

RFP for Analysis of Proposals for Achieving Universal Health Coverage in New York

Responses to Questions

A. Tasks

1. I am writing to ask your support for an expansion of one of the tasks included in the RFP “Analysis of Proposals for Achieving Universal Health Coverage in New York.” Task 2 for Private/Public Universal Coverage requires the contractor to make estimates of the “extent to which the proposal advances the goal of the universal coverage and reduces barriers to care.” I would suggest adding, “This should include for private insurers an assessment of the impact of payment denials, policy cancellations, etc. on the enrollees’ costs, coverage and access to care.” There is ample evidence of the medical and financial hardships imposed on people who are subject to these business practices.

We believe this to be beyond the scope of this project.

2. Section 2 - Proposed Tasks on Page 3 of the RFP highlights Tasks 1 and 2 presents the scope of services. Is it possible for DOH to elaborate how detailed of analyses are required? For Example: What is required? What elements should be included in the deliverable? Parameters around the level of the analysis DOH is expecting to assess the impacts presented in Tasks I and 2.

Section C.2. Proposed Tasks – Is the goal of the modeling to supply the State with high-level cost estimates and participation rates or is the goal to create precise actuarially certifiable cost estimates? What is the nature of the models being requested? Are they actuarial, economic or another type of modeling?

Tasks 1 and 2: Pages 3 and 4 of the RFP indicates that analyses of the proposals for universal health coverage shall include estimates of the "impact of the proposal on the business community, including small business, self-employed individuals and sole proprietors. This should include an assessment of the impact of the proposal on employment as well as on collective bargaining agreements." How detailed does the Department of Health anticipate that these estimates will be?

Will the consultant be expected to model both expenses and revenues?

We are looking for high level economic modeling that will include both expenses and revenues.

3. How many varieties of solutions to universal health coverage is the State looking to model? The more varied the solutions, the more intense the work can be. For example, some of the possible solutions to model could be:

- a. Publicly sponsored (or public/private) coverage program
- b. High risk pools
- c. Restructuring of the private market or an “exchange” model
- d. Reinsurance-based solutions
- e. Tax credits

How many coverage proposals would be considered under the publicly sponsored and private/public sponsored coverage proposals, respectively? Would the Department consider a bid that would limit the number of proposals modeled or that offered a fixed price bid per additional coverage proposal or change in specification of a coverage proposal?

We will be modifying the RFP to specify that we expect offerors to bid a fixed price for modeling three versions of a universal coverage proposal, including a single payer model and a public/private model which builds on existing health care programs. Modeling of additional proposals will be reimbursed at an hourly rate. See question E.1.

4. What role does the Department envision the consultant have in developing and refining the universal coverage proposals?

Section C.2. Proposed Tasks – Have the options for universal coverage been developed or are they currently being developed? Can the State provide further details as to the nature of the proposals that would be modeled? Or are there broader frameworks with the expectation that the consultant will assist in fleshing out the design and details of coverage options?

Has DOH or any other state agency developed or recommended proposals for providing or promoting universal health coverage that will need to be evaluated as part of this project? Have there been preliminary evaluations of certain designs by State agencies or other consultants that will be made available to the vendor for review?

Who will be involved in the selection of the proposals that will be modeled? Will the contractor have input into this process?

Proposals will come from the Departments of Health and Insurance. The Departments have scheduled a series of public hearings to be conducted between September and December through which we will be obtaining input on universal coverage from appropriate stakeholders. The Departments will also be conducting one-on-one meetings with stakeholders. These hearings and meetings will help to inform the Departments on designs to be modeled. We also expect to consult with the contractor on the design of the models. The schedule of public hearings is attached (Attachment I) and may also be accessed at www.partnership4coverage.ny.gov.

5. Section B. Background – Overall, what are the primary goals and objectives for launching a universal health care program? What factors will impact the evaluation most heavily?

The primary goals and objectives of a universal health care program are articulated in press releases from Governor Spitzer and the Departments of Health and Insurance. These press releases may be accessed at www.partnership4coverage.ny.gov. Governor Spitzer’s July 11 press release states, “In making their recommendation, the Health Commissioner and Insurance Superintendent will consider the extent to which proposals: (1) rapidly provide universal health coverage to the citizens of New York; (2) control the cost of health insurance and health care; (3) fairly and equitably distribute the cost of health insurance and health care; (4) improve the state’s economy and the competitiveness of the state’s businesses; (5) promote the economic viability of health care providers.”

6. Section C.2. Proposed Tasks – Is the consultant expected to assess the perspectives of various constituents as part of the assessment of the potential coverage models? For example, private insurer points of view, uninsured perspectives, providers, legislators, etc.? If so, has the State identified those important factors in developing a practical solution that will work such as what defines affordable, social goals and objectives, business constraints and impact for New York State-based insurers/employers?

Section C.2. Proposed Tasks – Is there interest in obtaining strategic lessons from other states regarding universal health care programs? While no state yet represents a “gold standard” for success, there will be many lessons to be had about what has worked well, and what was unexpected in the implementation and early roll-out of these programs.

No. The contractor will not be expected to gather this information (see response to question A.4., above). However, we would expect to draw upon any relevant experience the contractor has in working with other states in this regard to the extent that it can be shared.

7. Section C.2. Proposed Tasks – Will the consultant(s) be asked to provide public testimony supporting and defending the results of the report, as well as participating in public meetings? Or is the goal for the consultant’s role to be more behind-the-scenes and DOH and New York State Insurance Department staff will do most of the public testimony using the vendor deliverables?

We do not anticipate that the contractor will be asked to provide public testimony. However, the contractor may be asked to provide support to the Departments of Health and Insurance in this regard.

8. Section C.2. Proposed Tasks – Is program design and strategy assistance expected from the consultant(s) in addition to modeling and evaluating the different options?

Section C.2. Proposed Tasks – Will the consultant be expected to assess the operational feasibility of the various universal coverage models?

