, “Complete electronic proposal, including audited financial statements, in original formats submitted on 2 thumb drives”. It is not the intent of GovGuam to utilize Aon’s MFT site for the FY21 RFP. The current plan is to request 2 complete bid thumb drives along with the printed copies of the material. (We’re not able to find any reference to the MFT in Exhibit A. If we’re missing something, please follow-up, but know that the intent is for thumb drives for electronic proposals this year.)

36. Exhibit B, item #13 states “Will you agree to process and pay claims within 90-days of receipt from the provider? (Prompt Payment Act of Guam requires clean claims to be processed within 45 days. Will you agree to pay all other claims within 2x that requirement?)” Can you please be more specific with what is meant by “all other claims”? Are you referring also to not clean claims?

**RESPONSE:** Yes, we are asking that clean claims be processed in 45 days as required by law and that every effort be made to process ALL other claims (including not clean) within 45 days. Carrier’s defect in all other claims so they may be resolved in another 45 days.

37. Exhibit B, item #24 states “Confirm your organization will comply with Exhibit F: REPORTING GUIDELINES FOR HEALTH INSURANCE CARRIERS (Title 4 GCA § 4302 (g)).” – When must the reports be submitted?

**RESPONSE:** Reports are due every March 1 for the past 15 months of data and quarterly reports are due 45 days after the end of each quarter.

38. Exhibit B, item #26 states: “Any selected bidder must agree that upon notification of the termination of their contract with the Government, they will provide, in a standardly accepted format, within 5 days of request by DOA or DOA’s consultant, the following files to the new insurer(s).” Will GovGuam obtain authorization from each member to release such information to a new carrier? Current carrier members may elect not to enroll in the new plan offering, is the transfer of Protected Health Information (PHI) to a carrier for which a member may not enroll HIPAA compliant?

**RESPONSE:** GovGuam owns this data as the plan sponsor and is comfortable with our ability and legality to require secure transfer of the data from one plan administrator to another.

39. Exhibit B, items #28 and #29 (enrollment reports and invoicing by department) – Please provide a list of the departments.

**RESPONSE:** Refer to attached listing.
40. In Exhibit C, Claims lag, please confirm that column B is month of service and that row 3 is paid month.
   RESPONSE: This is correct.

41. In Exhibit C, can you please provide separate claims lag for medical claims, vision and pharmacy for each plan, by actives and retirees for (i) FY 2018, (ii) FY 2019 and (iii) FY2020 (at least up to 02.29.2020 service dates).
   RESPONSE: The claims lags provided are segregated by plan and coverage. Because vision and pharmacy are included in the medical premium, no further distinction is necessary. The timeframe (claims through December 2019) represents the data available upon implementation of the GHI overall timeline for the RFP. This is subject to review only if the overall timeline is amended.

42. In Exhibit C, do the Premiums Foster and Claims lag Foster include both medical and dental data?
   RESPONSE: The Foster plan experience (claims and premiums) include medical, pharmacy, vision, and dental coverages.

43. In Exhibit C, High Cost Claimants with $100k and over were provided for FY 2019. (i) Is the listing for all carriers? (ii) Can you please provide the list of high cost claimants with over $50k for FY 2020 (at least up to 02.29.2020). (iii) Can you also please provide the list of high cost claimants with over $50k - $100k for FY2019.
   RESPONSE: (i) FY19 is for all carriers combined (ii) Revised Exhibit C includes claims above $50K for FY20 as of December 2019 (iii) Revised Exhibit C has claims from $50K-$100K added.

44. Can you please provide claims incurred from GRMC and GMH for (i) October 1, 2018 to September 2019 paid through February 29, 2020 and for (ii) October 1, 2019 to February 29, 2020 paid through February 29, 2020.
   RESPONSE: The timeframe (claims through December 2019) represents the data available upon implementation of the GHI overall timeline for the RFP. This is subject to review only if the overall timeline is amended.

45. Can you please provide us with the claims pmpm or claims paid for dialysis claims for FY 2018 and FY 2019 by plan, separately for actives and retirees. (ii) What % of claims spend is for dialysis?
   RESPONSE: Significant dialysis claims are reflected in the large claimant summaries. Further breakdown is not available at this time.

