



Request for Proposals

RFP – 2016-11-34
Employee Health Insurance

Sealed proposals will be received until
12:00 p.m. on Thursday June 16, 2016

Return RFP To: *City of Copperas Cove*

 Attn: Velia Key

 914 South Main Street, Suite H

 P.O. Drawer 1449

 Copperas Cove, TX 76522



TO: Interested Insurance Carriers

RE: Request for Proposal City of Copperas Cove Employee Benefit Trust

May 13, 2016

Insurance Carriers:

I am writing to your company on behalf of the City of Copperas Cove Employee Benefit Trust, hereafter referred to as the "Planholder", requesting that you prepare a proposal reflecting your charges for Health Insurance. Our current Health Insurance is underwritten by Scott & White Health Plan.

The City of Copperas Cove is one of the largest local employers with about 275 full time employees providing police and fire protection, library services, water and sewer services, and parks and recreation as well as many others.

Deadline for any questions or requests for clarification must be submitted to Velia Key, Director of Finance, prior to 12:00 pm May 27, 2016. All questions must be sent via email to vkey@copperascovetx.gov. There will be no exceptions. All responses to the questions will be sent to all Proposers.

Submission of Proposals: Please provide **Two (2) copies of all proposal documents, along with one (1) electronic version of the submission in a PDF and Excel format on DVD/CD**. Proposals must include all exhibits and answers to specific questions and shall be sealed and submitted **no later than 12:00 pm on Thursday June 16, 2016 to:**

Mailing Address:

**City of Copperas Cove
Attn: Finance Department
P.O. Drawer 1449
Copperas Cove, TX 76522**

Delivery Address:

**City of Copperas Cove
Attn: Finance Department
914 South Main Street, Suite H
Copperas Cove, TX 76522**

MARK ENVELOPE: "RFP NO. 2016-11-34; EMPLOYEE HEALTH INSURANCE"

Late proposals will not be accepted.

Selection: Recognizing the fact that there are very important considerations involved in selecting an insurance carrier, the Planholder is not bound to accept the lowest proposal. The Planholder reserves the right to reject any or all proposals or to accept any proposal deemed advantageous to the Planholder. The award of the contract shall be made to the responsible offerer, whose proposal is determined to be the most advantageous offer resulting from negotiation, taking into consideration the relative importance of price and other evaluation factors set forth in the Request for Proposals in accordance with Texas Local Government Code, Chapter 252. Proposals will be evaluated based on the following criteria and in the following order (with #1 being the most important):

1. OFFERER'S GROSS PREMIUM (40%)
2. OFFERER'S AVAILABILITY OF LOCAL PHYSICIANS & HEALTH CARE FACILITIES (25%)
3. OFFERER'S SUPPORT/SERVICES PROVIDED INCLUDING ABILITY TO ENHANCE THE CITY'S ROBUST WELLNESS PROGRAM AND THE COMMITMENT YOUR ORGANIZATION CAN PROCESS 834 FILE FEEDS WITH THE CITY'S ONLINE ENROLLMENT PLATFORM, PLANSOURCE (20%)
4. OFFERER'S QUALIFICATIONS/EXPERIENCE (15%)

QUALIFICATIONS

1. All companies submitting proposals must be licensed by the State of Texas and be permitted to contract with the State or any of its subdivisions. Further, it is preferred that companies be recommended in the latest edition of Best's Life Insurance Reports with a general policyholder's rating of A.
2. Companies who fall under the guidelines of the Texas Political Subdivision Uniform Group Benefits Act (Chapter 172 Local Government Code) and the Interlocal Cooperation Act (Article 4413 (32e)) Vernon's Texas Civil Statutes will be acceptable.
3. All companies must be authorized and able to do business with an Employee Benefit Trust, and comply with providing rates excluding premium taxes.

PLAN ADMINISTRATION QUALIFICATIONS

Planholder Responsibility

- The Planholder will provide for payroll deductions of premium and Planholder's Enrollment system PlanSource will notify the carrier of additions/deletions from the coverage through weekly file feed. The Planholder will assist in the logistics of the enrollment process.

