## PROPOSAL SPECIFICATIONS

### 1.1 Background Information

Williamson County has a self-insured Medical benefit program administered by Aetna Inc. utilizing both Aetna's Choice POS 2 network and The Seton Health Alliance ACO. The County offers Four (4) Medical plans. These plans differ by network, deductible and co-insurance amounts.

The County's current ISL is $250,000 and the Aggregate is a 120% corridor.

This RFP is for:

Specific & Aggregate Stop Loss Insurance

The County does not have the staff to increase their job functions being performed currently. Therefore, any carrier/administrator must be willing to meet all the stated current services as a minimum and clearly outlined in his or her Proposal any deviations from those stated within the RFP.

You must specify any and all deviations in your Proposal and the RFP on the "Statement of Compliance". **It will be assumed that your Proposal is in compliance if deviations are not noted in the "Statement of Compliance".** This RFP has outlined the services the County expects as a minimum requirement.

Any prospective Respondent will be responsible for having qualified personnel and computerized systems capable of handling a case of this size and the flexible plan of benefits. The Respondent must provide references and proof of the provider's ability to serve satisfactory to the County. This Contract will not be based upon cost alone but will place equal importance on ability to pay claims timely and accurately, and on the ability of the provider to serve satisfactorily to the County.

It is not the intent of the County that commissions are built into the Proposals. Commissions, fees or other reimbursement arrangements are prohibited. Each Respondent must sign the **Non- Collusion Affidavit enclosed or their Proposal will not be considered.**

**If you have any technical questions about the specifications, please put all questions in writing to the attention of the Purchasing contact at khancock@wilco.org and copy purchase@wilco.org.**

***FOR AN ELECTRONIC COPY OF THE CENSUS OR INFORMATION ON CLAIMS THAT ARE 50% OF THE INDIVIDUAL SPECIFIC, PLEASE SUBMIT YOUR REQUEST IN WRITING*** **TO khancock@wilco.org and copy purchase@wilco.org**

### 1.2 General Carrier Requirements

#### 1.2.1 Specific Stop-Loss

Williamson County is looking to go to a 14 month contract from 1/1/17 through 12/31/17. The requested specific is for $250,000 Deductible and should be a 24/14 paid contract. The optional requests are for a $225,000 and $275,000 deductible and it should be a 24/14 contract. The specific and aggregate should include all **prescription drug** claims and exclude all claims from the stand alone dental and vision plans. Proposals must clearly

state any limitations in regards to an unlimited lifetime maximum benefit.

Note: Respondents are encouraged to give options for more than a single year contract. Any Lasers, Aggregating Specific or different contract periods, must be finalized after the receipt of updated materials. Non-acceptance of this requirement must be outlined on the Statement of Compliance Form in the Proposal.

### 1.2.2 Aggregate Excess Protection

The aggregate attachment point must be proposed on 120% of projected paid claims. Corridors of lesser amounts such as 115% will receive preferential review. A monthly cap should be given as an option. Each Proposal must state exactly the monthly and total attachment point dollar amount the time period covered, and if there are any restrictions.

### 1.2.3. Transitional Process

The selected carrier shall be responsible for all claims incurred on/or after **January 1, 2017 and paid from January 1, 2017 through December 31, 2017.** The County desires that covered employees and their dependents should not be adversely affected by a change in insurance carriers. A "no-loss/no-gain" approach will apply to all participants covered under the new plan. It is imperative that any exclusions, limitations, or any other deviation be clearly outlined and discussed. A Respondent is expected to explain, in detail, their approach and responsibilities for total disabilities, active at work clauses, or any other limitations.

**Proposals received with full protection – no limitations – will receive preference.**

### 1.2.4 Commission

No commissions or service fees shall be paid to any party without disclosure.

### 1.2.5 Compliance with the Proposal

All responses are to be prepared according to the Proposal. Any item(s) your company cannot accommodate are to be disclosed in writing prior to binding acceptance by the consultant and the County. Any deviations from this request are to be discussed, in writing, with the consultant in advance of the due date. After the County has made a commitment and awarded the Contract, the carrier will be held responsible for **All** items contained in the specifications.

### 1.2.6 Effective Date

The effective date of the new contract(s) will be **January 1, 2017 for 12 months.** Following the initial contract term from January 1, 2017 to December 31, 2017, the County will have the option to renew the contract for two (2) one-year annual renewals.

### 1.2.7 Proposed Rates

A minimum rate guarantee of 14 (fourteen) months is required. Please confirm this guarantee in your Proposal and denote any additional guarantees your company may wish to extend to the County. It is the County's intent to establish a one year contract with the new carrier(s) provided renewal rates are acceptable and can be given within your Proposal. **Multiple year. rate guaranteed. contracts will receive preference. Multiple year contracts must include a not to exceed cap for rate increase in the**

**additional years.**

### 1.2.8 Renewal Rates

The selected carrier is asked to deliver a rate adjustment no later than 90 (ninety) days prior to the anniversary date each year.

### 1.2.9 Ownership of Records

All records, member files and miscellaneous data necessary to administer the plan shall be the property of the County. The selected carrier will be asked to transfer records to the County within 30 (thirty days of notice of termination.

### 1.2.10 Master Policy

The master policy shall be provided to the County no later than 30 (thirty) days from effective date. Please confirm your ability to provide this service and meet the deadline in your Proposal.

### 1.2.11 Plan Changes and Amendments

If changes in the plan of benefits or servicing requirements are needed, such changes will be made in writing and deemed as an amendment to the Contract.

### 1.2.12 Carrier Selection

The selection of the carrier is tentatively scheduled to occur on 11-29-2016

### 1.2.13 Data Caveat

Williamson County and Aetna have supplied the data contained herein. It has been gathered and coordinated by the consultant and reviewed as to accuracy on a "best effort" manner. This Request for Proposal is qualified to the extent the data provided is accurate.

