City of Mt. Pleasant
Request for Proposal
for
Medical Plan Administration
and
Excess Risk Insurance

Presented by
Benefit Consulting Group, Inc.
115 ½ S. University
Mt. Pleasant, MI 48858
989-772-4969

Section I
General Information

About this Document

The City of Mt. Pleasant has engaged Benefit Consulting Group, Inc., to assist them in the selection of a third party administrator. The program will be self-insured with an effective date of January 1, 2015.

Objectives

The City of Mt. Pleasant provides benefits to approximately 175 employees and retirees with a total of 411 participants.

We wish to obtain the most competitive administrative and stop loss premium rates.

The City of Mt. Pleasant seeks to partner with an organization dedicated to providing excellent service to employees and the human resources team. Accurate, consistent, timely, and comprehensive management reporting is a critically important aspect of this service commitment, as are hands-on, day-to-day client services support and excellent employee communication tools.

Specifically, The City of Mt. Pleasant seeks a long-term partnership with an organization that:

- Is committed to educating employees and dependents to become better medical consumers;
- Demonstrates best practices in communication design and delivery;
- Has a proven track record of high quality, accurate, and effective medical management services;
- Monitors and measures quality of care;
- Encourages the use of preventive care;
- Is committed to providing employees, retirees, and their families with timely, courteous, knowledgeable, and solution-oriented customer service;
- Demonstrates its commitment to excellent service through investment in employee training and the development of creative service tools;
- Controls medical cost increases; and
- Has the financial strength and contractual arrangements to support a long-term commitment to deliver health care services.

Section II
Response Instructions

This section includes the information necessary for your organization to prepare a complete proposal. To be considered a qualified candidate, you must follow the directions below:

The proposal must:

- Assume January 1, 2015, effective date;
- Include the completed financial exhibits;
- Include a quotation for stop-loss coverage; and
- Provide responses to the all questions in the Questionnaire section.

Proposal Accuracy

Please submit your proposal with a cover letter including a statement, signed by an officer of your company, indicating your ability to duplicate the benefits and administrative arrangement requested. If you are unable to meet all requirements, please note variations in your cover letter. Said letter also should attest to the accuracy of the data you have provided.

Timing

Task	Timing
Release RFP	April 4, 2014
RFP responses due	May 15, 2014
Analysis of responses	May 16 – 31, 2014
Identify finalists and conduct finalist meetings	June 1 – 13, 2014
Present recommendations to management	June 23, 2014
Notification to bidders	June 24, 2014
Implementation	July/September 2014
Open enrollment	October 2014
Program effective date	January 1, 2015

Proposal Submission

Your proposal is due prior to 5:00 p.m., on May 15, 2014. One (1) electronic copy and two (2) hard copies of the completed proposal should be sent to Douglas Janes, as indicated below.

Benefit Consulting Group, Inc.
115 ½ S. University
Mt. Pleasant, MI 48858
Doug@BenefitConsulting.com
Fax: 989-772-3539

Section II
Response Instructions

Questions

Please direct all questions regarding this proposal to Douglas Janes via e-mail or fax. **Do not contact anyone at The City of Mt. Pleasant regarding the RFP process.**

Confidentiality

The materials and information contained in this document or otherwise supplied or revealed by The City of Mt. Pleasant or Benefit Consulting Group, Inc., related to this proposal process is strictly confidential and cannot be disclosed to any third parties without the express written consent of The City of Mt. Pleasant and Benefit Consulting Group, Inc.

Section III
Selection Criteria

These selection criteria are presented to assist your organization in preparing a proposal that thoroughly addresses the City's needs and objectives.

Customer service: Telephone representatives must be courteous, knowledgeable, and well trained. Special consideration will be given to those organizations able to demonstrate a strong commitment to customer service. Examples include extended customer service hours, e-mail access to customer service representatives, designated representatives, and/or web-based tools for claim payment inquiry.

Account management: The account executive and customer service team are highly experienced and responsive.

Financial efficiency: Cost savings are available via managed care network discounts, plan management, and utilization controls. Administration and stop-loss fees are highly competitive with those provided by other vendors. A minimum two-year fee guarantee is required.

Employee communication: Employee communication tools are creative, clearly written, and take advantage of current and emerging technologies. The third party administrator must understand that the employees/retirees they serve span several generations and must have the ability to communicate with all effectively.

Implementation: Commitment to a smooth and on-time implementation process is demonstrated through a detailed implementation plan and timeline, appropriate and experienced staffing, and financial guarantees.

Administration and reporting: A sophisticated and efficient system is utilized, including batch processing of claims, electronic submission of claims, and ability to electronically transfer claims and eligibility data to and from the City. Comprehensive and timely management reporting capabilities are provided.

