Request for Proposal

No. 26-22

Medical Insurance and Employee Assistance Programs

City of Clearwater

100 South Myrtle Avenue

Clearwater, Florida 33756

Date Solicitation Issued: April 22, 2022

Proposal Due Date: May 20, 2022

Plan Effective Date: January 1, 2023

SUBMIT PROPOSAL TO:	It is recommended that proposals are submitted electronically through our bids website at:https://www.myclearwater.com/business/rfp. Proposers may mail or hand-deliver proposals to the address below. E-mail or fax submissions will not be accepted. Use label at the end of this solicitation package **If responses are delivered electronically, hand-delivered copies are not required.** City of Clearwater Attn: Procurement Division 100 S Myrtle Ave, 3rd Fl, Clearwater FL 33756-5520 or PO Box 4748, Clearwater FL 33758-4748 No responsibility will attach to the City of Clearwater, its employees or agents for premature opening of a proposal that is not properly addressed and identified.	**Request for Proposal** **City of Clearwater**

Proposal Title: Medical Insurance and Employee Assistance Programs

PROPOSAL IS DUE: May 20, 2022 at 12:00pm DEADLINE FOR WRITTEN QUESTIONS: MAY 6, 2022 AT 3:00 P.M. MUST BE SUBMITTED TO lori.vogel@myclearwater.com Plan Effective Date: January 1, 2023	ISSUE DATE: April 22, 2022

Attachments: All attachments listed under SECTION VI in this RFP will be released via secure email by the City's Agent of Record: Gehring Group.

Submittal Instructions: It is recommended that responses are submitted electronically through our bids website at https://www.myclearwater.com/business/rfp.

For responses mailed and/or hand-delivered, firm must submit one (1) signed original (identified as ORIGINAL) response, five (5) copies of the response and one (1) copy in an electronic format, on a disc or thumb drive, in a sealed container using the label provided at the end of this solicitation.
NOTE: If submitting proposals electronically, copies are not required.

Addenda: From time to time, an addenda may be issued to this Request for Proposal. Any such addenda will be posted to the City's website at https://www.myclearwater.com/business/rfp. Prior to submitting a response to this solicitation, it is the vendor's responsibility to confirm if any addenda have been issued.

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Request for Proposal – Medical Insurance & Employee Assistance Programs

Please note: Medical Proposers are Required to Respond to Attachment #6 & #7

**Attachments released via secure email from the City's Agent of Record: Gehring Group*

SECTION I: RFP Overview

Coverage Effective Date: January 1, 2023

The City of Clearwater (hereafter referred to as "the City") is seeking experienced and qualified firms that demonstrate the highest level of ability to provide the following lines of insurance coverage:

- **Medical Insurance**
  - Self-Funded Quote
    - Medical Administrative Services Only
    - Pharmacy Benefits Management
    - Stop Loss Insurance
- **Employee Assistance Program**

Attachments: Attachments listed in SECTION VI of this RFP will be released via secure email from the City's Agent of Record: Gehring Group.

Due Date: It is recommended that proposals are submitted electronically through our bids website at https://www.myclearwater.com/business/rfp by the Response Deadline outlined in the Project Details.

Proposers may mail or hand-deliver proposals to the address below. E-mail or fax submissions will not be accepted. Use label at the end of this solicitation package
City of Clearwater
Attn: Procurement Division
100 S Myrtle Ave, 3rd Fl, Clearwater FL 33756-5520
or
PO Box 4748, Clearwater FL 33758-4748

Proposals will be received at this address. Proposers may mail or hand-deliver proposals; e-mail or fax submissions will not be accepted.
No responsibility will attach to the City of Clearwater, its employees or agents for premature opening of a proposal that is not properly addressed and identified.

Late Proposals. The proposer assumes responsibility for having the proposal delivered on time at the place specified. All proposals received after the date and time specified shall not be considered. Proposals that are hand delivered will be returned unopened to the proposer. The proposer assumes the risk of any delay regardless of whether sent electronically, by mail or by means of personal delivery. It shall not be sufficient to show that you mailed or commenced delivery before the due date and time. All times are Clearwater, Florida local times. The proposer agrees to accept the time stamp in the City's Procurement Office as the official time.

Firms interested in submitting a response to this RFP, agree not to contact (lobby) any employee or agent of the City at any time during the solicitation period and the selection process. All oral or written inquiries are to be directed to Lori Vogel, Procurement Manager at lori.vogel@myclearwater.com. Any other contact will be considered inappropriate and subject your response to rejection/disqualification.

The City reserves the following rights: to waive in-formalities in any proposal; to reject any or all proposals or portions of proposals; to accept any proposal or portions of proposals deemed to be in the best interest of the City; and to negotiate or refuse to negotiate with any offer.

SECTION II: General Information

SCOPE AND PURPOSE

The specifications include the complete set of requirements and proposal forms. Proposers are strongly encouraged to complete all proposal forms as specified and include all forms with your proposal. Failure to include proposal forms may be grounds for disqualification from this RFP Process.