### 1.2.14 Financial Statements

Two (2) most recent annual financial statements are required prior to contract award.

### 1.3 Stop Loss Questionnaire

CARRIER INFORMATION

1. When did the insurer start writing Medical Stop Loss Insurance?

2. Please note any years in which the insurer ceased writing or renewing medical stop loss business.

3. Please provide the names, titles and phone numbers for key contact persons for claims, billing and eligibility.

FINANCIAL INFORMATION

1. Please provide information relative to your reinsurance arrangements for your medical stop loss coverage.

2. What percentage of the risk do you retain? Describe in detail.

UNDERWRITING INFORMATION

1. At renewal, what information do you require? Specifically address all disclosure requirements.

2. How far in advance of the anniversary date (November 1) can the group expect to receive renewal rates?

RATING PROCEDURES

1. Discuss your renewal philosophy. Be specific as it relates to known ongoing large claims, high deductibles, lasering, rating up, exclusion, etc.

2. Has a renewal ever been denied solely due to claim experience?

3. Does your contract allow you to limit or exclude coverage for an individual who becomes disabled or begins receiving treatment after you are awarded the contract but prior to the contract effective date?

CLAIMS INFORMATION

1. What information do you require to process a specific stop loss claim?

2. What information do you require to process an aggregate stop loss claim?

3. What kind of timeframe can we expect for you to pay both claim types?

4. What proof of payment is required for specific and aggregate claims?

5. What is your definition of a paid claim?

6. If you purchase reinsurance protection, does the reinsurer need to review all claims before they are paid, or are your decisions binding on the reinsurance?

7. If a claim is delayed beyond the end of the contract period, do you grant a waiver of the time limits for payments if the circumstances are reported to you prior to the end of the period? If not, how are such situations handled?

8. Do you require that large claim management services be used? Under what circumstances? Do you pay for such services?

9. Do you accept the reasonable and customary determinations made by the TPA, or do you have a database you use?

CONTRACT INFORMATION

1. Please provide a sample policy for our review.

2. Please list any exclusion(s) that are mandatory, regardless of the client's proposed plan document language or benefit design.

3. Do you have an "actively at work" provision? What are the procedures for waiving it?

4. What is the maximum time allowed for submission after the termination date of valid claims that were paid within the contract period?

5. Please provide the definition of experimental procedures and note how this provision is interpreted for a claim approved for payment under the medical plan.

6. Does the insurer assist in claim determination before reimbursement is requested?

7. Are there any circumstances where the insurer can deny reimbursement of a claim which has been approved by the UR program and/or the Large Case Manager and paid under the Plan?

8. Please specify all terms and conditions under which the insurer may terminate or modify its policy.

9. If the policy is issued through an MGU, delineate what happens when the reinsurer changes on a date other than the client's Plan anniversary.

**1.4 Plan Designs Claims Experience**

**FOR AN ELECTRONIC COPY OF THE CENSUS AND LARGE CLAIMANT INFORMATION, PLEASE EMAIL khancock@wilco.org and copy purchase@wilco.org**

## 1.5 Network Benefit

This Plan provides benefits through a group of contracted providers (Network Providers). A Network Provider means using a Physician or other Licensed Health Care Provider who is part of a group of contracted providers. Using Network Providers offers cost-savings advantages because a Covered Person pays only a percentage of the scheduled fee for services provided.

To determine if a provider qualifies as an eligible Network Provider under this Plan, please consult A e t n a ' s website at www.aetna.com to access l inks for directories of Network Providers.

The Benefit Percentages for Medical Benefits may vary depending on the type of service and provider rendering the service or treatment. Non-Network Provider means a provider who is not a Network Provider. If a Non-Network Provider is chosen over a Network Provider, the Benefit Percentage will be lower (as stated in the following Schedule of Medical Benefits), unless one of the a Non-Network Benefit Exceptions stated below applies.

NON-NETWORK BENEFIT EXCEPTION

When a covered service is rendered by a Non-Network Provider, charges will be paid as if the service were rendered by a Network Provider only under the following circumstances:

1. Charges for an Emergency as defined by this Plan, limited to only those emergency medical procedures necessary to treat and stabilize an eligible injury or illness and then only to the extent that the same are necessary in order for the Covered Person to be transported, at the earliest medically appropriate time to a Network Hospital, clinic or other facility, or discharged.

2. Charges which are incurred as a result of and related to confinement in or use of a Network Hospital, clinic or other facility only for Non-Network services and providers over whom or which the Covered Person does not have any choice in or ability to select.

3. A Network Provider is not reasonably available within 50 miles (using Googlemaps.com) who can provide the service needed. To obtain this exception, the Covered Person must request the exception in writing indicating the name and address of the patient, the Participant=s name, identification number and group number, type of treatment, service or supply for which exception is needed. Requests for exceptions can be sent to Aetna. If this exception is granted by the Plan, charges made by the Non-Network Provider will be paid at the Network benefit level. This exception will not be granted until written approval is received from the Plan.

4. A Network Provider refers the patient to a Non-Network Provider. Medical documentation from the Network Provider stating the reason for referring the patient to a Non-Network Provider must be submitted to the Plan for review. To obtain this exception, the Network Provider must request the exception in writing indicating the name and address of the patient, the Participant=s name, identification number and group number, type of treatment, service or supply for which exception is needed including medical documentation stating the reasons for referring the patient to a Non-Network Provider. Requests for exceptions can be sent to Aetna. If this exception is granted by the Plan, charges made by the Non - Network Provider will be paid at the Network benefit level. This exception will not be granted until written approval is received from the Plan.