Health management: Programs with measured return on investment are available to manage individual health conditions and to assist employees in becoming better educated health care consumers.

Client references: Current and former customers must provide positive references.

Performance guarantees: Performance in the areas of network discounts, claim payment accuracy, claim turnaround, customer service, and account management is guaranteed via financial incentives.

Organizational stability: Annual financial reports or other documentation demonstrate long-term financial stability.

Section IV
Educational Support

The City expects up-to-date educational information be available to their HR team in the form of newsletters, webinars, e-mail blasts, etc., as it relates to all aspects of healthcare reform, compliance, and self-funded municipal plans.

Section V
Questionnaire

Each question should appear in your proposal with the response immediately following. Bullet points, or questions within questions, should be considered and answered separately. Responses should be complete yet succinct. Please avoid making references to pre-printed materials.

Responses should be based on current networks, services, administrative systems and programs. Anticipated changes/enhancements should also be described, and proposed effective dates should be clearly indicated.

General Information

1. Provide the name, address, phone and fax numbers, and e-mail address for the person to contact with questions regarding this proposal.
2. Provide the following information regarding the account service team that would be assigned to the City of Mt. Pleasant:

Position	Name And Location	Years of Industry Experience	Years with Organization	Years in Current Position
Account Executive				
Customer Service Manager				
Claims Manager				
Implementation Coordinator				
Corporate Officer				

3. Indicate your company's latest financial ratings from the following rating services:

   a. A.M. Best

   b. Standard and Poor's

   c. Moody's

4. Enclose a copy of your company's latest annual report and/or financial statement, as well as any financial information filed with state(s) regulatory agencies.
5. Are any agreements contemplated or in progress between your business and other parties which may affect the business's ownership, corporate structure, or management during the next year? If yes, please describe.
6. What level of liability insurance does your company carry?
7. In the last three years, how many lawsuits have been filed against your company?
8. Indicate the number of suits (by type) settled out of court and the number settled by a judge or jury.
9. Provide your hold harmless agreement language regarding liability for treatment decisions.
10. Provide the following information on the scale of your health care operations.

	Number of Employer Customers	Number of Covered Employees
<100 employees		
101 – 500 employees		
501 – 1,000 employees		
> 1,001 employees		

11. Will you certify that internal claim processing guidelines and/or stop-loss policy provisions do not violate HIPAA nondiscrimination rules? Examples include actively at work requirements, dependent non-confinement rules, and source of injury restrictions.

12. Please provide the names and contact information for three current and three terminated client references for the account team identified for City of Mt. Pleasant.

13. Please provide us specific client contact information for those clients who are self-funded municipalities.

Customer Service

1. What is the proposed customer service location for the City, and how long has it been in operation?

2. Are claims and customer service operations housed in the same office?

3. Is a toll-free customer service line available?

4. How are calls segmented (e.g., routing of inquiries about claims, requests to identify network providers, generalized member services questions, misdirected medical management calls, etc.)?

5. What information, if any, about network providers will you provide to a caller upon request (e.g., specialty, board certification, medical school attended, office hours, foreign languages spoken, etc.)? Will there be links to network providers on the self-service portal?

6. What are the hours that the phone lines will be staffed on an ongoing basis? During implementation?

7. What is your ratio of customer service representatives to enrolled members?

8. Describe your customer service internet capabilities in detail (enrollment, COB information, claims tracking, EOB availability, reporting, in-portal communication, HRA balances, etc.).

9. Describe your customer service tracking system. What issues are raised most frequently? Is a monthly report available? Provide a sample report.

10. What mechanisms are in place to protect PHI and other sensitive information when communicating securely with The City of Mt. Pleasant (ZixCorp, etc.)?

11. Do you survey employees and other plan participants regarding their satisfaction on an ongoing basis? If so, provide a copy of your most recent participant satisfaction survey results. Describe any action taken as a result of this survey.

12. Provide the following statistics for the customer service office that will handle the City's plan.

Section V
Questionnaire

Performance Measure	2013	2014 YTD	Target
Average customer service telephone response time			
Average e-mail response time			
Call abandonment rate			
Average turnaround time to resolve issues relating to claims			

13. After program start-up, what is the average delivery time for ID cards and printed materials, including provider directories, program descriptions, and out-of-network claim forms? Will this information be made available electronically as well? Is there an option to deliver printed materials electronically?