Section C.2. Proposed Tasks – Will the consultant be expected to develop any sort of an implementation plan for the recommended universal coverage model?

No

9. Section C.2. Proposed Tasks – Is the State looking for strategic assistance regarding federal waivers, State Plan Amendments, and federal financial participation options?

No.

10. Does the Department of Health have a preferred analytical methodology it would like the Contractor to use, i.e., microsimulation?

No.

11. Section B, Background – What is the State’s expectation of the timing to implement universal coverage? Is the goal, and thus the potential modeling to be explored in this RFP and involvement needed from the vendor, to be a phase-in approach of expanding coverage to currently uninsured individuals? Or is it expected to be a dramatic overhaul of the current health care system with the immediate implementation of universal coverage?

It is expected that the State will use a “building-block approach” to implementing universal health coverage. Please refer to Governor Spitzer’s July 11 press release, which may be accessed at www.partnership4coverage.ny.gov.

12. Section C.2. Proposed Tasks – Which populations would be included in the universal coverage proposals? Would they include all citizens in New York, just the Non-Medicare population, the currently uninsured population only or some other grouping of people?

We expect to focus on the non-Medicare population.

13. Section C.2. Proposed Tasks – Does the State anticipate that any of the options will be “system wide” delivery models? That is, broad-based programs that would replace existing coverage such as employer-sponsored insurance (ESI) or Medicaid, or that may change the existing small group and individual insurance markets? How will the options coordinate with existing programs such as Healthy New York, the expansion of Child Health Plus to cover children in families up to 400 percent FPL and extending the Family Health Plus program to private employers?

Does DOH anticipate that publicly sponsored universal coverage would be fully subsidized by the state, or would cost sharing mechanisms be allowed? If cost sharing is allowed, is it anticipated that 100% coverage may be unattainable because of the inability of some to pay? (Task 1 question only)

Will the state allow for increased flexibility in insured small group and individual health coverage premium rating and/or mandated benefit requirements in order to support the goal of universal coverage?

There are no pre-set prohibited policies. All things are on the table.

14. Section C.2. Proposed Tasks – Will the modeling include the development of potential savings associated with other health system reforms the Governor has proposed (e.g., “rationalizing Medicaid payments”)?

Yes, potentially.

15. Section C.2. Proposed Tasks – Does the State anticipate that modeling of any proposed options will involve valuing innovative care quality initiatives or consumer incentives for healthy behavior?

Yes, potentially.

16. Section C.2. Proposed Tasks – Is the modeling expected to quantify externalities of the expansion, such as the “woodwork” effect of attracting uninsured residents who are already eligible for an existing public program?

Yes.

17. Section C.2. Proposed Tasks – If one of the potential models is partially subsidized insurance, has there been a consensus on defining affordability? That is, if the State wants to subsidize the premium amount above the member's affordability level, you first need to define what is affordable. Is that something that the consultant(s) will be asked to develop?

Yes, the contractor will be asked to develop recommendations on standards for affordability.

18. Section C.2. Proposed Tasks – Will the modeling need to evaluate the impact of a residency requirement, especially with all of the states and commuters in close proximity to New York City? Is the vendor expected to quantify the possible increase of residents and cost of people that may move into the State from outside states to gain access to universal health insurance?

Yes.

19. Tasks 1 and 2: Will the Contractor have access to staff in other Departments to ask detailed questions regarding New York's health insurance market and other relevant issues (i.e., New York State Insurance Department and the New York Department of Taxation and Finance)?

Please describe the role that New York State Department of Health (DOH) staff will have in the preparation of the deliverable, including project organization, data analysis, and other, as appropriate.

The Governor has jointly charged the Departments of Health and Insurance with the task of developing a proposal for achieving universal coverage. Although the Department of Health has been the lead agency with respect to the issuance of this RFP, the Insurance and Health Departments will participate equally in all aspects of the review of proposals and in the subsequent work with the consultant that is awarded the contract. It is expected that the two Departments will work closely with the contractor with respect to project organization and data analysis. The two Departments will also facilitate any necessary discussions with other State agencies such as Tax and Finance.

20. Are there currently sources of public financing available for any proposed new programs? Please describe the sources and amount of available funding and any limitations regarding their use.

Any additional public financing necessary to fund the selected model will be discussed as part of the State's legislative agenda.

21. Does the state have its own estimates of the size of the sole-proprietor population?

Yes. There is a report published in 2006 on the Tax Department's website entitled "Small Business Report: Statistics for Tax Year 2002" that includes figures on the number of sole proprietors in NYS as well as a good deal of other data. SID also has data regarding the number of insured sole proprietors covered by HMOs or not for profit carriers.

22. What are the expectations of the Department of Health with regard to reports, briefings, and other presentations?

We anticipate production of a draft and final report as part of the fixed bid. We also anticipate the contractor will be asked to conduct multiple briefings and should include cost projections for four briefings/presentations in the fixed bid (see question E.2.).

23. Section C.2. Proposed Tasks – At the bidder's conference, the State clarified that the Contractor should assume that three models will be developed as part of the deliverable-based component of the project. Is the Contractor to assume that these

would be three distinct and different models, or the same model with different inputs and assumptions?

They will be three distinct models.

24. Is it a requirement for the contractor to take a position on Universal Health Coverage in New York or are the expectations that the contractor will be an objective, third party that will analyze each reform proposal in an unbiased manner?

The contractor should provide an objective, unbiased analysis.

B. Data

1. Section B. Background – What data is available to use on the project? Will the contractor be able to request the State to run special data reports from its government programs? What state-specific data will be available to the Contractor (i.e., data from the New York Department of Health, New York Insurance Department, and the New York Department of Taxation and Finance)? What cost, if any, is there to the Contractor to obtain this data?

In general, whatever data is available to the Departments of Health and Insurance will be made available to the consultant at no cost. The data will generally be made available in its existing format but to the extent possible, the Departments will try to accommodate requests for special reports and reformatting.