Selected Carrier Responsibility

- The carrier **will** provide claim instructions, employee booklets outlining the benefits and instructions on filing a claim, and orientation materials. The carrier **will** participate in Open Enrollment meetings scheduled at the convenience of the City, which may include early morning and/ or evening meetings. The carrier **will** provide online access to identification cards, EOB's, Health and wellness tools and appropriate communication materials deemed necessary by the Planholder to properly administer the Plan of Benefits.
- The carrier will provide the following monthly claim reports:
 1. Summary of Paid Claims
 2. Summary of Paid Claims by Covered Person (employee, dependent)
 3. Summary of Paid Claims by Benefit
 4. Upon request, summary of Claims in excess of \$10,000 including diagnoses and prognosis

GENERAL INFORMATION AND INSTRUCTIONS

1. All proposals must be received at the designated location by the deadline shown. Proposals received after the deadline shall be considered void and unacceptable. The City of Copperas Cove Employee Benefits Trust is not responsible for non-delivery of mail, carrier, etc.
2. Proposals are anticipated to provide a 12-month rate guarantee, with a contract period of October 1, 2016 through September 30, 2017. Preference will be given to companies that are able to provide multiple year rate guarantees based on claims performance. Premium rates proposed must be firm and not subject to change based upon enrollment.
3. The Planholder reserves the right to reject any and all proposals and to accept any proposal deemed advantageous to the Planholder. Receipt of any proposal shall under no circumstances obligate the City to accept the lowest dollar proposal. The award of this contract shall be made to the responsible Proposer whose proposal is determined to be the highest evaluated offer resulting from negotiation, taking into consideration the relative importance of price and the other evaluation factors set forth in the Request for Proposals.
4. Any direct contact by proposers or their representatives to any City officials, City Manager, or staff involved in the RFP process, other than those listed within this RFP as authorized is strictly prohibited and could result in disqualification of the proposal.
5. The Carrier must submit evidence of ability to service the group without undue requirements of the Planholder. Each Carrier should list as references groups that it services that are approximately the same number of participants as the City of Copperas Cove Employee Benefits Trust. References

may be checked if deemed advisable. (Form provided)

6. Your proposal must conform in all respects to the specifications outlined in this letter and attached exhibits. If your company's practice prohibits you from submitting a proposal on the same basis as outlined in the specifications, you may submit a proposal on a basis that is in accordance with your practice. Please state clearly, in detail, any deviation from the specifications outlined in this letter with complete reference to the provision from which the deviation is being made.
7. Proposals must be based on benefits similar to the current plans; the current plans include routine vision exams. The current plan is fully insured, however all funding options for health care coverage will be considered, including; partially Self-Funded or Level Funded options. Please include any cost saving network options that may meet the city's needs for insurance and must include coverage for Chiropractic care. Provider Networks should include the Major Hospital Systems within the City's geographical area including, Baylor Scott & White Hospital, Metroplex and Seton. Network options may include, HMO, PPO, POS, and offer plans that will coordinate with FSA, HRA and HSA's. The current plan with Scott & White Health Plan is through an agent; a proposal submitted to provide health care benefits should be inclusive of 1% (one Percent) commission.
8. HIPAA Compliance with Privacy & Confidentiality guidelines will be required. Specifically, Plan Sponsor certifies that:
 - PHI will not be used or disclosed other than as permitted by plan documents or required by law;
 - Any agents and subcontractors of Plan Sponsor have agreed as part of their contracts with Plan Sponsor to the same restrictions and conditions with regard to use of PHI; and
 - PHI shall not be used for employment or benefit-related decisions.
9. Proposals must include coverage on all eligible full-time employees and with optional coverage available for dependent coverage. Fulltime is defined as 30 hours or more per week. Dependent is defined as the employees' legal spouse and/or domestic partner as well as child(ren) from birth to age 26. Adopted child(ren), stepchild(ren) or foster child(ren) who is in a legal parent-child relationship is also classified as eligible dependents. Children who are currently disabled will be covered as long as they are totally disabled and dependent upon support from their parents.
10. Waiting Period: Newly hired employees and their dependents must complete up to a 90 day waiting period before becoming eligible for coverage.
11. Eligibility: All full-time employees and their dependents are eligible for benefits on the 1st of the month following 60 days of employment. Retired employees and their dependents may continue participation after retirement through their continued payment of premiums or under COBRA. Terminated employees may continue coverage under COBRA.
12. If proposed contracts are to replace existing contracts of the same type, the new contract must assume the current policy benefit structure and provide a "no loss / no gain" assumption of risk, and give credit for all annual deductibles.
13. The employee has the option of electing to pre-tax 125 premiums for out of pocket expenditures for health insurance premiums.
14. Currently the employer offers three plans with the current carrier with the employer paying the same fixed amount towards all plans. The employee has the choice of which of the three plans they want to elect. The employer pays 0% of the dependent premium and 0% of the retiree premium on all three plans offered. This is subject to approval by the governing body.
15. Please complete the appropriate enclosed proposal forms, these attachments include:
 - Vendor Information (Attachment A)
 - Proposal form including rate information (Attachment B)