Intent of RFP

The City is soliciting the following lines of insurance: Self-Funded Medical Insurance including Medical ASO Services, Pharmacy Benefits Management, Stop Loss Insurance, and Employee Assistance Programs for its employees, officials, retirees, COBRA participants and their families.

CALENDAR

The intended timeline of this RFP is as follows:

- Release of RFP..... (4/22/2022)
- Advertise in the Tampa Times ..... (4/27/2022)
- Deadline for receipt of questions.....(5/6/2022)
- RFP addendum addressing questions released.....(5/13/2022)
- Deadline to receive proposals.....(5/20/2022)
- Initial proposal meeting..... (6/3/2022)
- Best and final offers (BAFO) requested from finalists.....(6/6/2022)
- Deadline to receive BAFO proposals.....(6/17/2022)
- Selection Committee Meeting.....(6/24/2022)
- Council Meeting to Approve Carrier Selection .....(8/4/2022)
- Open Enrollment Period..... (September – October 2022)
- Plan Effective Date..... (January 1, 2023)

This timeline is subject to change.

CONTACT PERSON
Lori Vogel, CPPB
Procurement Manager
Lori.vogel@myclearwater.com

SECTION II: General Information

ADDITIONAL INFORMATION/AMENDMENT Request(s) for additional information or clarifications must be made in writing no later than the date specified in the RFP timeline stated previously.

Changes to this RFP, when deemed necessary, will be completed by written addendum issued prior to the proposal due date. Proposers should not rely on any representations, statements, or explanation other than those made in the RFP or in any addendum to this RFP. Where there appears to be a conflict between the RFP and any addenda issued, the last addendum will prevail.

It is the proposer's responsibility to assure receipt of all addenda. The proposer should verify with the designated contact person prior to submitting a proposal that all addenda have been received. Proposers shall acknowledge receipt of each addendum issued on the EXCEPTIONS / ADDITOINAL MATERIAL / ADDENDA form.

PRESENTATIONS/INTERVIEWS Presentations and/or interviews may be requested at the City's discretion. The location for these presentations and/or interviews will be determined by the City and may be held virtually.

COSTS INCURRED BY PROPOSERS All expenses involved with the preparation and submission of proposal to the City, or any work performed in connection therewith, shall be borne by the responding party.

EVALUATION CRITERIA Proposals will be evaluated based on the criteria listed below. A breakdown of points is provided below for 100 total maximum points. In the event the below evaluation criteria does not apply to a specific line of proposed coverage (for example, prescription drug formulary strength for EAP services), the applicable criteria will be proportionally adjusted. The City at its sole discretion may create a short-list of the highest ranked proposals based on evaluation against the evaluation criteria.

No.	Criteria	Maximum Points
1	Proposed Cost	20 Points
2	Benefit Design Strength	20 Points
3	Provider Network Strength	15 Points
4	Prescription Drug Formulary Strength	15 Points
5	Network Discount Strength	15 Points
6	Customer Service Ability	10 Points
7	Performance Guarantee	5 Points
Total Possible Points		**100 Points**

SECTION II: General Information

ACCEPTANCE/REJECTION OF PROPOSALS

The City reserves the right to reject any and all proposals submitted in response to this RFP, or to cancel, in part or its entirety, this request, if it is in the best interests of the City to do so.

The City reserves the right to accept or reject any or all proposals received as a result of this request, or to negotiate separately with competing proposers simultaneously, and to waive any in-formalities, defects, or irregularities in any proposal.

The City reserves the right to accept the proposal of a proponent other than that of the lowest proponent.

DISCLOSURE OF PROPOSAL CONTENTS

All material submitted becomes the property of the City. The City has the right to use any or all ideas presented in any reply to this RFP. Selection or rejection of the proposal does not affect this right.

RENEWAL

The awarded firm shall give a minimum of 180 days written notice prior to any renewal date to the city stating specifically what, if any, rate change is proposed.

City Insurance Requirements and Terms & Conditions

The City's insurance requirements and Terms and Conditions are included in the attachments released for this RFP. All vendors are required to review that information prior to submitting their proposal.

SECTION III: Vendor Requirements

- **Proposal Effective Date**: January 1, 2023

- **Commissions**: All carrier proposals to this RFP must be submitted net of broker commissions.

- **Retirees**: Florida Governmental Retirees must be allowed to continue coverage under the City's insurance program as required by Florida Statue 112.08.

- **Reference Requirement:** It is a requirement that all insurance carriers currently provide group insurance to at least three other Municipal entities with at least 2,000 employees. Proposers not able to list two current Municipal entities meeting these requirements as references may be disqualified from consideration.

- **Inquiries**: All questions regarding the document shall be submitted in writing to lori.vogel@myclearwater.com.

- **Wellness Funds & Programs**: Proposers are encouraged to include a minimum of $50,000 in wellness funds per year for the duration of the contract. If there are certain criteria for using the wellness funds, please disclose in the RFP. Additionally, proposers are also encouraged to include any wellness programs offerings in their proposals.

