**Southwest Florida Water Management District**

**ITN 002-18 Employee Benefits Insurance Plans**

**Exhibit XIX**

**Questionnaire Response Form**

**General Information**:

1. Are you willing to provide performance guarantees for implementation and servicing of your products? If so, please describe the performance guarantee programs you are proposing. Please indicate the group name, address, contact person, and telephone number for three firms in Florida to whom your company has forfeited money because of service problems in the last three years.
2. Please describe your process for handling transition of care?
3. Do you utilize any “wrap” or leased networks not negotiated or owned by your company?
	1. If yes, what is the name of the network?

1. Do you agree to allow retirees over and under 65 to continue coverage under the same plan at the same rate as active employees as required by Section 112.08, Florida Statutes, for public entities?
2. Please provide the name, title, contact information and resumé of the individual who would have direct daily account responsibility for the employee benefits program(s) you are proposing. If more than one person will be filling this role, please respond with complete information for all.

1. What is your company’s current A. M. Best, Moody’s and Standard and Poor’s ratings?
2. What is your account service team’s average response time to client requests or questions?
3. Describe the services provided by your account service team to the employees.
4. Describe the services provided by your account service team to the Human Resources department responsible for overseeing the employee benefits programs.
5. Describe any other services provided by your company that will support employee benefit initiatives.
6. Describe any available benchmarking tools you can provide.
7. Does your company help facilitate annual open enrollment? i.e. Onsite meetings, Educational materials, printed materials at no cost?
8. Please confirm you can waive the requirement for a binder check at time of application submission.
9. Describe and list your company’s “Centers of Excellence”, if available.
10. Describe any prior or pending litigation, debarment action, performance improvement plan, sanctions, etc. either civil or criminal involving a government agency or the private sector which may affect the performance of the services to be rendered herein, in which the Respondent or any of its employees or subcontractors or sub consultants is or has been involved within the last 3 years. If so, please explain.

**Enrollment & Implementation Technology:**

1. Does your company (or third-party) process electronic eligibility files via automation or are manual steps necessary? If manual steps are required to process files, please explain this process and impact on processing time.
2. Does your company outsource the processing of electronic eligibility to a third-party? If so, please provide company name.
3. Please specify if your company (or third-party) accepts the HIPAA 834 5010 file layout as well as all other file layouts accepted for automated enrollment. Please provide applicable coding supplements and other applicable file specification documents.
4. What is your company's (or third-party's) standard processing time for electronic eligibility to be updated in all applicable internal systems (eligibility/claims/billing/etc.)? If time varies, please specify for each system.
5. Will your company (or third-party) provide confirmation notification to the group when files are processed? Please provide details related to this notification process (email, requirement of group log into company website, etc.)
6. Please provide implementation time (in days) for initial set-up of automated enrollment (electronic eligibility) of an established group with your company.
7. Please provide implementation time (in days) for initial set-up of automated enrollment (electronic eligibility) of a new group with your company.
8. Please provide set-up time needed for changes to file structure, plans, funding strategy, platform changes for an established group with your company. What alternative options does your company provide to receive enrollment should these changes cause delay in set-up of the EDI process?
9. Please provide file testing time frame (in days) for initial set-up and structure changes.
10. Please provide the standard time frame required to process files, generate, and mail member ID cards. What options does the group have if ID card delivery is delayed beyond the plan effective date?

**Data & Reports:**

1. Please specify if your firm is SSAE 16 / SOC / SAS certified.
2. What is your company's standard billing snap shot date and grace period for payment? What is your preferred method of payment? (ACH, EFT, check etc.)
3. Describe the reports you will provide regarding the utilization and claims associated with the employee benefits program(s) you are proposing. Please indicate in your description if any of the reports would be provided at an additional cost over the fees associated with the programs.
4. How often are claim audits conducted and what percentage of claims are audited? If you use a third party to audit claims, please disclose the name of auditor.

1. How do you identify fraudulent claims and how will you notify the District?
2. Describe the process for identifying and paying claims which may be subrogation claims.
3. What is your proposed frequency of reporting on utilization experience? Is there a charge for utilization data analysis?
4. Will there be online access for claim reports by the District and Gehring Group?
5. The District uses a third-party vendor for our data analytics. Would you charge a fee to send our claims data to the District’s third-party vendor for data analytics? If yes, how much? Is the pricing based on a one-time fee set up for the feed monthly or based on a frequency of the feed from you as the carrier to our TPA for data analytics? Please list the data analytics providers you currently work with to send data feeds.
6. Do you offer self-bill?
7. Describe the reports you will provide regarding the utilization and claims associated with the employee benefits program(s) you are proposing. Please indicate in your description if any of the reports would be provided at an additional cost over the fees associated with the services and products.
8. What is your proposed frequency of reporting on utilization experience? Is there a charge for utilization data analysis?