- Summary/Comparison of benefits (MUST be completed in Excel) (Attachment C)
- References (Attachment D)
- Questionnaire (Attachment E)

All who submit proposals, including the current carrier or administrator, shall complete the proposal forms provided. An authorized official of the carrier must sign all proposal forms submitted.

Please remember to include a declaration of compliance for HIPPA within your RFP submission.

FAILURE TO COMPLETE ALL PROPOSAL FORMS MAY RESULT IN PROPOSAL BEING DISQUALIFIED

Enclosed are the following Attachments which, together with the letter, will serve as the basis for your proposal.

ATTACHMENTS:

- Attachment A - is the form to provide your information.
- Attachment B - is the form for your Health Insurance costs quotation based on a fully funded plan.
- Attachment C - is the form to provide a comparison of the plan benefits submitted in the proposal to provide a comparison to current plans. Complete the form in Excel for each plan proposed.
- Attachment D - is the form to provide information on references.
- Attachment E - Questionnaire contains specific information for your company to provide. If you do not use the form for your responses you need not repeat the questions, however, your answers must be numbered in accordance with the questionnaire.

EXHIBITS: The Exhibits listed will only be provided on written request to Velia Key, Director of Finance, City of Copperas Cove, via email at vkey@copperascovetx.gov.

- Exhibit A - Current health plan benefits summary.
- Exhibit B - Current health insurance premium rates, claims and participation history.
- Exhibit C - Census data for all full time employees.
- Exhibit D - Census data for retirees and COBRA participants.
- Exhibit E - Claims Data for current plans; additional information on claims/claimants will be provided in accordance with HIPPA regulations.

In preparing your premium quotations, please use the forms provided and include the signature of your authorized representative.

The City of Copperas Cove is aware of the time and effort you expend in preparing and submitting proposals to the City of Copperas Cove. Please let us know of any requirements in the RFP, which are causing you difficulty in responding. We want to make this process as easy as possible so that all responsible vendors can compete for the City of Copperas Cove's business.

If you have any questions, please direct all inquiries in writing to **Velia Key, Director of Finance, via email at vkey@copperascovetx.gov, prior to 12:00 p.m. on Friday May 27, 2016. There will be no exceptions. All responses to the questions will be sent to all Proposers.**

We look forward to receiving your proposal. This letter provides you with the information necessary for you to submit a proposal, which includes complete and carefully prepared information for consideration by the Planholder. Remember that when submitting proposals, **two (2) copies along with one (1) electronic version of the submission in a PDF and Excel format on DVD/CD** of all documents, attachments, and answers to specific questions shall be sealed and **submitted no later than Thursday June 16, 2016, at 12:00pm.**

Vendor Information

Name of Organization	_____
Date Founded	_____
Name of Contact Person	_____
Title	_____
Phone Number	_____
Address	_____ _____
Email	_____
Fax Number	_____
Website	_____

PROPOSAL FORM

The undersigned, does hereby declare that they have read the specifications for Group Health for the Planholder, and with full knowledge of the requirements, does hereby agree to furnish the administrative services in full accordance with the specifications and requirements. The undersigned also agrees to duplicate present coverage and if not, will attach itemized detail of any differences.

Please provide monthly health care costs in the table below.

