Appendix A – Bid Proposal Questionnaire (Self-Insured)

Bidder shall provide responses to each question included within this document. Responses must be numbered according to the “Part” and the Question “number” (i.e. A1, A2, A3). Provide all your responses in order. Do not refer to content included in your previous responses, as each Question/Response should stand on its own. Bidder shall provide a complete response individually for each question for proper scoring.

Part A - General Services:

1. Describe options and flexibility of healthcare plan design and benefit levels using a self-insured methodology. What plan design elements fall outside the PPACA/ACA requirements for a Self-Insured program at this time? If there are known Sunset provisions for certain allowable practices/designs, please identify and provide corresponding details.

2. Describe the on-line resources available to GHS as the employer.

3. Describe the on-line resources available to the employees and retirees of GHS as qualified enrollees into GHS sponsored health plans.

4. Describe your overall Account Management structure and the role each member provides. Include the name and location of the Account Executive that will be assigned to the GHS account.

5. Provide the name and location of the senior claim consultant or claim section manager that would be assigned to the GHS account.

6. Describe your support services for communicating the new medical plan to employees and retirees.

7. Describe the employee “self-service” capabilities available via the internet for employees. Address provider search capabilities; claims status checks; plan information; ID card or other member service requests; etc. Detail specific services available to support participants in the GHS sponsored healthcare plans.

8. Describe what services or data the GHS HR/Payroll Staff will be able to access directly via the internet. Will HR/Payroll Staff have access to member level eligibility and claims data?

9. Describe your account implementation process. Include a timeline noting major events.

10. What are your customer service hours to obtain a “live person”?

Part B - Eligibility and Enrollment:

1. Can your company provide an online, PC based eligibility system? If there are associated costs, please provide details.
2. As an alternative, can your company accept eligibility reporting and updates through a file transfer? Please provide an example of the preferred formatting.

3. Can you provide GHS with ongoing eligibility reports to confirm accuracy of the data? If there are associated costs, please provide in detail.

4. Does your eligibility system *(and claim system)* maintain an online listing of all covered dependents by name? By social security number? Including birthdate?

5. Will your company provide Medical ID cards for each employee and adult dependent? Is there one ID card for medical and prescription drug coverage? Please provide a sample of your ID card.

**Part C – Plan Design:**

1. Can your company duplicate all benefits and plan provisions of the current Under 65 - Non-Medicare Eligible Health plans identified as Exhibit A and Exhibit B? Please provide your closest match for GHS’s existing HMO and PPO plan designs with associated premium cost for Single; Double; and Family rates.

2. If no, clearly specify those provisions that you cannot match and your alternative.

3. Describe the specific information needed for you, as a potential new TPA servicing GHS, to be able to conduct a disruption analysis; especially as regards the PCP providers of our existing HMO network.


5. If you do not offer Medicare Advantage plan options, what is your solution for the over 65 Medicare eligible retirees? Provide similar Benefit Summaries and describe the Network and coverage areas. Provide a cost per plan enrollee. How does this option differ from what the under 65 aged group benefits would look like? Describe Networks available and geographic reach for coverage area.

**Part D – Network and Capabilities:**

1. Does your company offer HMO platforms; and, PPO platforms? Please describe existing capabilities, as appropriate, including varying network coverage areas and size of participating provider pool within the various networks available to GHS. Provide additional network specifics as warranted to best describe the range and reach found within the networks.

2. Describe your available Network Coverage Areas; specifically MI plus National coverage, overlapping networks, etc.. Please present Network Coverage Areas within Michigan graphically via colorized maps.
3. What are some of the strengths which distinguish your company as a provider of healthcare administrative services and networks from other potential companies? Strategic advantages.

Part E - Claim Administration:

1. Where is your medical claims office located? Please provide general information about the size, scope, and experience of this office and staff.

2. What is the ratio of “covered employees per examiner” for your company at the location where claims for GHS staff will be paid?

3. Describe the team that will be assigned to GHS as the client. Will there be any specific examiners assigned? A team of examiners? Please describe this structure in detail.

4. What is the turnover rate and average length of service for your medical claims examiners?

5. Describe your procedure for “pending” incomplete medical claim submissions. Comment specifically on your claim examiners’ willingness to contact medical service providers directly to obtain missing information before contacting employees or rejecting claims.

6. Provide details regarding who handles claim fiduciary responsibilities. Explain the process for level 1 and 2 appeals and any costs associated with this function. If you outsource this function to a third-party, provide data on them. When it comes to a final claims determination, are you or your designated party willing to defend its decision up to and including a court case (litigation, court appearances, etc.)?

Part F - Customer Service:

1. Demonstrate and provide details of your Customer Service philosophy and capabilities with numbers of staff, hours of operation, and other details, which prove to distinguish your company from others in the marketplace.

2. Where is your customer service office located? Provide general information about the size, scope, and experience of this office. Include hours of availability.

3. What is the ratio of “covered employees per service rep” for your company at the location where calls for the client will be handled?

4. Describe the team that will be assigned to the client. Will there be any specific representatives assigned? A team of representatives? A toll-free number specific for the GHS employees? Please describe this structure in detail.

5. What is the turnover rate and average length of service for your customer service representatives?
6. How are claim administration and customer service integrated? Are they in the same location? Same department?