2. Section B. Background – Are there existing analyses of the uninsured population that would be provided (e.g., a survey or other analysis of data sources such as CPS and MEPS), or should the vendor include this type of analysis in scope?

The Departments will make available any analysis of CPS and MEPS data that it has conducted. However, it is expected that the consultant will need to supplement this with its own analysis of this data.

3. Section B. Background – Will the State provide data on existing coverage in New York, including demographic information for various markets? Has the state developed the population and premium estimates for each of the population groups that may be affected by the proposals (e.g., individuals, small business owners, large business owners, public program enrollment, etc.).

Section B. Background – Will the State provide data on the State Employee health plan, if that experience is determined to support the analysis?

Section B. Background – Will the State provide data on ESI in New York and other employment statistics, as needed to analyze the impact of the options on employment and ESI patterns?

For the insured marketplace, SID has information reported in the annual statements and the NYS data supplements on an annual basis. For Healthy NY and the Direct Payment program, we have aggregate claims against the state funded stop loss pools as well as some survey data and loss ratio reports. There also may be some aggregate claims data from the market stabilization pools applicable to the individual and small group health insurance markets. Demographic information, including age and sex, is available for those insured through the HMO market. Some aggregate population and premium estimates for the insured market is also available.

4. Section B. Background – Does the State have data on New York safety-net system expenditures for patients without health insurance coverage?

Data is available on State funding to providers for bad debt and charity care. Data is also available from hospitals on their costs and units of service provided to the uninsured.

5. Section B. Background – For recent expansions of health insurance such as the Child Health Plus and Family Health Plus, there may not be data available for these populations. Will the State provide any data or budget estimates related to these new enrollees?

The Department of Health can provide claims and encounter data for the Medicaid and Family Health Plus programs. This detail is not available for Child Health Plus. Managed Care Plan premium and financial performance information is available for all three programs. Demographic information is available for all three programs.

6. Will DOH seek cooperation from licensed health insurers, including managed care plans, in collecting data and other information that may be used in this analysis?

Yes - within reasonable parameters and where possible within the project timeframes.

7. Is there readily accessible data available regarding premium tax collections subset by group size?

No.

8. Section 2. Tasks 1 and 2. (pg 3-4) How much and what kinds of data are available both from the state and industry? In particular, would detailed historical (a few years) utilization, cost and enrollment data for existing government programs as well as

private insurance be available to the contractor? Also, would historical premium rate information for both government programs and private insurance and associated benefit plan designs be made available?

See responses to Questions B.1., B.3. and B.5., above.

C. Deliverables

1. Section E.6. Term of Contract – Please explain the timing of the contract. It is a 2 year contract but the RFP states the work plan should reflect the majority of the modeling work to be completed in the first quarter of 2008. What is the expected involvement of the vendor over the following 21 months and what is the expected timeline from the State with respect to the draft and final report deliverables?

The contract anticipates an award date of December 17, 2007 with a total period of performance of two years. Within this time frame, how should the level of effort be spread over the anticipated period of performance? That is, within the period of performance do you envision deliverable dates for specific products such as coverage and cost estimates?

Section 5, RFP Page 15: Section 5 outlines four main deliverables and the corresponding percentage payment. What are the Department of Health's anticipated timeframes for these deliverables? Are there other key timeframes that the Contractor should consider when developing the workplan?

What is the anticipated format of the deliverable to be provided?

It is our expectation to make an award and have a contract in place by year end. Although the contract will be a two year contract, we do expect that the activity will be frontloaded. Our goal is to have most of the modeling done in the early months of 2008. We will be seeking deliverables in the form of a draft report on or about April 15, 2008 and a final report by May 15, 2008. The contract will be a two year contract and we do expect that there will be additional activity after the final report which may include some additional modeling and consulting services and additional reports.

2. With whom will the deliverable or results of our analysis be shared? Will the report be a public document or used internally to assist DOH in making decisions?

Any reports will be public documents. The Departments anticipate that there will be considerable interest in the modeling and that the process will be as transparent as possible.

3. May bidders suggest alternative deliverables or an alternative payment schedule?

No.

D. Bidder Requirements/Qualifications

1. On page 16, section E.8, Vendor Responsibility Questionnaire, our firm does not have audited financial statements completed each year. Would other evidence of financial responsibility and solvency be allowed, such as corporate tax returns or an internally generated income statement or balance sheet signed by the President of the company?

It is preferred that Offerors provide proof of financial stability in the form of independently certified reports, such as audited financial statements. In the event that an Offeror does not have independently certified financial reports, other proofs of financial stability, such as Dunn & Bradstreet Reports, corporate tax returns or internally-generated income statements or balance sheets signed by the President of the company, may be submitted with the proposal. The Department will determine whether the documents submitted provide sufficient proof of financial stability to help support a determination of vendor responsibility.

2. On page 16, section E.8, Vendor Responsibility Questionnaire, having never contracted with New York State, we need to file with the Department of State and Department of Taxation. In the event that we have not received a confirmed vendor number from the State by the time the proposal is due, would it be permissible to include in our proposal the signed and dated applications with the Department of State and Department of Taxation?

Yes

3. Section C, Paragraph 6--Conflict of Interest, pages 5 of the RFP.

This section of the RFP references that ... "Offerors (or any subcontractor) must disclose all business relationships with or ownership interest in entities including but not limited to insurers, New York employers, providers of medical services, and the collective bargaining units, organizations or trade associations representing New York State's insurers and employers. In cases where such relationships exist, Offerors must describe how the potential conflict of interest and/or disclosure of confidential information relating to this contract will be avoided. The Department reserves the right to reject bids, at its sole discretion, based on any perceived conflict of interest. "

Our questions related to the above provision are twofold.

- a) If the Offeror provides consulting and/or professional services to insurers, employers and providers in New York State, all which would be impacted in some manner under a New York State Universal Health Coverage program (if

implemented), are such unrelated "consulting relationships" (to this RFP) viewed as a potential conflict by the Department?