Claims Administration

1. What is the proposed claims administration location for the City, and how long has it been in operation?
2. How long has the proposed claim system been in use?
3. Describe claim system changes planned for the next two years.
4. Please describe the claims payment process from the time a claim is received until it is paid.
5. Describe how reimbursements are distributed. What security measures are in place to ensure that reimbursements are issued to the proper party? Describe how you handle overpayments and collections.
6. How are pended claims tracked and monitored? How often are follow-ups prompted? Who is responsible for the follow-up? What is the average turnaround time for pended claims?
7. How long is individual claim history maintained on-line?
8. Describe the claim exception process.
9. Describe your capabilities to perform the following for professional and facility providers, indicating any variations by type of provider and procedure.
    a. Detecting fee unbundling and other overcharging.
    b. Automatic editing to flag questions on medical necessity and appropriateness, as well as possible provider abuses.

c. Cross-applying in-network and out-of-network deductibles and out-of-pocket maximums.
d. Specific attention to the City's 90 mile in/out of network provider rule.

10. What percentage of "clean" claims received is automatically adjudicated by the respective claims systems? What percentages of claims are submitted electronically by providers in the office(s) that will process City's claims?

Hospital	_____% AA	_____% EDI
Physician	_____% AA	_____% EDI
Other Providers	_____% AA	_____% EDI

11. Describe the method and level of integration between the claims payment system and the eligibility, medical management, member services and case management functions.

12. Do you apply R&C criteria to out-of network claims? What R&C data do you use? What percentile of R&C do you typically apply? What options are available?

13. To which specific procedures does R&C apply (e.g., office visits, X-ray, lab, etc.)? How often are the R&C profiles updated?

14. How will transition of care/provider issues be handled? What is your policy regarding transition of maternity cases, etc.?

15. Describe the appeals process for denied claims. Do you contract with an outside vendor to settle disputes related to appeal and grievances?

16. Describe COB procedures for in-network and out-of-network claims. How do you determine COB savings for Medicare eligible? For non-Medicare eligible?

17. Submit an example of your standard EOB.

18. What provider specific data is loaded into your claims system for contracted network providers? What percent of network fee schedules are on-line? How often is the claims system updated for new contracts?

19. Provide the following statistics for the claim office that will handle the City's plan.

Performance Measure	2013	2014 YTD	Target
Claim processing accuracy *(Number of claims processed with 100 percent accuracy divided by number of claims)*			
Financial accuracy *(Dollars paid correctly divided by dollars paid)*			

Average turnaround time *(Period from the date a claim is received until the date the transaction is processed completely and an EOB is issued)*			
Non-Medicare COB savings as a percentage of paid claims			
Average e-mail response time			
Average customer service telephone response time			
Call abandonment rate			

20. If you utilize other administrative and financial accuracy benchmarks, please provide information.

21. Describe internal audit procedures. What percentage of claims is audited? How are claims selected? Are audits conducted before or after claim payment? Do you have dedicated internal audit staff?

22. Do you offer clients on-line eligibility reporting and claim inquiry capabilities? If so, briefly describe them.

23. Describe your standard approach to subrogation. Is subrogation included in your basic administrative fee? What is the dollar threshold? Do you utilize an outside vendor for subrogation?

24. Will you accept liability for claim processor negligence? Fraud?

25. In the case of termination, what are your provisions for handling claims run-out? What are the fees?

26. Please describe the enrollment and eligibility data management methods.

27. How do you provide communication assistance to employees during the pre-enrollment and enrollment process?

28. How will you provide services to people not able to access/uncomfortable with the Internet?

29. Please describe your Internet and data security. How will you protect the personal health information of the members?

30. What cost and quality information will be available to employees?

31. Will employees have the option/capability to receive price estimates for medical procedures?

32. How will you provide employees with the tools to make informed decisions regarding their health?

33. How do you assist in improving the health of your membership?

Medical Management

1. Do you provide the following services? Check all that apply.

Service	In-Network	Out-of-Network
Pre-certification		
Concurrent stay review		
Retrospective utilization review		
Discharge planning		
Individual case management		
Psychiatric care review		
Inpatient surgical review		
Outpatient procedure review		
Outpatient diagnostic test review		
Hospital audits		
Disease management		
Health education		

2. How is medical management data integrated with the claim system? How is the claims processor notified when a claim has been or is subject to medical management review?

3. Where would the medical management for the City be performed? Is medical management handled in house or contracted to a third party?

4. Describe the qualifications of the staff involved in utilization management determinations.

5. Discuss education and experience, requirements and the role and responsibilities of the medical directors.

6. Identify the number of full-time, board certified medical directors on staff.

7. Briefly describe your case management program, including any qualitative and quantitative results.

8. What enhancements have been made to your case management program within the last year and what changes are being planned for implementation within the next year?