- **On-Site Wellness Representative Subsidy:** Proposers are encouraged to include an On-Site Wellness Representative for the City to utilize. Proposers are encouraged to offer the City the option of either hiring the employee themselves or having the proposer find the employee. This is an on-site employee whose job role is focused on the City's wellness initiatives. Proposers are encouraged to include the option for the City to receive this fund as a credit to their ASO fee or as a direct payment.

- **Discretionary Funds:** The City's current arrangement with Cigna includes flexible funds for a wellness coordinator, wellness fund, data files, enrollment system, EAP premium, COBRA services and staffing overages at their wellness center. Proposers are encouraged to include any similar discretionary funds that they see fit to both strengthen their offer and benefit the City's insurance program.

SECTION III: Vendor Requirements

- **Proposal Data:** In addition to completion of response forms, proposers are encouraged to include all data relevant to each line of coverage proposal. For example, carriers should provide the following proposal data:

    - Medical Insurance
        - Proposed Benefits
        - Proposed Pricing
        - Network Disruption Response Data
        - Formulary Disruption Response Data
    - Employee Assistance Programs
        - Proposed Benefits
        - Proposed Pricing

- **Guarantees**: Proposers are encouraged to include performance guarantees, implementation guarantees, service guarantees, and network discount guarantees.

- **Rate Guarantees**: Proposers are encouraged to include multi-year rate guarantees for any proposed line of coverage.

- **Plan Implementation**: It is a requirement that the proposer awarded this contract provides representative(s) to assist with implementation, open enrollment, employee communications and ongoing assistance with routine plan administration.

- **Employee Communications:** It is the responsibility of all successful proposers to provide the necessary papers, forms, etc., for initial enrollment and the administration of benefits including but not limited to: brochures outlining schedule of benefits, directories, certificates, claim forms, identification cards, benefit booklets, etc., where applicable.

- **Benefits Administration**: The City has retained Bentek for on-line enrollment and electronic administration of the City's benefit programs, all proposers must have the technological capacity to transmit and accept a HIPAA 834 5010 eligibility file with proper confirmation of receipt and discrepancy reporting.

SECTION IV: Background & Underwriting Information

Carrier History and Funding Arrangement History:

- **Medical Insurance**
  - The City has offered their medical insurance plan through Cigna for the past 10+ years.
  - In 2013 the City began self-funding their medical insurance plan. Prior to 2013, the City's medical plan was fully insured (minimum premium). The City currently still self-funds their medical plan.
  - Both the City's ASO coverage and stop loss insurance is with Cigna.

- **Employee Assistance Program**
  - The City has offered their Employee Assistance Program through Cigna since 2016. Prior to 2016 the City's EAP program was with MHNet.
  - This coverage is fully insured.

Please note, both bundled carrier proposals for multiple lines of coverage as well as standalone proposals for coverage will be considered.

Plan Design Offering History:

- **Medical Insurance**
  - In 2012 the City transitioned from a dual medical plan offering consisting of an in network plan only and a PPO plan to a single offering PPO plan. The City currently still offers a single option PPO medical plan.
  - The City offers a near-site Employee Health Center administered by Evernorth Direct Health that provides non-emergeny care. All services rendered at the Employee Health Center are at no cost to the City's members. Costs associated with the Employee Health Center are not shown in the claims costs data provided in the attachments data of this RFP.
  - The City offers a wellness program through Cigna known as MotivateMe. The incentive plan encourages employees and retirees to participate in annual wellness screenings, preventive care visits, health assessments and more by rewarding members for completion.
  - The City offers a diabetes management program called Omada.
  - The City offers Telehealth through Cigna's MDLIVE.

- **Employee Assistance Program**
  - The City has offered their Employee Assistance Program through Cigna since 2016. Prior to 2016 the City's EAP program was with MHNet.
  - The City's EAP program includes 5 face to face sessions per person, per issue, per year.

SECTION IV: Background & Underwriting Information

Claims Experience Data Provided

The following data will be provided for your underwriting team's consideration:

- Medical Claims Experience Data
- High Cost Claims Experience Data
- Enrollment Data
- EAP Utilization Data

RFP attachment data will be released via secure email from the City's Agent of Record: Gehring Group

Rates and Contribution History (Active Employees)

Medical Insurance	2021			2022		
	EE/Month	ER/Month	Total/Month	EE/Month	ER/Month	Total/Month
Employee	$0.00	$754.82	$754.82	$0.00	$774.45	$774.45
Employee + 1	$323.34	$970.02	$1,293.36	$331.75	$995.24	$1,326.99
Employee + Family	$679.11	$1,443.12	$2,122.23	$696.77	$1,480.64	$2,177.41
Dual Spouse w/ dep.	$0.00	$2,122.23	$2,122.23	$0.00	$2,177.41	$2,177.41
Medical Insurance	**2019**			**2020**		
	EE/Month	**ER/Month**	**Total/Month**	**EE/Month**	**ER/Month**	**Total/Month**
Employee	$0.00	$718.88	$718.88	$0.00	$754.82	$754.82
Employee + 1	$307.94	$923.83	$1,231.77	$323.34	$970.02	$1,293.36
Employee + Family	$646.77	$1,374.40	$2,021.17	$679.11	$1,443.12	$2,122.23
Dual Spouse w/ dep.	$0.00	$2,021.17	$2,021.17	$0.00	$2,122.23	$2,122.23
EAP	**Fully Employer Paid**		**2019**	**2020**	**2021**	**2022**
			$1.67	$1.67	$1.67	$1.74