- b) Are consulting firms with direct ownership links to major health insurers (e.g., a number of large health insurers have wholly owned consulting business subsidiaries); who operate in New York State and who do business with State/Municipal governmental entities and/or Collective Bargaining Units for the same; and who could potentially have a material financial benefit from a universal health coverage program in New York; viewed by as having a potential conflict of interest by the Department?

Offerors should follow the instructions provided in the RFP, including identifying all business relationships and ownership interests that may present a conflict of interest and describing how any potential conflict of interest will be avoided. Based on this information, the Department will make a determination on a case-by-case basis.

E. Bid Development

1. Do you require that bids on this work be firm fixed price, or (because the nature of the work not well-specified) would the Department consider a time-and-materials bid listing staff rates and anticipated time required for each task? In either case, is there a specific level of effort that is anticipated for this work?

Section E.5. Payment (Deliverable) – In the final report, how many universal coverage proposals are expected to be modeled and included as part of the deliverable-based payment? If additional modeling is needed outside of these options can the work performed be billed at an hourly rate?

Offerors should assume that the fixed price bid covers analysis of three proposals involving a single payer model and a public/private model which builds on existing health care programs.

In addition, the RFP has been amended to include a separate composite hourly cost rate to be applied to additional models that may be requested by the Department. A revised Attachment VII - Cost Proposal is attached. Offerors should use the revised Cost Proposal form to develop their Cost Proposals. Offerors should note that the composite hourly rate bid will apply only to additional models requested by the Department, in its sole discretion, and to travel costs for meetings not included in the fixed price bid (see question E.2., below).

2. Section E.6. Term of Contract – Is the consultation after the submission of the final report part of the Contractor fixed price or subject to hourly rates? If this is expected to be part of the Contractor fixed price, does the State have an estimate of the hours,

or number of meetings that would be needed in follow up after the submission of the final report?

Consultation after submission of the final report with regard to that report should be considered part of the fixed price. Consultation with regard to new activities or additional variations on models will be reimbursed at the hourly rate. The Department anticipates that there will be ongoing discussions between the contractor and the Departments during the creation and refinement of proposals. For purposes of developing a cost proposal, offerors should assume two meetings in Albany and two meetings in New York City as part of the fixed price. Any subsequent meetings requiring the contractor to travel will be reimbursed at the hourly rate.

3. Section D. Proposal Requirements – Is there a page limit for the RFP response?

No

4. Section D(1)(a), Format for Required Information: This section indicates that “The Format of the proposals must follow, in sequence, each of the sections outlined below.” Section 2, "Required Forms" includes the Offeror's Questionnaire as does Section 5. Is it acceptable in Section 2 to refer the reader to Section 5 instead of repeating the information in both places?

Yes, the Offeror’s Questionnaire should be included in Section 5).

5. Attachment VII (Cost proposal) – Would the State consider cost proposal bids that identify multiple scopes with multiple pricing for the deliverable-based component of the bid?

No, proposals must be comparable to ensure the validity of the bid evaluation.

6. Attachment VII (Cost Proposal) – Given the ambiguity of the scope, would the State consider modifying the RFP to reflect solely an hourly-based proposal, without obligating the contractor to a fixed price for the deliverable component of the project?

No.

7. Attachment VII (Cost Proposal) – Does the State intend to use the hourly rates for any projects outside of the deliverable-based component that are necessary during the two-year contract period?

Analysis of proposals over and above the three analyses included in the fixed price bid will be reimbursed at the hourly rate. In addition, travel costs over and above those included in the fixed price bid (see question E.2) will be reimbursed at the hourly rate.

F. RFP Provisions

1. On page 15, section E.5, Payment, please provide clarification that although the Cost Proposal should list the number of hours proposed and hourly rate by person, the payments will not be made on a periodic basis (e.g. monthly) based on hours incurred; rather, they will be made on a percentage of total contract based on successful completion of deliverables.

This is correct for the fixed price bid. Please refer to Questions E. 1. and E.2. for information concerning the revised Cost Proposal.

2. Page 33, item 20, asks whether there are any individuals now serving in a managerial or consulting capacity to the vendor, including principal owners or officers who have served in various capacities. Can this question be limited to member of the proposed project team and key executive officers of the Firm?

Offerors must fully respond to all questions in the Vendor Responsibility Questionnaire.

G. Miscellaneous

1. Attachment II indicates the Offeror's Assurances form must be signed in ink by an official authorized to bind the organization to the provisions of the RFP and Proposal. However, the RFP indicates that contract terms can be negotiated once the contract is awarded. Is it acceptable to provide in the proposal response a summary of the contract terms for DOH to consider modifying once it is awarded?

Attachment II. c. Offeror's Assurances – It states that the Offeror agrees to the proposed contract language, as defined in the RFP and all appendices. Will the State allow for negotiation of any of the terms and conditions in the standard contract? If so, should those be provided with our response or will that be part of the contract negotiation?

Would the Department of Health and Insurance Department be willing to agree to a clause in the contract that contains a limit of liability with a specific dollar limit?

Attachment II has been modified to allow Offerors to submit proposed exceptions and modifications to contract language as part of the Transmittal Letter. Contract changes must be approved by the Department, the Attorney General and the State Comptroller. Revised Attachment II is attached.

2. Can DOH provide a list of the vendors who received the RFPs?

This information may not be released until a contract has been approved by the Office of the State Comptroller.

3. Section A. General Information for Prospective Offerors – What is the State’s budget for this project? Does the State have any expected number of hours it expects the contractor to commit to on the contract? How many staff hours does the State anticipate spending on this project over the course of the contract?

Has the Department of Health and Insurance Department set a budget or range of budget for these consulting services? If yes, what is that budget or range of budget?

Offerors should prepare their Cost Proposals based on their best estimate of funding necessary to satisfactorily complete all tasks required by the RFP.