	Proposed Plan 1	Proposed Plan 2	Proposed Plan 3
Employee only			
Employee & Spouse			
Employee & Children			
Employee & Family			
Retiree <65			
Retiree & Spouse			
Retiree & Children			

Health Plan Carrier: _____

Address _____

Printed Name _____ Title _____

Signature: _____ Date _____

(Electronic format is provided/ **MUST be completed in Excel**)

Carrier			
In-Network benefits	High Plan	Low Plan	HDHP/ Plan HSA Compatible
Plan Name			
Individual/Family Calendar Year Deductible			
Co-Insurance			
Individual/Family Out of Pocket Maximum			
What benefits apply toward Out of Pocket Maximum			
Preventive Visit Copay			
Physician Office Visits/ Specialist Office Visits			
Lab & Radiology Services/ Imaging (CT/MRI/PET)			
Urgent Care Copay			
Emergency Room Copay			
Outpatient Surgery			
Inpatient Hospital / Facility Fee			
Prescription Deductible/Co-Pay/Co-Insurance (Retail)			
Prescription Deductible/Co-Pay/Co-Insurance (Maintenance)			
Outpatient Specialty Drugs Deductible/Co-Pay/Co-Insurance			
Out of Network Y/N			
Medical Rates	Proposed Rates (Even Numbers Please)	Proposed Rates (Even Numbers Please)	Proposed Rates (Even Numbers Please)
Employee			
Employee + Child/ren			
Employee + Spouse			
Employee + Family			

** Complete this document for each plan proposed**

Attachment D

Please provide **four** references that have been insured with your company for at least three years.

<p>COMPANY: _____ Number of employees _____</p> <p>Contact Person: _____</p> <p>Title: _____</p> <p>Address: _____</p> <p>_____</p> <p>City: _____ State _____</p> <p>Zip Code: _____</p> <p>Phone Number: _____ Fax # _____</p> <p>Email: _____</p>
<p>COMPANY: _____ Number of employees _____</p> <p>Contact Person: _____</p> <p>Title: _____</p> <p>Address: _____</p> <p>_____</p> <p>City: _____ State _____</p> <p>Zip Code: _____</p> <p>Phone Number: _____ Fax # _____</p> <p>Email: _____</p>
<p>COMPANY : _____ Number of employees _____</p> <p>Contact Person: _____</p> <p>Title: _____</p> <p>Address: _____</p> <p>_____</p> <p>City: _____ State _____</p> <p>Zip Code: _____</p> <p>Phone Number: _____ Fax # _____</p> <p>Email: _____</p>
<p>COMPANY: _____ Number of employees _____</p> <p>Contact Person: _____</p> <p>Title: _____</p> <p>Address: _____</p> <p>_____</p> <p>City: _____ State _____</p> <p>Zip Code: _____</p> <p>Phone Number: _____ Fax # _____</p> <p>Email: _____</p>

QUESTIONNAIRE

1. Please describe your company, including the structure of your company (date established, number of employees, number of insured, corporation, partnership, sole-proprietorship, etc.).
 - a. Is your company independently owned or affiliated as either a subsidiary or division of some other organization?
 - b. If affiliated with another organization, what is the major business of the parent firm?
 - c. Is any attempt or actual takeover of your company in progress? Are you planning or executing any acquisition that involves group business in excess of 20% of your current portfolio?
2. Is your company licensed to do business in the State of Texas?
3. What office would handle the general servicing of this account? What are the standard office hours for this service office?
4. How many claims processors do you currently have employed?
5. How many dedicated customer service representatives will be assigned to this account?
6. Are customer service representatives separated from the claim-processing unit, or do claim processors have customer service responsibilities?
7. Do customer service representatives have on-line access to current claim processing information?
8. Do Planholder's employees have on-line account access? If yes, please describe.
9. The City utilizes PlanSource as their Online Benefits Enrollment system. This robust system provides online enrollment for all Employee Benefits, houses carrier billing and ACA reporting. PlanSource is the system of record for eligibility and coverage elections. Please provide confirmation that your company will allow self-billing and that your company has the ability to receive and process a EDI (Electronic Data Interface) 834 file feed on a weekly basis. What is your standard timeframe for set up and testing? How are discrepancies handled? Will your company be willing to provide a cost offset for ongoing administration of the PlanSource system? IF so, will this be in the form of a premium reduction or wellness credits. Please outline your response.
10. What are your most recent turnaround times for claim processing and payments? How do you define "turnaround time"?
11. Which type of claims processing characterizes your method of claims processing that you will use on this account? Manual or Manual Assisted (i.e. partially computerized) or fully computerized.
12. Describe your procedures for handling appeals of denied or disputed claims.
13. How do you establish "usual and customary" or "reasonable and customary charges"?
14. Do you have any special programs you provide to plan members who speak a language other than English as their primary language? If yes, please describe. (Be sure to indicate any additional costs for these programs.)