SECTION IV: Background & Underwriting Information

Other Important Information for Underwriting

- Retirees pay 100% of the premium for any medical coverage they are enrolled in.
- Renewal Rates are not yet available at the time of release of this RFP.
- The City's ASO/PBM contract with Cigna includes pharmacy rebates .
- The City's Stop Loss Insurance includes a $250k/$350k Individual Stop Loss Threshold with a 50% cost share. For example, if an individual member's claims costs are $280k, stop loss pays $15k of that member's claims (50% of the margin between $250k and $280k). In other words, the City's maximum liability on an individual claimant is $300k. If an individual exceeds $350k in claims costs, stop loss picks up all the additional claims costs.

EMPLOYEE ELIGIBILITY and Benefit Deductions:

Eligible employees working a minimum of 37.5 hours per week will be eligible to participate in all City insurance plans.

Eligible employees working an average of 30 to 37.5 hours per week will be eligible to participate in the City's medical benefit offerings.

Coverage will be effective on the first day of the month following the date of hire. For example, if employee is hired on April 11, then the effective date of coverage will be May 1.

Benefit Deductions: 24 Annual Benefit Deductions.

SECTION V: Response Forms

Exhibit I: Medical Plan Response Form – Please Complete Below Form

	Current		Proposed – Please Match as Closely As Possible	
Schedule of Benefits	**Cigna OAP Plan**			
Network Utilized:	**Open Access Plus**			
Calendar Year Deductible (CYD)	**In Network**	**Out of Network**	**In Network**	**Out of Network**
Single	$2,000	$2,000		
Family	$4,000	$4,000		
Coinsurance	10%	30%		
Calendar Year Out of Pocket				
Single	$3,500	$3,500		
Family	$7,000	$7,000		
Physician Services				
Primary Care Physician (PCP) Visit	$20 Copay	30% after CYD		
Specialist Office Visit	$40 Copay	30% after CYD		
Telehealth Services	No Charge	Not Covered		
Non-Hospital Services				
Clinical Lab (Bloodwork)	No Charge	30% after CYD		
X-Rays/Advanced Imaging	No Charge	30% after CYD		
Outpatient Surgery in Surgical Center	10% after CYD	$300 + 30% after CYD		
Outpatient Physician Services	10% after CYD	30% after CYD		
Urgent Care Center	$75 Copay	$75 Copay		
Hospital Services				
Inpatient	10% after CYD	$500 + 30% after CYD		
Physician Services at Hospital	10% after CYD	30% after CYD		
Emergency Room	$150	$150		
Ambulance	10% after CYD	10% after CYD		
Outpatient Rehabilitation				
Facility Charge	$40 Copay	30% after CYD		
Mental Health/Substance Abuse				
Inpatient	No Charge	30%		
Outpatient Facility	$10 Copay	30%		
Prescription Drugs				
Generic	$10 Copay	30%		
Preferred Brand Name	$30 Copay	30%		
Non-Preferred Brand Name	$50 Copay	30%		
Mail-Order Drug (90 Day Supply)	2x Retail	Not Covered		
Monthly Premium Equivalents	**Current**		**Provide Recommended Premium Equivalents Below**	
Employee Only	$774.45			
Employee + One	$1,326.99			
Employee + Family	$2,177.41			

SECTION V: Response Forms

Exhibit II: Medical Administrative Services Only Response Form – Please Complete Below Form

Administrative Services Only	Proposed
ASO Fee Components	
Name of Proposer	
Name of Network(s) Utilized	
Administration Fee (PEPM)	
Utilization Review (PEPM)	
Network Access Fee (PEPM)	
Disease Management (PEPM)	
Pharmacy Management Fee (PEPM)	
Wellness Program Fee (PEPM)	
HIPAA Certification	
COBRA Administration (PEPM)	
Other Fees (PEPM)	
Termination Fees (PEPM)	
Rate Guarantee	
TOTAL ADMIN FEE (PEPM) Year 1	
TOTAL ADMIN FEE (PEPM) Year 2, if applicable	
TOTAL ADMIN FEE (PEPM) Year 3, if applicable	
TOTAL ADMIN FEE (PEPM) Year 4, if applicable	
TOTAL ADMIN FEE (PEPM) Year 5, if applicable	

SECTION V: Response Forms

Exhibit III: Pharmacy Benefits Management Response Form – Please Complete Below Form