4. Section E.1. Issuing Agency – Who is on the task force that will be directing the project? Who will be the primary project coordinator from the State? How will the DOH and the New York State Insurance Department coordinate on the project?

See response to question A.19. The project coordinators will be Kathleen Shure (Health Department) and Troy Oechsner (Insurance Department).

5. General Question: What other organizations have submitted questions in response to the Request for Proposals?

This information may not be released until a contract has been approved by the Office of the State Comptroller.

6. Will you provide a list of the firms in attendance at the bidders conference along with their contact information?

The list is attached.

7. General Question: Who has the Department of Health contracted with previously to assist with analyses of health care insurance coverage expansions? How long has the Department of Health had a relationship with this individual/entity (or multiple individuals/entities) and how much is the total dollar value of the corresponding contract(s)?

Have you been working with any consultants on related studies in the past three years? If yes, please name the consultants and the associated fees for the studies.

The Departments have not previously retained consultants to work on analyses of health insurance coverage expansions.

8. General Question: What kind of process does the Department of Health anticipate using to obtain stakeholder feedback through, the project? What is the Contractor's anticipated role in interacting with stakeholders, including the number of anticipated on-site meetings?

The Department will be conducting public hearings during the period September - December 2007. The schedule of hearings is attached. The Contractor will have access to the information obtained at these hearings.

9. Quick scan indicates there do not appear to be routine electronic/Internet communication references and related material in this RFP. This omission appears to include email addresses for "designated contacts" and live internet access for the public for the bidders conference in Albany, NY on 16 August 2007 and the "pre-bid conference" (page 4) which is not listed on the "Schedule of Key Events." There is no indication that these events are subject to the Open Meetings Law.

Designated contacts are available by telephone or fax. The Open Meetings Law only applies to meetings of public bodies. A meeting of a public body is defined as "the official convening of a public body for the purpose of conducting public business", i.e., when a quorum gathers for the purpose of discussing public business. In addition, a public body is defined to include an entity which consists of two or more members, performing a governmental function for the state or for an agency or department thereof. Staff of an agency does not constitute a public body and, therefore, meetings of staff, whether internally or with outsiders, is not subject to the Open Meetings Law. While bid conferences and bid openings may be open to offerors and/or the public in order for the process to be open and fair, these forums also do not constitute a meeting of public bodies and, therefore, are not subject to the Open Meetings Law. There is no "pre-bid conference" referenced in the RFP.

10. The code letters GNARESP appear several times in the text of the RFP. I could not find any translation of this code term.

"GNARESP" refers to the Governor Nelson A. Rockefeller Empire State Plaza

11. Other than item 12, "Disclosure of Proposal Contents," (page 13/3) I find no information concerning applicability of the state's Freedom of Information and Open Meetings laws. Accordingly, and by copy of this communication, I am asking the state Committee on Open Government to rule on this matter for all RFP No. 0706041203 communications and meetings that are not subject to the trade secret exclusion.

With respect to the Freedom of Information Act, according to the RFP (Section C.12.), all materials submitted by offerors, with the exception of information that has been designated as a trade secret, will be available to the public upon request only after approval of the resulting contract by the State Comptroller. Please see the answer to question #9 of this section for a description of the applicability of the Open Meetings Law.

Attachment I

Public Hearing Notice

Increasing Access to Health Insurance Coverage and Moving Toward Universal Healthcare Coverage: Defining the Goals and Identifying the Steps

At the direction of Governor Eliot Spitzer, the New York State Departments of Health (DOH) and Insurance (DOI) will conduct a series of public hearings to solicit input on the development of proposals for achieving health system reform, increasing access to health insurance coverage and moving toward universal healthcare coverage in New York. The Governor has articulated a multi-faceted charge to all participants in New York's health care system to work in partnership to meet the State's unique challenges:

"Our 'partnership for universal health coverage' will be based on a building-block approach that ensures access to affordable, high quality medical care for every single New Yorker, reduces the overwhelming and unsustainable cost of healthcare incurred by the public and the state, and avoids the significant implementation problems that have plagued other state efforts in this area," said Governor Spitzer. "This incremental effort will draw from the experiences of other states, but will ultimately result in a plan that is uniquely suited to New York's uninsured population and healthcare challenges." - *Governor's Press Release of July 11, 2007*

The Governor has made clear that reforming the health care system to make quality care more affordable is inextricably linked to expanding health insurance coverage and moving toward universal healthcare. As the Governor said earlier this year:

"... we will develop a plan for affordable, universal health insurance for all New Yorkers. To be clear, we cannot achieve this goal unless we first restructure our health care delivery system to lower health care costs. Otherwise, we will force an undue burden on families, businesses and government to cover the cost of universal coverage." - *Governor's Health Care Speech, January, 2007*

This hearing notice provides some basic information about the current state of health insurance coverage, health care costs and health care reforms in New York, sets forth the schedule of anticipated public hearings and contains questions that can be addressed at the public hearings. The list of questions is not exhaustive and participants in the hearings should feel free to provide in their oral remarks or prepared testimony any additional information they feel to be useful.

Background Information

According to data from the 2006 Current Population Survey, close to 2.5 million New Yorkers are uninsured. Many of these uninsured New Yorkers work but cannot afford to purchase health insurance. Others, whether working or not, are eligible for public health insurance programs such as Medicaid, Child Health Plus and Family Health Plus, but are not enrolled in them.

Currently, New York State spends more per capita on health care than any other state in the nation, and our per enrollee spending for Medicaid is the highest or second-highest in the nation, more than double the amount expended by California. Medicaid is the largest item in the State budget. Despite this level of spending, recent studies by the federal Agency for Healthcare Research and Quality and the Commonwealth Fund rank New York State as average or worse on important quality indicators. The gap between New York's performance and those of the leading states represents diseases that could have been prevented or better managed, costs that could have been avoided and families that could have been insured.