9. Describe how you propose to transition case management participants from the current program to your program.

10. For substance abuse and mental health treatment services:

    a. Do you utilize specialized medical management staff for mental health and substance abuse claims? Are these services sub-contracted? If so, please identify the contractor.

    b. What guidelines do you use to determine the appropriate length of inpatient confinement?

    c. How do you identify situations that require case management?

    d. What guidelines do you use to manage outpatient treatment?

11. Do your case managers refer to hospitals, convalescent facilities, rehab centers, etc., that have contractual agreements with your organization? Does your organization have contractual agreements with home health agencies or durable medical equipment suppliers for patients in your large case management program? If so, what kinds of arrangements do you have?

12. Do you offer a Centers of Excellence program? If so, please describe it in detail.

13. Describe the methods your Medical Management program(s) uses to target areas where you believe you can make a difference in managing healthcare utilization and costs.

14. Do you offer a service such as a "24 hour nurse/care line" through which registered nurses provide answers to participant medical questions? If so, describe the program. During what hours is the line open? What is the average hold time?

15. Can you provide self-help books and other wellness materials to city employees? If so, is there an additional and fee and what is it?

16. Do you offer health risk assessments and analysis? If so, is there an additional and fee and what is it?

17. Do you offer disease management programs? If so, is there an additional and fee and what is it?

18. Is participation in disease management programs voluntary? How do members enroll? Which diseases do you target?

19. How do you measure outcomes for these disease management programs?

Exhibit E
Excess Claims Experience

Eligibility

1. What type of eligibility information is required? What is your preferred medium for accepting this information?
2. Can you accept enrollment information electronically?
3. Do you have internet enrollment capability?
4. Can monthly enrollment data (adds, deletes, changes) be reported to the City's vision and flex spending providers?
5. Describe the process used to update and maintain eligibility information on an ongoing basis.
6. Describe any online systems for eligibility maintenance available. Who, at your company, has the authority to change eligibility data (with respect to individual changes that may be requested from time to time over the phone)?
7. Describe how your system handles eligibility changes for employees and dependents. What resources are required of the City? Include the following:
   a. Identifying dependents exceeding or nearing a plan's limiting age
   b. Identifying disabled dependents
   c. Identifying full-time students
   d. Adding or deleting a spouse
   e. Adding a newborn

Management Reporting

1. Indicate whether the following reports are included in a standard reporting package, or if they are available on a custom basis. Provide samples of actual reports you currently produce (deleting customers' names) which demonstrate your ability to meet the reporting requirements.

Report Type	Standard	Custom	Frequency	Cost
Claim and Utilization				
Monthly paid claims				
Large claims				
In-network/out-of-network usage				
Claim lag (triangle)				
Paid claims by payment range				

Paid claims by MDC or IDC-10				
Hospital admission data				
Adjudication report (from submitted charges to paid amounts)				
Type of service				
Utilization review activity				
Claim detail				
Other				
Enrollment summary				
By coverage tier				
By demographic profile				
Financial				
Renewal package				
Settlement (annual accounting)				
Banking reconciliation				

2. Please describe any web-based reporting capabilities that you would be able to provide to the City. Will the City be able to produce ad hoc reports via the Internet?

3. Describe your ability to provide ad hoc reports. Do you charge for such reports?

4. Describe any proactive review of the City claims experience you will provide to identify trends and/or potential case or disease management opportunities?

5. Please describe your abilities to provide normative utilization and cost data. Include description of and source of normative data, frequency of updating and adjustment methodologies (i.e., case mix).

Section V
Questionnaire

Banking Arrangements

1. Describe the banking process you recommend for claims reimbursement, including your audit trails, bank reconciliation systems, and funding options and also the authorization process for requesting wire transfers.
2. Who performs the bank account reconciliation and how often (i.e., weekly, monthly, etc.)? How will differences and discrepancies be resolved?
3. Please confirm that you will accept self-billing of ASO fees. If not, please explain.
4. What types of financial reports will be generated in conjunction with the banking reconciliation and edit/auditing procedures? Please show examples.