**References/Other:**

1. Describe any other facets of your company and its experience which are relevant to this response that have not been previously described and that you feel warrant consideration.

**Renewal Planning & Additional Fees:**

1. Will your company be willing and/or able to provide the annual renewal for the services and products you are proposing a minimum of 150 days prior to the renewal date?
2. Will you attempt to recruit a specific provider per the District’s request?
3. Describe any plan modeling tools that you provide to assist us with evaluating additional plan designs.
4. Are any of the rates you proposed contingent on any additional information? If so, please disclose. If you require additional information to provide us with proposed rates, a request for such information should be requested under the procedure set forth in Section 1.11, Technical Questions.
5. Is your response contingent upon receiving updated claim reporting? If yes, through what time frame?
6. Would you allow a grace period after the due date of 45 days for payment of an invoice?
7. What additional services are available and the cost?

**Medical/ASO/TPA**:

1. Is your company willing to provide administrative fee guarantee for your self-funded response? If so, please provide the details of your guarantee.
2. Medical respondents must provide a Geo Access report that illustrates the number of:
	1. 1 Hospital within 10 miles
	2. 2 PCPs & Pediatricians within 10 miles
	3. 2 OBs/Gyns, within 10 miles
	4. 2 Specialists within 10 miles
	5. 2 Urgent Care Centers within 10 miles

The report format should include a breakdown by employee city of residence with the number of employees in that location and the number of providers servicing that location. The report should also include reporting on the number and location of employees who do not meet the above criteria.

1. Provide a medical disruption report for the attached provider list.
2. What are the average network discounts for the area the census covers broken down by:

| Charge Type | Hernando | Hillsborough | Manatee | Pasco | Pinellas | Polk | Sarasota |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Doctors |  |  |  |  |  |  |  |
| Urgent Care Centers |  |  |  |  |  |  |  |
| Out-Patient Hospital |  |  |  |  |  |  |  |
| In-Patient Hospital |  |  |  |  |  |  |  |
| All Others |  |  |  |  |  |  |  |

1. Are you willing to provide performance guarantees for your network discounting? If so, please describe what you are proposing.
2. Please identify which of your networks are included in your response.
3. What are the options and pricing of the network of providers your company offers? What support does your company provide for customizing the network (adding or deleting providers or pharmacies that are important to the plan)?
4. Please describe your medical out-of-area coverage for retirees, dependent students or other dependents not residing with the employee (because of divorce or other reasons) but covered under their medical plan.
5. For plans that provide out-of-network coverage, if radiologists, anesthesiologists and pathologists are not part of the network, is the member responsible for cost at the in-network or out-of-network reimbursement levels?
6. How do you handle transition of care for members currently undergoing treatment or have existing relationships with the incumbent carrier’s network providers?
7. Please confirm requirements for coordination with Medicare.
8. Confirm that your company will provide the following reports upon request of the District or Gehring Group:
	1. Large Claimants (over $25,000) inclusive of gender, plan, diagnosis, last date of service, prognosis and if the claimant remains covered on the plan.
	2. Utilization reports by diagnosis, place of service, employee vs. dependent costs.
	3. Monthly paid claims.
9. Please confirm your participation in an annual in person program utilization review (including the medical director and underwriter/analyst) with the District and Gehring Group.
10. Please list and describe your Disease Management programs that will be offered to the District.

**Pharmacy:**

1. Please confirm that your response includes Rx rebates payable directly to the District.
2. Does your company allow the client the right to accept or reject formulary content decisions that impact plan design? Can a client make changes to the preferred list? Please provide data analytics specific to the client’s drug mix and the associated economic impact.
3. Are there therapeutic switching programs in mail order or retail edits to flag preferred drugs?
4. Does your company reimburse pharmacies at a rate different from what it charges to the plan?
5. Does your company own the mail order program? If not, how does the sub-contractual relationship work between the two organizations?
6. How are mail order claims monitored for accuracy and timeliness?
7. Will you cover the cost of transferring existing mail order prescriptions from the incumbent carrier?
8. Does your prescription drug response include Step Therapy (ST), Prior Authorization (PA) and Quantity Limits (QL)? If so, describe your process for each and provide a list of medications that require ST, PA and QL.
9. Will you allow the current population taking medications that require pre-authorization (including specialty medications) be grandfathered into the new plan without having to meet the requirements again?
10. Are Lifestyle drugs covered? If yes, explain program limitations.
11. Does your prescription drug response include an open or closed formulary?
12. Please outline your Specialty Drug Process:
	1. How are specialty medications managed?
	2. List internal/external organizations you work with.
	3. What are your proposed discounts on Specialty Pharmacy?
13. What is the generic substitution policy and process for both mail order and retail? What steps do you implement to increase generic utilization?
14. Is your pricing offer based on implementation of any new mandatory mail order programs, clinical programs or plan design changes?
15. If the client elects to utilize a third party PBM, will that affect any services or costs proposed including utilization integration reports? If yes, please describe.