Pharmacy - Discounts, Fees, and Rebate Sharing	Description	Proposed
Pharmacy Network Information		
Network Size (Number of Network Pharmacies)	-	
Major Retail Pharmacies Excluded from Network	-	
Admin Fees		
Per Script Administrative Fee (Retail and HD)	Per paid script	
PEPM Administrative Fee	PEPM	
Retail Discounts and Fees (30 day)		
Retail Brand Discount	AWP	
Retail Generic Discount	AWP	
Retail Dispensing Fee Brand	Per script	
Retail Dispensing Fee Generic	Per script	
Retail Discounts and Fees (90 day)		
Retail Brand Discount	AWP	
Retail Generic Discount	AWP	
Retail Dispensing Fee Brand	Per script	
Retail Dispensing Fee Generic	Per script	
Mail Order Discounts and Fees		
Cigna Home Delivery Brand Discount	AWP	
Cigna Home Delivery Generic Discount	AWP	
Cigna Home Delivery Dispensing Fee (including specialty)	Per script	
Specialty Discounts and Fees		
Specialty Retail Brand Discount	AWP	
Specialty Retail Brand Dispensing fee	Per script	
Rebate Sharing		
Retail 30	Per Brand	
Retail 90	Per Brand	
Mail Order	Per Brand	
Estimated Rebates*		
Total Estimated Annual Rebates	**Please Include Projected Rebates:**	

SECTION V: Response Forms

Exhibit IV: Stop Loss Insurance Response Form – Please Complete Below Form

Stop Loss Insurance	Current	Proposed
Specific Stop Loss		
Individual Pooling Point	$250,000	
Tiered Pooling Point	$350,000	
Tiered Pooling Cost Share	50%	
Run In Cap (Per Participant)	N/A	
Laser(s)	None	
Benefits Covered	Medical/MHBH/Rx	
Contract Basis	12/36	
Annual Maximum Reimbursement	Unlimited	
Composite Specific Stop Loss PEPM	$72.65	
Other Terms		
Please Confirm your quote does Not include Aggregate Stop Loss Coverage	Does Not Include	
Are Retirees Covered?	Yes	
Are Proposed Stop Loss Fees Firm?	N/A	
If you are unable to quote the same tiered stop loss, please quote a $300k ISL		

SECTION V: Response Forms

Exhibit V: Employee Assistance Program Response Form – Please Complete Below Form

EAP VENDOR NAME:	**Provide Vendor Name Here**
Eligibility	
Please define Eligibility: (EE, Retiree, Dep, Household Members)	
Core Benefits	
Number of Face-to-Face Visits Included:	
Number of Telephonic Visits Included:	
24/7 Counseling Available Telephonically?	
Onsite Hours	**Please specify if different buckets**
Onsite Hours Included in Proposal:	
Onsite Hours Hourly Rate:	
First Responder/CISD Assistance	
Will First Responders be identified upon calling?	
Critical Incident Stress Debriefing (CISD) Pricing	
Fitness for Duty Evaluation/Referrals	
Services/Materials included in Pricing	
Online Resources	
Mobile App Included?	
Webinars Included?	
Management Referrals & Training	
Brochures & Workplace Posters	
Referrals to Community Service	
Substance Abuse Assistance & Referrals	
Legal Assistance & Referrals	
Financial Assistance & Referrals	
Child Care/Elder Care Assistance & Referrals	
Network Details	**# Providers in your Network/ County**
Pinellas County	
Pasco County	
Hillsborough County	
Manatee County	
Willing to Network outreach to non-contracted providers?	
Other	
Utilization Reporting Frequency	
Designated Account Manager Included in Proposal?	
Levels of Education of Telephonic Consultants?	
Licenses, Degrees, and Certifications of Local Panel Providers?	
Rate Guarantee?	
Rate (PEPM)	

SECTION VI: Questionnaires

Questionnaire - General Information

1. Are you willing to provide performance guarantees for implementation and servicing of your products? If so, please describe the performance guarantees you are proposing.

2. Please indicate the group name, address, contact person, and telephone number of up to three firms in Florida to whom your company has forfeited money because of service problems in the last three years.

3. 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?

4. Provide the name, title, and contact information of the individual who would have direct daily account responsibility for the services you are proposing. If more than one person will be filling this role, please respond with complete information for all.

5. Provide the name, title, and contact information for three (3) references from public entity clients with a minimum of 2000 employees for at least three (3) years immediately preceding the response due date.

References	**Reference 1**	**Reference 2**	**Reference 3**
Group Name			
Contact Name			
Contact Title			
Contact Phone			
Contact Email			
Coverage/Services Provided			
Length of Time			

SECTION V: Response Forms

Exhibit VI: Questionnaire - General Information

6. What is your account service team's average response time to client requests or questions?

7. Describe the services provided by your account service team to the employees.

8. Describe the services provided by your account service team to the Human Resources department.

9. Does your company help facilitate annual open enrollments? a. Onsite meetings? b. Educational materials? c. Printed Materials at no cost?

10. What is your company's current A. M. Best, Moody's and/or Standard and Poor's ratings?

11. Do you utilize any "wrap" or leased networks not negotiated or owned by your company? If yes, what is the name of the network?

12. Describe capabilities available through member website and mobile app. Please describe further any additional functionality available to employer as plan administrator.

13. Please specify if proposer is SSAE 18 / SOC / SAS certified.

Exhibit VI: Questionnaire - Data and Reports

1. 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.

2. What is your proposed frequency of reporting on utilization experience? Is there a charge for utilization data analysis?