Performance Guarantees

Provide your suggested performance guarantees/risk sharing in the following areas:

1. Plan implementation
    a. Provider directory distribution
    b. ID cards
    c. Overall satisfaction
2. Customer service

Telephone answering time

    a. E-mail response time
    b. Telephone abandonment rate
3. Claim administration
    a. Claim financial accuracy
    b. Claim processing accuracy
    c. Claim payment accuracy
    d. Claim turnaround time
    e. Problem resolution
4. Account management
5. Member satisfaction (via survey)

Section V
Questionnaire

In developing your fees, assume the following:

- A self-insured, ASO funding arrangement.
- All claims incurred on or after January 1, 2015, will be covered under this arrangement. The current administrators will be responsible for paying all claims incurred prior to January 1, 2015, under the current arrangements.
- Identify separately any "first year" implementation fees.
- A three-year contract period, with fees guaranteed a minimum of two years and, preferably three years.
- All charges and fees are to be quoted on a per employee, per month basis.
- Specifically identify any qualifications or contingencies on your proposed fee guarantees.
- No commissions should be included in your quote. If a financial or other arrangement exists between your organization and Benefit Consulting Group, Inc., the issuer of this proposal, please describe the arrangement, including the impact on rates for fees or any other type of remuneration.
- Future proposed fee changes must be provided no later than 90 days prior to a contract anniversary date.
- All medical claims will be paid directly to providers or employees by your organization. Your personnel will respond directly to inquiries from the City's HR representatives and/or employees as necessary.
- No actively-at-work and dependent non-confinement requirements will apply.
- Your organization will bear the cost and responsibility for securing claim history from the current administrator.
- Administrative fees should include the cost of all normal claim-processing services. Other services to be included in the fee are:
  - Utilization review and medical management services;
  - Administrative materials such as the contract, plan documents, and booklets;
  - Management, financial, and performance reports;
  - Toll-free telephone line for employees and HR staff;
  - Dedicated claim and service units;
  - An administrative manual that documents material pertinent to successful administration of the program; and

- All other services needed to administer the program described in these specifications (including directories, ID cards, and out-of-network medical claim forms);
- At least 25 hours of ad hoc reporting each year; and
- Basic underwriting services on an annual basis.

The City reserves the following rights:

- Right to receive all claim data — All claim records and supporting documentation are the property of and will be made available to the City as needed. The City has the right to determine which records or facts are needed and the carrier/administrator agrees to provide the information within a reasonable time frame at no additional cost.
- Future transition — In the event that the City subsequently transfers the program to another carrier/administrator, the vendor must agree to provide the successor carrier/administrator with claim history, prior eligibility data, and any other claim records deemed necessary by the City in a timely manner. The vendor must make every effort to cooperate with the successor and the City in order to facilitate the transition. Final accounting and settlement of claims and fees must be completed within 12 calendar months of termination.
- Right to audit — the City has the right to audit medical claim files, eligibility records, and/or financial accounting data. **The City will not be held responsible for costs incurred by the claims administrator in connection with these audits.**

Section V
Questionnaire

Other Services and Related Charges

Provide fees for services listed along with any other fees not covered elsewhere in your proposal. Please indicate which services are included in the basic administrative fees quoted.

Fee Quotations (All Coverages)

- If your organization has quoted an implementation fee, please outline the services that your fee is intended to cover.
- Please list any other miscellaneous administrative fees not yet reported.
- How are fees and reimbursement rates determined in subsequent years?
- Are there any other start-up fees not included in the exhibits?
- Please provide a sample of a monthly administrative services invoice and corresponding supporting documentation.

Stop-Loss Coverage

Provide stop-loss quotations using the following assumptions and table:

- Quote individual, specific stop-loss at $125,000, $150,000, $175,000 and $200,000 attachment points.
- Contracts should be quoted on a 12-month incurred/paid in 12 months and a 12-month incurred/paid in 15 months basis.
- Specifically identify any qualifications or conditions on your rate guarantees. Rates should be guaranteed for two years, at a minimum.

Each plan year runs from January 1 to December 31.

Stop Loss Coverage is offered through independent carriers with ratings of A or above. Each carrier may have differing responses to each request below.

Section V
Questionnaire

Additional Information:

- Fully describe the specific disclosures, procedures, and activities required of the City by your organization to effect and maintain stop-loss coverage.
- Note any variations in covered benefits, exclusions, or internal limitations between the stop-loss coverage and the medical plan's benefit provisions.
- Does the policy provide for unlimited reimbursement in excess of the specific deductible?
- What are the policy's standard provisions regarding the timing of policyholder reimbursement? Do you pay interest? If so, on what basis?
- Describe your policy's definitions of when a claim is incurred and when it is paid.
- What are your standard policy provisions regarding coverage of the following classes of participants?
  - Disabled employees (and their dependents); and
  - COBRA beneficiaries.
- Describe how the following types of claims would be covered under the provisions of your stop-loss policy on its effective and renewal dates:
  - Adjudicated, but pended;
  - Not paid or fully adjudicated;
  - Checks issued but not cashed;
  - Reissued checks or drafts;
  - COB payments and audited claims;
  - Subrogation (or third-party reimbursement); and
  - Claims spanning policy effective or renewal date