New York has already begun to reform our health care delivery system and expand health insurance coverage in the State. Legislation passed this year contains key building blocks of Governor Spitzer's effort to increase access to coverage, improve the quality of health care and control health care costs, including: expansion of eligibility under Child Health Plus to 400 percent of the federal poverty level to make health coverage available to all 400,000 of New York's uninsured children; simplification of Medicaid enrollment to help ensure that those already eligible for health coverage receive and maintain coverage; expansion of the Family Health Plus program to allow employers to participate; reallocation of Medicaid spending to follow the patient and

improve patient outcomes; and control of the growth rate of Medicaid spending from an annual average of 8 percent since 2001 to approximately 1 percent this year to promote the efficient delivery of healthcare services. These initiatives and accomplishments begin the essential restructuring of the State's health-care system to ensure that health care dollars are spent wisely for comprehensive coverage and high-quality, cost-effective care.

Additional information about health insurance trends, health system restructuring and Medicaid reform efforts in New York is available at partnership4coverage.ny.gov.

Public Hearings

The [hearings](#), which will be held between September and December 2007, will provide DOH and DOI with valuable information to assist in development of (i) a high-quality and cost-effective health care system, (ii) increased access to health insurance coverage and (iii) identifying what is required to create an effective and sustainable economic model for universal coverage. DOH and DOI are interested in proposals to increase the level of insurance coverage, improve the quality and efficiency of the health-care delivery system in New York, control the cost of health insurance and health care, distribute the cost of health insurance and care fairly and equitably, improve the State's economy and the competitiveness of its businesses, promote the economic viability of health care providers and determine ways to achieve universal coverage.

The Departments are seeking input from the general public, stakeholders in the health care system, academics and others with expertise in this area as well as legislative representatives. Testimony should address any or all of the following questions:

1. What additional building blocks or incremental steps can be taken to increase access to health insurance in New York State?
2. To what extent are the high costs of health care making health insurance unaffordable and universal coverage more difficult or impossible to achieve? What factors contribute to the especially high cost of health care in New York? How should these factors be addressed?
3. What steps should be taken to improve quality and deliver cost-effective care? How do we eliminate unnecessary utilization of health services? How do we make providers more efficient? How do we move to a system of health-care financing

where providers are rewarded for doing better rather than doing more? To what extent should payment be linked to outcomes?

4. How can we make coverage more affordable and accessible to individuals and small businesses? How do we attract young and healthy individuals and small businesses to the insurance market? Should we expand the State's Healthy New York program?
5. How should insurance risk be pooled? Should there be modifications to community rating/open enrollment? Should markets (i.e., individual, small group, large group) be combined? How do we make the pools big enough to maximize affordability? How do we stabilize the individual market (also known as the "direct pay" market)?
6. What are the possible funding sources for increased access to coverage? How do we effectively and equitably maximize these sources? Given the budget gaps the State faces in coming years, what is the role of State fiscal policy in supporting access to coverage? How do competing state fiscal objectives balance with various proposals or options? How does the State assure itself that the proposals to increase access to coverage are cost effective and balance within the overall state budget?
7. What role should the federal government play in assisting New York? Where might the State seek financial support from the federal government? Are there proposals that are national in scope that we should be aware of or support?
8. What role does federal preemption under ERISA play?
9. Is increased regulation of insurer premiums, profits and business practices appropriate and necessary? Should the State follow proposals in other states to increase the minimum amount that health plans must pay toward claims (i.e., the minimum medical loss ratio), or would this diminish the ability of health plans to support various health care programs through assessments on premiums?
10. How do we make sure that everyone who is eligible for public health insurance programs is enrolled in them? Should we expand public health insurance programs like Family Health Plus? If yes, how should they be expanded? If subsidies at reduced levels are provided to families with higher incomes than are currently eligible, how do we assure that individuals opt into coverage? If no, what other mechanisms should we use to expand coverage? How do we ensure that public coverage does not "crowd out" private coverage?
11. Given that the State's Medicaid Program is the most expensive in the nation, what steps can be taken to control costs and make service delivery more cost effective to fiscally accommodate all persons eligible for public programs once they are properly enrolled?

12. How do we make coverage affordable for those at lower income levels? Should government subsidize private coverage for those who have too much income to qualify for the public programs but who cannot afford other coverage? If yes, how? Are direct premium subsidies best or would reinsurance mechanisms designed to reduce premiums be better? If no, what other mechanisms should we use to expand coverage to those at lower income levels?
13. What level of benefits should be provided? Should benefit levels be standardized across public programs, private programs or both public and private programs? Should a comprehensive range of benefit options be available? What is the right balance between comprehensiveness and affordability?
14. What level of consumer cost-sharing is appropriate? What role does personal responsibility have in containing future health care costs? Are high-deductible health plans a reasonable alternative for certain sectors of the population?
15. What standards or measurements should be used to determine how much an individual should contribute toward coverage (e.g., a percentage of income or a household budget)? Should all costs, such as co-payments or co-insurance, be considered or only premiums?
16. What should an individual's responsibility be for obtaining and maintaining insurance coverage? Do we need an individual mandate?
17. What responsibility should employers have for providing coverage to their employees? How should we encourage businesses to offer coverage? Should a fee be imposed on employers that don't offer insurance? How? If yes, what impact might such a requirement have on New York State's economy and employment in the state?
18. How do we retain employer participation, if public programs expand?
19. What are the advantages and disadvantages of a single-payer model of universal coverage? Of a multiple-payer model? Do both models promote effective cost controls, administrative efficiencies, and high-quality care?
20. How do we address the health-care needs of adult undocumented immigrants? If coverage options are extended to adult undocumented immigrants, will they opt in?
21. Will provider subsidies for indigent care continue to be necessary?
22. How should health insurance be regulated in New York? Should oversight by both the Health and Insurance Departments continue? Should there be a single regulatory authority? Are regulatory reforms needed to provide more effective oversight and consistency in regulatory requirements across all types of health insurers?
23. Is there a role for an entity that acts as an insurance exchange or clearinghouse? Should that role be limited to simply acting as a facilitator that directs consumers

to insurers, or should it have broader authority to negotiate rates? If so, what, if any, parameters should be placed on how such negotiations are conducted?