46. Exhibit D 1500 Plan/2000 HSA
   a. Out of Pocket Maximums – (i) Please confirm that the Government plan has a $30,000 maximum per plan year for out of network service or nonparticipating providers per individual or per family. (ii) For a family, is the $30,000 accumulative among the family members? (iii) Also, the column “Current Benefits” reflects $30,000 Out of Pocket maximum but the FY 2020 plan brochures say Unlimited. Please clarify.
      RESPONSE: The member’s OON out-of-pocket maximum (not plan maximum) is $30,000 per individual and $90,000 accumulative for family coverage. Plan coverage is unlimited. Current benefits for OON OOP are $30,000/$90,000 and should be reflected as such in the brochures. Also, the current plan maximum is unlimited and should be reflected in the brochures.
   b. Annual Eye Exam – Please confirm that the 12 months is counted from an annual eye exam under Government plan and not from an annual eye exam that the member had while covered under a non-Government plan.
      RESPONSE: The only known information is under the GovGuam plan.
   c. Hearing Aids – Please confirm that hearing aids is a not a covered benefit under Government plan when provided by out of network or nonparticipating providers.
      RESPONSE: This is an error in the Exhibit. Out-of-network coverage for hearing aids should be 70%/30% after deductible.
   d. Please confirm that AIDS Treatment is a covered benefit under Government plan.
      RESPONSE: Yes, treatment for AIDS and all other health conditions are covered by the Government's plan.
47. Exhibit D, 1500 Plan,
   a. Implants - Please confirm that member pays 30% for implants when provided by out of network or nonparticipating providers.
      RESPONSE: Correct
   
b. Services subject to Deductible and Services not subject to Deductible - The Current Benefits column provides that only Preventive Health Services, Chiropractic Care, Occupational Therapy, Physical Therapy and Injections are not subject to deductible. However, the FY 2020 PPO 1500 plan brochure says that Urgent Care, Physician Services, Mental health/substance abuse outpatient services, x-rays, labs and prescription drugs are also not subject to deductible. (i) Can you please clarify which one is the correct FY 2020 benefits? (ii) Also, the Proposed Benefits for 1500 Plan for FY 2021 show that all services listed after row 36 are subject to deductible. Please confirm that this is correct.
      RESPONSE: For Row 36 of the 1500 plan and after, the intent is that deductible will apply to most of these services. Please replace the wording in Row 35/26 with this instead “Except when coverage is 100%, a copay amount, or noted as “deductible does not apply”, then Deductible must be met for the following services:

For further clarity, no deductible applies to urgent care, physician services, mental health/substance abuse outpatient services, x-rays, labs and/or prescription drug.
   
c. No cost preventive drugs (specific list). Can you please clarify what this means?
      RESPONSE: Aetna offers a specific list of preventive medications that are covered at 100% by the plan. This list is propriety to Aetna formulary.

48. In Exhibit D, please rank by claims paid the providers listed in Network Med, Network Pharmacy and Network Dental.
      RESPONSE: The following table represents the 10 highest plan paid amounts by facility for FY19:

<table>
<thead>
<tr>
<th>Provider</th>
<th>Plan Paid FY19</th>
</tr>
</thead>
<tbody>
<tr>
<td>GUAM MEMORIAL HOSPITAL</td>
<td>12,626,988</td>
</tr>
<tr>
<td>GUAM REGIONAL MEDICAL CITY</td>
<td>6,928,377</td>
</tr>
<tr>
<td>RSA-GUAM,LLC</td>
<td>4,172,118</td>
</tr>
<tr>
<td>SEVENTH DAY ADVENTIST CLINIC</td>
<td>2,120,428</td>
</tr>
<tr>
<td>GUAM RADIOLOGY CONSULTANTS</td>
<td>2,098,607</td>
</tr>
<tr>
<td>ST. LUKE'S MEDICAL CENTER, GLOBAL CITY</td>
<td>2,576,602</td>
</tr>
<tr>
<td>CEDARS SINAI MEDICAL CENTER</td>
<td>1,569,750</td>
</tr>
<tr>
<td>WESTPAC HEMATOLOGY &amp; ONCOLOGY CENTER</td>
<td>1,539,589</td>
</tr>
<tr>
<td>DIAGNOSTIC LABORATORY SERVICES</td>
<td>1,501,166</td>
</tr>
<tr>
<td>AMERICAN MEDICAL CENTER, LLC</td>
<td>1,391,644</td>
</tr>
</tbody>
</table>

49. Can you please provide separately for each plan the list of top 20 Rx usage and the corresponding % of Total Rx Spend for each for (i) FY 2019 and for (ii) FY 2020 (at least up to 02.29.2020).
      RESPONSE: The timeframe (claims through December 2019) represents the data available upon implementation of the GHI overall timeline for the RFP. This is subject to review only if the overall timeline is amended. Further claims split by plan should be gleaned from the lag tables specific to each plan.