3. Are there any additional fees for reporting? Please provide all reporting options/packages and their associated costs.

4. Will there be online access for claim reports?

5. 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.

6. How do you identify fraudulent claims and how will you notify the entity?

7. Describe the process for identifying and paying claims which may be subject to subrogation.

8. Will there be online access for claim reports by the Entity and Gehring Group?

SECTION V: Response Forms

Exhibit VI: Questionnaire - Implementation and Billing

1. Please provide a brief description of the implementation process, including requirements and timeline.

2. Please confirm proposer is flexible to modify standard contract language.

3. Please confirm proposer is willing to waive binder payment requirements.

4. Please confirm proposer is willing to accept a self-bill for proposed line(s) of coverage.

5. What is proposer's standard billing snapshot date and grace period for payment?

Exhibit VI: Questionnaire - Renewal Planning and Additional Fees

1. Is proposer willing to provide renewal offer at least 180 days prior to renewal effective date?

2. Are any of the rates proposed contingent on any additional information? If so, please disclose.

3. What additional services are available and at what cost?

4. Would you allow a grace period after the due date of 45 days for payment of an invoice?

5. Please confirm any bundling discounts you are offering here.

SECTION V: Response Forms

Exhibit VI: Questionnaire - 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?

SECTION V: Response Forms

Exhibit VI: Questionnaire - Medical

1. Please provide a Medical Geo Access report that illustrates the number of: a. 1 Hospital within 10 miles b. 2 PCPs & Pediatricians within 10 miles c. 2 OBs/Gyns, within 10 miles d. 2 Specialists within 10 miles (excluding OBs/Gyns) e. 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.

2. Please confirm average discounts for the geographic area represented in employee/member census as follows: Please provide this information for the following counties in order: Pinellas County, Hillsborough County, Pasco County, Manatee County, Hernando County.

Charge Type	Pinellas County	Hillsborough County	Pasco County	Manatee County	Hernando County
Location					
Doctors					
Urgent Care Centers					
Out-Patient Hospital					
In-Patient Hospital					
All Others					

SECTION V: Response Forms

Exhibit VI: Questionnaire - Medical

3. Please identify proposed provider network.

4. For bidders not proposing national network coverage, please describe available access for out-of-state residents (retirees and/or dependents of covered participants).

5. Is proposer willing to provide performance guarantees for your network discounting? If so, please include details.

6. Please confirm requirements for coordination with Medicare for both active employees and their dependents, as well as retired employees and their dependents.

7. Each proposer must confirm that they will provide the following reports upon request (possibly quarterly) by the Entity or its Agent of Record: a. Large Claimants (over $25,000) inclusive of gender, plan, diagnosis, last date of service, prognosis and if the claimant remains covered on the plan. b. Utilization reports by diagnosis, place of service, employee vs. dependent costs. c. Monthly paid claims.

8. Are you willing to conduct face-to-face meetings annually (including medical/pharmacy director and financial analyst support) with the client to discuss financial and program enhancement/cost containment ideas that will assist the client in benefit design strategy, and will not necessarily be focused on plan design coverage reductions?

9. Are you willing to waive the actively at work, dependent non-confinement limitation provisions for all currently enrolled individuals on medical?

10. Please list and describe your Disease Management programs that are included in proposal.

11. Please list and describe Utilization Management programs included in proposal and other available options, if applicable.

12. Please confirm dependent child(ren) eligibility.

13. Please confirm proposer has included telemedicine benefit in medical quote.

14. How do you handle transition of care for members currently undergoing treatment or have existing relationships with the incumbent carrier's network providers?

15. Self-Insured: Provide recommended premium equivalents for the current plan designs shown in the medical benefit response form section.

16. Self-Insured: Please confirm if medical ASO quote is contingent upon bundled Stop Loss and/or PBM administration. If so, please confirm what is required to be attached and/or pricing differential without bundled administration.

SECTION V: Response Forms

Exhibit VI: Questionnaire - Medical

17. Self-Insured: Is your company willing to provide administrative fee guarantee? If so, please provide the details of your guarantee.

18. Please confirm you provided a response to the medical provider network disruption report indicating which of those medical providers are in or out of your proposed network.

19. Please confirm you provided a response to the prescription drug disruption report indicating which Pharmacy benefit tier each of the listed drugs is covered under or if they are not included in your formulary.

20. Please confirm the additional funds included in your proposal here including wellness funds, on-site wellness representative fund, employee wellness center fund, discretionary funds, or any other funds.

21. Is proposer willing to provide performance guarantees around Rx rebates? If so, please include details.

22. Please confirm your medical insurance proposal is submitted net of broker commissions.

SECTION V: Response Forms

Exhibit VI: Questionnaire - Stop Loss

1. Please confirm proposed quote is firm. If not, please provide details as to why.

2. Please confirm proposed quote contract terms.

3. Please confirm proposal does not include lasers.

4. Please confirm proposer's process for inclusion of lasers, if applicable, at renewal.

5. Please detail data requirements in order to process reimbursements.

6. What is the period for reimbursements once the claim information is submitted for payment? Do you offer Advanced Funding on claims reimbursements at no cost to the client?