The Public Hearing Schedule

Date	Time	Location
September 5, 2007	10 a.m. - 5 p.m.	Glens Falls Civic Center Heritage Hall Glens Falls, NY
October 3, 2007	10 a.m. - 5 p.m.	Erie County Community College Auditorium Post Building City Campus 121 Ellicott Street Buffalo, NY
October 30, 2007	10 a.m. - 5 p.m.	Fordham University Lowenstein Building 12th Floor Lounge 113 West 60th Street New York, NY
November 13, 2007	10 a.m. - 5 p.m.	Onondaga Community College Storer Auditorium Syracuse, NY
December 5, 2007	10 a.m. - 5 p.m.	SUNY College at Old Westbury Recital Hall Campus Center Old Westbury, NY

Requirements for Public Hearing Participation

All individuals planning to attend a hearing must pre-register with the New York State Department of Health or the New York State Insurance Department. To pre-register, please contact:

Ms. Cindy Esterby
Office of Health Insurance Programs
New York State Department of Health
Corning Tower Bldg., Room 1483
Empire State Plaza
Albany, New York 12237
(518) 474-5737

Ms. Deborah Greer
New York State Insurance Department
One Commerce Plaza

*Albany, NY 12257
(518) 474-4567*

All speakers are required to provide six (6) written copies of their testimony to be presented at the hearing and an electronic copy that can be uploaded onto the Partnership for Coverage Web site. The paper copies of the testimony must be provided to Department staff on the date of the hearing being attended and the electronic copy must be emailed to partnership4coverage@health.state.ny.us on the date of the hearing. Individuals who are unable to attend may submit written comments to the address noted above and electronic comments to the email address above.

For further information, please contact the individuals listed above.

Last updated: August, 2007. [Privacy Policy](#)

Attachment II Revised Cost Proposal

ATTACHMENT VII
Cost Proposal

This Cost Proposal consists of two parts:

- A. Fixed Price Bid for analysis of **three** proposals; and,
- B. Composite Hourly Rate Bid for analysis of any additional proposals, as requested by the Department.

A. Fixed Price Bid

The Fixed Price Bid must reflect the Offeror's total costs for analysis of three proposals for the full term of the contract.

Payments to the Contractor under the Fixed Price Bid will be made for analysis of three proposals, based on satisfactory completion of deliverables, as described in Section E.5. of this RFP. Information requested below concerning hourly rates and number of hours is for informational purposes only.

The hourly rates must be inclusive of all costs including salaries, fringe benefits, administrative costs, overhead, travel (two meetings each in Albany and New York City), presentation costs and profit. Include the title and composite hourly rate for each staff person that will work on the project.

<u>Staff Listing</u> <u>(list separately by title)</u>	<u>Hourly</u> <u>Rate</u>	X	<u>No. Hours</u> <u>on Project</u>	=	<u>Total Cost</u> <u>per Staff</u>
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Total Fixed Price Bid (three proposals)
(Total of last column)

B. Composite Hourly Rate

The Composite Hourly Rate will apply to all additional proposals the Contractor is asked to analyze.

Payments to the Contractor under the Composite Hourly Rate Bid will be made for any additional proposals (over three) requested by the Department, based on the rate calculated below, contingent upon satisfactory completion of deliverables pursuant to a workplan approved by the Department.

The hourly rates must be inclusive of all costs including salaries, fringe benefits, administrative costs, overhead, travel, presentation costs and profit. Include the title, composite hourly rate and number of hours to be worked for each staff person that will work on the project.

For purposes of evaluation, an estimated 2,000 billable hours was chosen to provide a baseline from which Offerors may calculate a standardized hourly rate. The number of billable hours is the Department’s best estimate of hours that may be required for additional analyses. The actual number of hours may be higher or lower based on the number of analyses needed. Hours should be distributed among listed staff in proportion to the Offeror’s estimate of each staff person’s relative contribution.

<u>Staff Listing</u> <u>(list separately by title)</u>	<u>Hourly</u> <u>Rate</u>	X	<u>No. Hours</u> <u>on Project</u>	=	<u>Total Cost</u> <u>per Staff</u>
			_____		_____
Totals			2,000		
Composite Hourly Rate Bid (additional proposals) (Total of last column)				\$	_____

Signature of Authorized Official

Date

This signature binds the Offeror to the Fixed Price Bid and the Composite Hourly Rate Bid for RFP #0706041203 Analysis of Proposals for Achieving Universal Health Coverage in New York.

Attachment III

ATTACHMENT II

Offeror's Assurances

The Offeror's Assurances form **MUST** be signed in ink by an official authorized to bind the organization to the provisions of the RFP and Proposal. Proposals which do not include this signed form will be considered non-responsive, resulting in rejection of the Proposal.