50. Can you please provide the average drug costs by Tier for (i) FY 2019 and (ii) FY 2020 (at least up to 02.29.2020).
      RESPONSE: The timeframe (claims through December 2019) represents the data available upon implementation of the GHI overall timeline for the RFP. This is subject to review only if the overall timeline is amended. Further claims split by plan should be gleaned from the lag tables specific to each plan.
51. Can you please provide separately for each plan the Average Length of Stay, Average Paid amount per admission and Average Paid per day for (i) FY 2018 and (ii) FY 2019.

**RESPONSE:** The timeframe (claims through December 2019) represents the data available upon implementation of the GHI overall timeline for the RFP. This is subject to review only if the overall timeline is amended. Further claims split by plan should be gleaned from the lag tables specific to each plan.

52. Exhibit D, RSP under Current Benefits state "When Medicare is not payable (outside U.S.), covered services under the plan are paid at the copay or coinsurance listed and the Plan pays primary in this circumstance. There is no deductible under this plan."

Can you please confirm that the claims data provided for RSP for FY 2018 and FY 2019 include payments for covered services rendered outside the U.S.?

**RESPONSE:** This is confirmed; the data includes all claims, including those outside of the U.S..

53. Exhibit D, RSP, Current Benefits, Plan Description: “Out-of-Network services are not covered unless referred and pre-approved by an in-network provider.” Please confirm that this is correct. Should not this be “pre-approved by the carrier/insurance plan”?

**RESPONSE:** Correct. This is outdated language. It should say that the insurance carrier will review the request and provide approval for the member to seek service out of network, not the provider.

54. Exhibit D, Wellness C, (i) Please provide the number of members that are currently availing the gym benefit under Government plan. (ii) What is the current plan share and member share for gym benefit? (iii) Can you please confirm that the enrollment cap of 10,000 members is to be used to determine the capitated rate for the gym benefit.

**RESPONSE:** (i) There are approximately 4,000 gym members currently. (i) The gym membership cost is propriety to the current carrier’s contracted vendor arrangements and their wellness benefit. (iii) Yes, for your estimates, assume a cap of 10,000 members.

55. Exhibit D, Network Dental; For Dental Clinics that had been closed (GCIC Dental and Hightower Dental), should these still be included in the list of Networks?

**RESPONSE:** Please simply mark that they are now closed in your response. We’re providing you with accurate claims experience.

56. Exhibit D, Network Pharmacy; For FHP Pharmacy, should we take it out from the Network since Mega Drug III is already indicated?

**RESPONSE:** We suggest you answer the same if they are the same pharmacy. We are providing claims experience as it appears on the report, so it seems that they process claims under different names.

57. Exhibit E, RSP provides the following tiers:
   I. Single Medicare Retiree/Survivor
   II.a. Single + Spouse (both Medicare)
   II.b. Single + Non-Medicare Spouse*
   III. Single + Non-Medicare Child(ren)*
   IV.a. Single + Medicare Spouse + Non-Medicare Child(ren)*
   IV.b. Single + Non-Medicare Spouse + Non-Medicare Child(ren)*

   *Assume non-Medicare dependents enroll in 1500 plan, but allow the option for the 2000 plan if they desire.

Can you please clarify what is meant by “Assume non-Medicare dependents enroll in 1500 plan, but allow the option for the 2000 plan if they desire.”

**RESPONSE:** Yes, we assume that most RSP members will want to have their family members on the 1500 plan due to HSA’s not being applicable after that age of 65 when a person is enrolled in Medicare. However, we acknowledge that some RSP members may desire that their family members continue to have access to HSA contributions under the 2000 plan and want to allow them that option.
58. Exhibit E - PGs - Member Service - 2.c Member Satisfaction - Please clarify what 85% member satisfaction is referring to – Is it Customer service? What does a 15% minimum participation mean?

**RESPONSE:** The carrier is responsible for surveying members after a service interaction. At least 15% of the surveys requested must be responded to by members and included in member satisfaction reporting. Of the members who are responding to the survey, they must cumulatively be at least 85% satisfied with the service.

59. Exhibit E, PGs Account Management/Client Service Satisfaction 3.a – Are these reports the same or different from those in Exhibit F?