7. Please confirm that proposer will base stop loss coverage reimbursements on the 'Eligible Expenses' as defined by the medical ASO plan document.

8. Does proposal exclude any member population included in census?

9. If proposer is awarded the Stop Loss insurance contract, please confirm if policy is guaranteed renewable.

10. How many months of current year experience are required to offer a firm renewal?

11. Upon underwriting approval, does proposer offer a maximum renewal rate cap on specific rates?

12. Please confirm if your stop loss proposal matches the City's current ISL layout ($250k ISL/$350k ISL with 50% cost share). If you are unable to quote this option please confirm you are quoting a $300k ISL.

13. Please confirm your stop loss proposal does not include aggregate stop loss coverage.

SECTION V: Response Forms

Exhibit VI: Questionnaire - Wellness

1. Please disclose the name of your proposed wellness program and any wellness funds you are offering the City.

2. Did proposer include the criteria associated with how the Entity can use the wellness funds?

3. Are there any additional costs to the Entity or employees for participation in your wellness programs or services?

4. Will the account team assigned include a designated wellness coordinator? If so, which wellness services will be included?

5. 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.

6. Does your wellness program provide a proactive health education and improvement program for those with a chronic condition?

7. Does your wellness program utilize behavioral coaching principles and evidence-based medicine guidelines to optimize self-management skills to foster sustained health improvement?

8. Does your wellness program include: a. Chronic condition-specific coaching? b. Pre- and post-discharge calls? c. Lifestyle management coaching: stress, weight management, and tobacco cessation? d. Treatment decision support and coaching?

SECTION V: Response Forms

Exhibit VII: Other Required Forms

Proposers shall indicate any and all exceptions taken to the provisions or specifications in this solicitation document. Exceptions that surface elsewhere and that do not also appear under this section shall be considered invalid and void and of no contractual significance.

Exceptions (mark one):

****Special Note – Any material exceptions taken to the City's Terms and Conditions may render a Proposal non-responsive.**

_____ No exceptions

_____ Exceptions taken (describe--attach additional pages if needed)

Additional Materials submitted (mark one):

_____ No additional materials have been included with this proposal

_____ Additional Materials attached (describe--attach additional pages if needed)

Acknowledgement of addenda issued for this solicitation:
Prior to submitting a response to this solicitation, it is the vendor's responsibility to confirm if any addenda have been issued.

Addenda Number	Initial to acknowledge receipt

Vendor Name_____ Date: _____

SECTION V: Response Forms

Exhibit VII: Other Required Forms

Company Legal/Corporate Name: _____

Doing Business As (if different than above): _____

Address: _____

City: _____ State: _____ Zip: _____-_____

Phone: _____ Fax: _____

E-Mail Address: _____ Website: _____

DUNS #_____

Remit to Address (if different than above):

Address: _____

City: _____State: ____Zip: _____

Order from Address (if different from above):

Address: _____

City: _____State:_____Zip: _____

Contact for Questions about this proposal:

Name: _____ Fax: _____

Phone: _____ E-Mail Address: _____

Day-to-Day Project Contact (if awarded):

Name: _____ Fax: _____

Phone: _____ E-Mail Address: _____

_____ Certified Small Business

Certifying Agency: _____

_____ Certified Minority, Woman or Disadvantaged Business Enterprise

Certifying Agency: _____

Provide supporting documentation for your certification, if applicable.

SECTION V: Response Forms

Exhibit VII: Other Required Forms

By signing and submitting this Proposal, the Vendor certifies that:

a) It is under no legal prohibition to contract with the City of Clearwater.
b) It has read, understands, and is in compliance with the specifications, terms and conditions stated herein, as well as its attachments, and any referenced documents.
c) It has no known, undisclosed conflicts of interest.
d) The prices offered were independently developed without consultation or collusion with any of the other respondents or potential respondents or any other anti-competitive practices.
e) No offer of gifts, payments or other consideration were made to any City employee, officer, elected official, or consultant who has or may have had a role in the procurement process for the services and or goods/materials covered by this contract.
f) It understands the City of Clearwater may copy all parts of this response, including without limitation any documents and/or materials copyrighted by the respondent, for internal use in evaluating respondent's offer, or in response to a public records request under Florida's public records law (F.S. 119) or other applicable law, subpoena, or other judicial process.
g) Respondent hereby warrants to the City that the respondent and each of its subcontractors ("Subcontractors") will comply with, and are contractually obligated to comply with, all Federal Immigration laws and regulations that relate to their employees.
h) Respondent certifies that they are not in violation of section 6(j) of the Federal Export Administration Act and not debarred by any Federal or public agency.
i) It will provide the materials or services specified in compliance with all Federal, State, and Local Statutes and Rules if awarded by the City.
j) It is current in all obligations due to the City.
k) It will accept such terms and conditions in a resulting contract if awarded by the City.
l) The signatory is an officer or duly authorized agent of the respondent with full power and authority to submit binding offers for the goods or services as specified herein.