- a) The Offeror is willing and ready to provide the services defined in the RFP in a timely manner.
- b) The Offeror is financially able to perform the tasks related to this project.
- c) The Offeror agrees to the proposed contract language, as defined in the RFP and all appendices, except to the extent that the Offeror sets forth, within the Transmittal Letter, explicit exceptions or modifications that are clearly identified as such. The Offeror understands that any such exceptions or modifications are not binding until agreed to by the Department and approved by the Office of the State Comptroller and the Attorney General. The Offeror further understands that, depending on the nature of the exceptions or requested modifications, such exceptions or requested modifications may render the Offeror's proposal non-responsive and, hence, lead to its rejection.
- d) The Offeror assures that the proposal will remain valid and not subject to change for a minimum period of 270 days from the proposal due date.
- e) The Offeror assures that no funds were paid or will be paid, by or on behalf of the Offeror, to any person for the purpose of influencing or attempting to influence any officer or employee of the federal or State government with regard to obtaining a contract.
- f) The Offeror assures its ability to perform all services required under the contract, or, if the Offeror intends to subcontract, the Offeror assures that it will perform the majority of services under the contract and will retain all management and oversight responsibilities.
- g) The Offeror agrees to meet the criteria for the Federal Health Insurance Portability and Accountability Act (HIPAA) as found in the Business Associate Agreement found in Appendix H of Attachment XVI.
- h) The Offeror agrees to comply with the requirements of the Procurement Lobbying Statute. The Offeror has also completed, and returned with the proposal, the "Bid Form" included in Attachment IV of this RFP.
- i) The Offeror agrees to disclose information as required by the Consultant Disclosure Legislation. The Offeror has also completed, and returned with the proposal, "State Consultant Services Form

A, Contractor's Planned Employment from Contract Start Date through End of Contract Term", included in this RFP as Attachment VIII.

- j) The Offeror assures that it conforms to vendor responsibility requirements of State Finance Law. The Offeror has also completed, and returned with the proposal, the "Vendor Responsibility Questionnaire" (Attachment VI) and all other related documentation listed in Section E.8. of this RFP.

Signature of Authorized Official

Date

Attachment IV – Bidders Conference Attendees

Burns & Associates, Inc.
3030 North Third St, Suite 200
Phoenix, AZ 85012
Contact: Mark Podrazik
Phone: 703.313.9772

CMA Consulting Services
700 Troy-Schenectady Rd.
Latham, NY 12110
Contact: Peter Chynoweth
Phone: 518.783.9003

Communication Concepts
10 East Bayberry Rd.
Glenmont, NY 12207
Contact: Tim Cronin
Phone: 518.859.8647

Deloitte Consulting
127 Public Square, Suite 3300
Cleveland, OH 44114
Contact: Christopher Kalkhof
Phone: 216.830.6090
Cell phone: 716.912.0309

Empire Health Advisors
60 Railroad Place, Suite 101
Saratoga Springs, NY 12866
Contact: Jack Knowlton
Phone: 518.583.4900

Health Management Systems
16 Corporate Woods Blvd
Albany, NY 12211
Contact: Chris Haley
Phone: 518.465.4395 Ext. 7840

KPMG
515 Broadway
Albany, NY 12207
Contact: Brian Murphy
Phone: 518.427.4600

Manatt, Phelps
30 So. Pearl St.
Albany, NY 12207
Contact: Mark Ustin
Phone: 518.431.6795

Mercer
3131 East Camelback Rd., Suite 300
Phoenix, AZ 85016
Contact: Justyn Rutter
Phone: 602.522.8555
Contact: Mark Hoyt
Phone: 602.522.6535

Milliman, Inc.
One Penn Plaza, 38th Fl.
New York, NY 10119
Contact: Cathy Murphy-Barron
Phone: 646.473.3204

Navigant Consulting
30 So. Wacker Dr., Suite 3100
Chicago, IL 60606
Contact: Candace Natoli
Phone: 617.748.8332

Policy Studies, Inc.
2009 Old York-Hampton Hwy.
Yorktown, VA 23692
Contact: Christie VanClear
Phone: 757.890.0506
202.904.7372

PricewaterhouseCoopers
80 State St.
Albany, NY 12207
Contact: Rick Henze
Phone: 518.427.4456

TKL Healthcare Consortium
21A Arts Center Court
Avon, CT 06001
Contact: Eric Fishbein
Phone: 860.677.7888

Towers Perrin
335 Madison Ave.
New York, NY 10017
Contact: Pete Lopatka
Phone: 212.309.3492
Contact: Kristin Manzillo
Phone: 212.309.3569

Attachment V

Other Modifications to the RFP

Section D.1.c. Cost Proposal (page 9)

The first paragraph of this section is revised to read as follows:

This is a competitive procurement, which will result in a fixed price budget for analysis of three proposals, plus a composite hourly rate which will apply to any additional proposals the Contractor is asked to analyze.

Section D.1.c.2) Cost Proposal Form (page 10)

This section is revised to read as follows:

Offerors must complete the Cost Proposal Form, Attachment VII, based on the following:

- a) The Cost Proposal Form consists of two parts: A Fixed Price Bid for analysis of three proposals; and, a Composite Hourly Rate Bid for analysis of any additional proposals, as requested by the Department.
- b) The total Fixed Price Bid must reflect all costs associated with analysis of three proposals.
- c) The hourly rates must be inclusive of all costs, including salaries, fringe benefits, administrative costs, overhead, travel, presentation costs and profit.
- d) Include the title, composite hourly rate and number of hours to be worked for each staff person that will work on the project.

Section D.2.d. Acceptance of Deliverables and Payments (page 12)

A new first paragraph is added and the former first paragraph is revised to read as follows:

Prior to beginning a task under the Composite Hourly Rate component of the budget, the Contractor shall submit, within three business days of the Department's request, a plan for completing the task. Such plan shall include the anticipated time frame for completion of the task, the number of hours required to complete the task and the total cost for completion of the task. The plan and any subsequent modification shall be subject to approval by the Department. This requirement may be waived at the Department's discretion where immediate turnaround is required.

Payments will be made for satisfactory performance of the services described, based on the contractual fixed price and composite hourly rate, as agreed upon by the Contractor and the Department, up to the maximum amount payable under the contract.

Section E.5. Payment (page 15)

Items a. and b. of this section are revised to read as follows:

- a. In consideration of the Contractor's satisfactory performance of the services described in the Agreement, the Department agrees to pay the Contractor the contracted fixed price for analysis of three proposals and a composite hourly rate for any additional proposals the Contractor is asked to analyze.
- b. The State will issue payments under the fixed price budget to the Contractor at the percentages shown in the following schedule, provided that the Contractor has provided the corresponding deliverables to the State's satisfaction.