**RESPONSE:** These are different. There are no service satisfaction reports required in Exhibit F.

60. Exhibit F, Report Specifications 3. Monthly Premiums Paid – Is Agency the same as Department? If not the same, please provide a list of agencies.

**RESPONSE:** Yes, Agencies and Departments are used interchangeably in this RFP.


**RESPONSE:** The references to Payor, Agency, and Department can be used interchangeably for reporting enrollment and premiums paid.

62. Can policy forms and contracts for FY2021 follow the previous years' GovGuam policy forms and contracts format?

**RESPONSE:** No. GovGuam has invested significant time and effort in cleaning up the contracts and policies to provide clarity to both members and administrator regarding how a claim should be processed. The old contracts had many concerns in this regard.

63. Exhibit B, 10 vii Allows a covered person to access a treatment cost estimator? Please explain what is meant by this?

**RESPONSE:** A treatment cost estimator is a web or app-based tool that allows a member to search by provider, by treatment plan, by surgery, or by facility to estimate the cost of a service they are planning to have under the plan. The tool applies real time deductible, coinsurance, copay, and out-of-pocket information to estimate a member's financial impact for the desired service.

64. The RFP states that “Carriers shall make available upon request, marketing products, to include provisions of alternative formats/services (audio tape, radio announcements, large print braille, and use of ASL interpreters, open/closed captions for videos, ASCII, or word processing form on a computer diskette or CD or HTML on an accessible website upon request.” How much notice would be provided to us in the event an alternative format/service is needed?

**RESPONSE:** GovGuam will work reasonably with their carrier(s) in the event that these special communications are needed. We recognize that some require more time to produce than others. The carrier should make every effort to be prepared to supply these before being requested. For example, have a partner company in place who can produce braille materials if requested.

65. Exhibit B, item #22 states “Please identify any charges that may be assessed to Government of Guam other than rates, i.e. marketing costs, printing costs, site meetings, ad hoc reporting, etc.?”. Separate from the premium, does GovGuam pay for marketing cost, printing cost, site meetings, etc? If not, will GovGuam reimburse the vendor for these types of expenses?

**RESPONSE:** GovGuam does not pay for marketing of the plan to members. That is the sole cost of the carrier(s) and will not be reimbursed.

66. The RFP states the Type of Contract to be awarded is a Fixed Price Contract. Please explain what this means.

**RESPONSE:** Premiums and administrative fees are a fixed price that will not change over the term of the contract.

67. Page 8 of the RFP states, “...The most economical and beneficial healthcare insurance proposal plan [is] defined as the lowest cost option of either the exclusive or non-exclusive [bids] and not forward both an exclusive and a non-exclusive proposal to the Governor.” Will expected medical loss ratios and rate sufficiency, which is critical to the carrier’s ability to pay claims, be considered alongside the cost?

**RESPONSE:** Yes, a vendor's ability to pay claims and also the sufficiency of their rates proposed are considered as part of the financial evaluation of each bidder.
68. Please clarify the following: “selected bidder must agree to address each department separately on the master invoice. Confirm this is something you will administer”. Will this mean that the carrier will bill each department separately to include defined contribution retirees or will all retirees be enrolled and bill under the retirement fund?

RESPONSE: The Department of Administration (DOA) will remit premiums for all line agencies to include Defined Contribution retirees under its auspice. The carrier will have to have separate invoices for each department under DOA. Autonomous agencies will have to be invoiced separately to include their Defined Contribution retirees. Defined Benefit retirees can be invoiced to the retirement fund.

69. Does GovGuam expect bills on a bi-weekly and semi-monthly basis for retirees to each agency and department? Or is this just at the department level only?

RESPONSE: The Government of Guam requires monthly billings for actives and retirees.

70. Will GovGuam establish deadline protocols for enrollment, so that the aforementioned bills to departments are issued timely?

RESPONSE: There are already protocols set up for submitting new hire enrollments and HIPAA life event enrollments within 30 days of the event. No new deadlines are planned.

71. Please explain the requirement of a licensed individual to be located at DOA. Since electronic enrollment is also being required, shouldn’t this requirement be more flexible?

RESPONSE: The intent is for the individual seated at DOA to answer member and potential-member phone calls and walk-in questions. In addition, this person would be available to departments to support their enrollments and billings. This person would also coordinate meetings with benefits staff from all departments on a monthly basis to work through issues together.

72. Will we be provided a summary of all questions and answers?

RESPONSE: Yes.
## DEPARTMENT LISTING

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