QUESTIONNAIRE (cont.)

15. How are the identification cards distributed to enrolled employees?
16. Are the rates quoted guaranteed for 12 months? Are you willing to provide a multiple year rate guarantee based on claims? If so, please outline your requirements.
17. Your contract must provide that any changes to the premium rates be effective on the policy anniversary with the additional provision that advance notice be given to the City by the last work day of April preceding the effective date of the change. Is your company willing and able to comply with these provisions?
18. Will your company honor deductibles, which have been satisfied for the current calendar year? If so, what evidence would need to be furnished?
19. Will employees retain freedom to choose their own physician? If no, how are physicians selected?
20. Please provide a GEO Access report of In-Network Participating Hospitals within a 100 mile radius of zip code 76522. Please provide the URL link for your companies Provider directory for the City of Copperas Cove employee service area.
21. Does your company have their own network? If so, how are providers in the network credentialed?
22. How are providers and members of the network identified? Can the plan sponsor or plan participants nominate providers to be considered for inclusion in the network panel? If so, what steps would be required to be made by the plan sponsor and/or participant?
23. Describe the nature of the network structure (e.g. staff model, IPA) network sponsor (e.g. MCO, provider, insurer, other,).
24. What geographic areas constitute the service areas of the network?
25. How do you define whether an employee is within a service area (e.g. three digit zip, county)?

QUESTIONNAIRE (cont.)

26. Describe how participants select network providers. Do you provide member support services for selecting and/or locating network physicians and for answering provider credential questions that members may have? Do you have on-line access to network provider listings and locations to assist members with provider selection? What other member services are provided with regard to provider selection assistance.
27. What assistance do you provide plan members if a network physician terminates their contract during the plan year? How and when are members notified? What happens to patients that are receiving on-going treatment from that network provider?
28. Do you have a schedule of mandatory second opinions? Please include your schedule. What procedures require pre-authorization? Is there a penalty for not pre-authorization. What other cost containment procedures do you have in place including step therapy, Coordination of care, Disease management?
29. What provisions are made for emergency care when the employee is away from the service area?
30. Do you monitor waiting times for patient appointments? If so, what is the average waiting time for a patient with an appointment to be seen by a physician? What is the average waiting time for a patient to be seen when scheduling a wellness appointment?
31. What health education and/or wellness programs are available through your organization? Please describe in detail. Is there an additional cost for any of these services?
32. Will you agree to notify the contract holder immediately if the network loses any accreditation, licenses or liability insurance coverage, security or bonding?
33. Explain what provisions you have made in order to comply with any state regulatory requirements in Texas.
34. What are the termination provisions of your contract?
35. Will you administer COBRA benefits for the Planholder? Please explain. Is there an additional charge?
36. Are there any other services, which you would be willing to provide that are not shown in these specifications?

Carrier	
In-Network benefits	High Plan
Plan Name	
Individual/Family Calendar Year Deductible	
Co-Insurance	
Individual/Family Out of Pocket Maximum	
What benefits apply toward Out of Pocket Maximum	
Preventive Visit Copay	
Physician Office Visits/ Specialist Office Visits	
Lab & Radiology Services/ Imaging (CT/MRI/PET)	
Urgent Care Copay	
Emergency Room Copay	
Outpatient Surgery	
Inpatient Hospital / Facility Fee	
Prescription Deductible/Co-Pay/ Co-Insurance (Retail)	
Prescription Deductible/Co-Pay/ Co-Insurance (Maintenance)	
Outpatient Specialty Drugs Deductible/Co-Pay/Co-Insurance	
Out of Network Y/N	
Medical Rates	Proposed Rates (Even Numbers Please)

Employee	
Employee + Child/ren	
Employee + Spouse	
Employee + Family	

** Co

Low Plan	HDHP/ Plan HSA Compatable
Proposed Rates (Even Numbers Please)	Proposed Rates (Even Numbers Please)

Complete this document for each plan proposed**