7. Describe in detail how a claim call from an employee is handled. Is the call directed to claim administration?

Part G - Financial and Statistical Reporting:

1. Please provide a listing of the standard reports included in your medical administrative fee.

2. How are reports delivered? (CD, E-mail, Excel file, Picked-up Online) Can the client access these reports directly? Please describe in detail. Provide example reports that demonstrate the most common report structures as well as other prominently beneficial reports, which GHS should monitor on a regular basis.

3. Are detailed reports available to your customer administrators via an online method (if applicable)? Are the methods & processes used to obtain online reports considered user friendly? Are they easily customizable across various time periods and employee segments (i.e. suffixes, divisions)? Please describe.

4. Describe the timing of standard reports and data availability. For any given month, at what point in the following month will the data be available to the client?

5. Describe additional medical reporting available to GHS on an ad-hoc basis. Include any costs and standard fees for each ad-hoc report. What is the average turnaround time for an ad-hoc report of various degrees of complexity?

Part H - Disease & Case Management:

1. Does your company make use of Case Managers, and if so, describe some of the following characteristic of your team and the members which might include: typical credentials, educational degrees, certifications, training, average tenure, # of case management staff and supervisors available across differing time periods, typical case load, calls processes in a shift, etc..

2. Describe in detail how potential high cost claims are identified, tracked, managed, through their life cycle.

3. Describe the efforts undertaken by your staff to aid in reducing the potential for high cost claims, and potentially reduce future high costs claims for an individual in the current year and future years, if different strategies.

4. Describe cost reduction strategies employed by your company which aid in reducing general claim costs incurred by GHS as a self-insured employer.

5. Do you offer Disease & Case Management programs? Are these programs included in your base administrative fee or do they result in additional cost? Provide details as appropriate.

6. If yes, are they “in-house” or subcontracted? Please describe.
7. How long have you made use of Disease & Case Management programs?

8. What diseases are covered by your Disease & Case Management program?

9. Provide information on the ROI or financial results typical of the programs. Provide levels of participation and engagements, or other appropriate figures to describe the successes of the program.

10. Describe how you engage members with your Disease & Case Management programs in detail. Please provide data on what percentage of the population targeted for Disease & Case Management programs actually participate in the program. Are there published industry norms, if so please provide currently reportable norms.

11. Can you provide management reports on the outcome of your Disease & Case Management program that are specific to the client? Please provide a sample.

12. Provide any other relevant information on your Disease & Case Management program not included above.

Part I – Cost Savings:

1. Describe typical discounts obtained across Provider network; by Prescription Drug provider; by Facility Type, etc. with other categories, as appropriate.

2. Describe the services utilized to reduce the cost of large medical case claims; provide examples of the extra efforts undertaken to reduce the end cost to the employer; provide examples of recent medical cost reduction percentage reductions (i.e. initial claim of $50,000 XYZ medical procedure, resulting in a $25,000 final paid total cost applied to the claim and 50% reduction. Looking for the average reduction obtained for certain medical procedures.)

3. Describe how and where Rebates may be generated and to what extent we might expect to see rebates as an average dollar return or percentage based upon categories which typically generate rebates for a client. Are there strategies available which would increase rebates substantially to a client, if so please provide details.

4. As the TPA, describe to what degree your company works to reduce individual claims, high cost claims, potential future/high cost claims, etc.? At what point or under what conditions would your company begin to take an active role in managing potential high cost claims.

5. Are there any additional areas, which have not been identified to this point, which would help in maintaining a more flattened health premium experience for GHS year over year? Additional strategies GHS might deploy to assist in these efforts?

Part J - General TPA Administration Costs:

1. GHS is interested in a complete Third Party Administrator (TPA) services to be handled by the associated Group health insurance company. What is the itemized and total cost for TPA services to be provided in conjunction with a January 1, 2021 Effective health plan renewal? Describe the components and itemized costs that make up the Per Employee Per Month (PEPM) total Administrative TPA cost.
2. Does your TPA service include providing all necessary documentation, tracking, reporting required to complete the administration functions typical in Stop-Loss Policy requirements?

3. Identify in detail the TPA services, which would not be included in your PEPM rate, and if there are additional fees for these additional service, reports, etc., what are these associated costs?

4. Provide your plan’s ASO Group Notice Regarding Updates to your 2021 Benefit Guide (proposed plan).

5. Provide your plan’s ASO Group Notice Regarding Updates to your previous 2020 Benefit Guide, to establish a baseline (proposed plan).

**Part K – Pricing:**

1. Provide a Stop-Loss Reinsurance bid proposal.

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<th>Option 2</th>
<th>Option 3</th>
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2. Existing carrier with stop loss shall continue to offer a PAID contract type (Response to this Question K2 shall be “PAID”). *New bidders* shall confirm that they are quoting a 24/12 stop loss program where claims incurred in 24 months, are paid in 12 months. (New bidder must Confirm the Contract type:________ presented in K1 above.)

3. Provide your proposed plan(s) Administrative Service fee rate(s) for 2021.

4. Describe the expected increase in the Administrative Service fee rate for renewal years 2022, 2023, 2024, and 2025? Provide a maximum percentage increase allowed, based upon the previous year’s rate?

5. Describe the Administrative Services which are included as part of your package for
the associated rate with your proposed plan. Include in-house activities; and contracted activities with their associated cost.

6. Provide your proposed Self-Funded (Renewal) Cost Illustration for Plan Year 1/1/2021 through 12/31/2021. (i.e. the components building up to the illustrative rates.) (i.e. also provide Illustrative Rates for 2021.)