**Health Savings Account:**

1. How are fees established?
2. Are employee fees based on the amount in accounts or on how much is contributed monthly?
3. Can employees pay fees directly or must they pay out of the HSA?
4. Does the account trustee/custodian impose limits on the number of distributions that employees can take for a specific period of time?
5. Do employees have access to price transparency information and health care quality comparison tools?
6. Does the account trustee/custodian provide phone or Web counseling to help employees review and minimize their spending?
7. Does the provider prepare annual IRS reports for the employer?
8. Does the provider provide assistance with following comparability rules for employer contributions?
9. Does the provider offer checks or a debit card for HSA payments or withdrawals?

**Wellness:**

1. The District seeks responses to include wellness dollars. Respondents are encouraged to provide at least $50,000 in wellness funds on an annual basis. Please disclose the amount of wellness dollars provided in your response and any restrictions/criteria for use of those funds.
2. Are there any additional costs to the client or employees for participation in your wellness programs or services?
3. Is a designated wellness coordinator assigned to the group when wellness funds are provided? If so, which wellness services will be included?
4. Does your company offer rate discounts on the proposed programs, in dollars or percent, to employer groups who implement an active, participatory Wellness Program? If so, please describe the discount model amount and requirements.
5. Does your wellness program provide a proactive health education and improvement program for those with a chronic condition?
6. Does your wellness program utilize behavioral coaching principles and evidence-based medicine guidelines to optimize self-management skills to foster sustained health improvement?
7. Does your wellness program include:
	1. Chronic condition-specific coaching?
	2. Pre- and post-discharge calls?
	3. Lifestyle management coaching: stress, weight management, and tobacco cessation?
	4. Treatment decision support and coaching?

**Dental**:

1. Dental respondents must provide a Geo Access report that illustrates the number of:
* 2 General Dentists within 10 miles
* 1 Specialty Dentists within 10 miles
* 2 Orthodontists within 10 miles

The report format should include a breakdown by employee city of residence with the number of employees in that location and the number of providers servicing that location. The report should also include reporting on the number and location of employees who do not meet the above criteria.

1. Provide a dental disruption report for the attached provider list.
2. Are you willing to waive the actively at work and pre-existing limitation provisions for all currently enrolled individuals on dental?
3. Is there a missing tooth clause provision included in your response?
4. How does the proposed plan treat coverage for composite resin (non-amalgam) fillings on molar teeth?
5. Does the proposed plan include coverage for implants? If so, what tier would implants be categorized.
6. Please confirm dependent child(ren) eligibility.

**Life and Disability**:

1. Are you willing to waive the actively at work and pre-existing limitation provisions for all currently enrolled individuals on disability?
2. Confirm the Life and AD&D rounding rules (i.e., rounded to next highest or nearest $1,000 if a multiple of salary).
3. If awarded the voluntary life insurance contract, confirm that you will grandfather current coverage amounts for which premiums have been paid by employee. If “No”, please outline your proposed alternative.
4. Will there be a true open enrollment period every year for current employees?
5. Do you have the option of online Evidence of Insurability (EOI) forms for voluntary life?
6. Confirm if voluntary spouse and child(ren) life and AD&D benefits are bundled or separate.
7. Are the voluntary spouse life rates based on age of the spouse or the employee?
8. For life beneficiary forms, please confirm electronic beneficiary designations are accepted from the benefit administrator.
9. Are the long-term rates calculated on the benefit amount or the weekly/monthly salary?
10. Does your response include W-2/FICA tax services for disability? If no, explain any additional cost.
11. Confirm that all employees enrolled in the client’s plans who are currently not “actively at work” due to disability, FMLA, or any other reason, will be covered under the plans implemented for the effective date stated in this RFP.
12. Confirm respondent can match current LTD policy takeover provisions. If “No”, please detail proposing firm’s proposed provisions where conflicting.
13. Is a claims manager assigned on a case-by-case basis or is one claims manager specifically assigned to the group?
14. Are additional value-added programs offered with the basic life and/or LTD (i.e. Will Preparation, Beneficiary Assistance, Life Assistance Program, etc.)?
15. Is a claims manager assigned on a case-by-case basis or is one claims manager specifically assigned to the group?