ACCEPTED AND AGREED TO:

Company Name: _____

Signature: _____

Printed Name: _____

Title: _____

Date: _____

SECTION V: Response Forms

Exhibit VII: Other Required Forms

SCRUTINIZED COMPANIES AND BUSINESS OPERATIONS WITH CUBA AND SYRIA CERTIFICATION FORM

IF YOUR BID/PROPOSAL IS $1,000,000 OR MORE, THIS FORM MUST BE COMPLETED AND SUBMITTED WITH THE BID/PROPOSAL. FAILURE TO SUBMIT THIS FORM AS REQUIRED MAY DEEM YOUR SUBMITTAL NONRESPONSIVE.

The affiant, by virtue of the signature below, certifies that:

1. The vendor, company, individual, principal, subsidiary, affiliate, or owner is aware of the requirements of section 287.135, Florida Statutes, regarding companies on the Scrutinized Companies with Activities in Sudan List, the Scrutinized Companies with Activities in the Iran Petroleum Energy Sector List, or engaging in business operations in Cuba and Syria; and
2. The vendor, company, individual, principal, subsidiary, affiliate, or owner is eligible to participate in this solicitation and is not listed on either the Scrutinized Companies with Activities in Sudan List, the Scrutinized Companies with Activities in the Iran Petroleum Sector List, or engaged in business operations in Cuba and Syria; and
3. Business Operations means, for purposes specifically related to Cuba or Syria, engaging in commerce in any form in Cuba or Syria, including, but not limited to, acquiring, developing, maintaining, owning, selling, possessing, leasing or operating equipment, facilities, personnel, products, services, personal property, real property, military equipment, or any other apparatus of business or commerce; and
4. If awarded the Contract (or Agreement), the vendor, company, individual, principal, subsidiary, affiliate, or owner will immediately notify the City of Clearwater in writing, no later than five (5) calendar days after any of its principals are placed on the Scrutinized Companies with Activities in Sudan List, the Scrutinized Companies with Activities in the Iran Petroleum Sector List, or engaged in business operations in Cuba and Syria.

_____
Authorized Signature

_____
Printed Name

_____
Title

_____
Name of Entity/Corporation

STATE OF _____

COUNTY OF _____

The foregoing instrument was acknowledged before me by means of ☐ physical presence or ☐ online notarization on, this _____ day of _____, 20____, by _____ (name of person whose signature is being notarized) as the _____ (title) of _____(name of corporation/entity), personally known _____, or produced _____ (type of identification) as identification, and who did/did not take an oath.

_____
Notary Public

_____
Printed Name

My Commission Expires: _____
NOTARY SEAL ABOVE

SECTION V: Response Forms

Exhibit VII: Other Required Forms

SCRUTINIZED COMPANIES THAT BOYCOTT ISRAEL LIST CERTIFICATION FORM

THIS FORM MUST BE COMPLETED AND SUBMITTED WITH THE BID/PROPOSAL. FAILURE TO SUBMIT THIS FORM AS REQUIRED MAY DEEM YOUR SUBMITTAL NONRESPONSIVE.

The affiant, by virtue of the signature below, certifies that:

1. The vendor, company, individual, principal, subsidiary, affiliate, or owner is aware of the requirements of section 287.135, Florida Statutes, regarding companies on the Scrutinized Companies that Boycott Israel List, or engaged in a boycott of Israel; and
2. The vendor, company, individual, principal, subsidiary, affiliate, or owner is eligible to participate in this solicitation and is not listed on the Scrutinized Companies that Boycott Israel List, or engaged in a boycott of Israel; and
3. "Boycott Israel" or "boycott of Israel" means refusing to deal, terminating business activities, or taking other actions to limit commercial relations with Israel, or persons or entities doing business in Israel or in Israeli-controlled territories, in a discriminatory manner. A statement by a company that it is participating in a boycott of Israel, or that it has initiated a boycott in response to a request for a boycott of Israel or in compliance with, or in furtherance of, calls for a boycott of Israel, may be considered as evidence that a company is participating in a boycott of Israel; and
4. If awarded the Contract (or Agreement), the vendor, company, individual, principal, subsidiary, affiliate, or owner will immediately notify the City of Clearwater in writing, no later than five (5) calendar days after any of its principals are placed on the Scrutinized Companies that Boycott Israel List, or engaged in a boycott of Israel.

_____
Authorized Signature

_____
Printed Name

_____
Title

_____
Name of Entity/Corporation

STATE OF _____

COUNTY OF _____

The foregoing instrument was acknowledged before me by means of ☐ physical presence or ☐ online notarization on, this _____ day of _____, 20____, by _____ (name of person whose signature is being notarized) as the _____ (title) of _____(name of corporation/entity), personally known _____, or produced _____ (type of identification) as identification, and who did/did not take an oath.

_____
Notary Public

_____
Printed Name

My Commission Expires: _____
NOTARY SEAL ABOVE

SECTION V: Response Forms

Exhibit VII: Other Required Forms

VERIFICATION OF EMPLOYMENT ELIGIBILITY FORM

PER FLORIDA STATUTE 448.095, CONTRACTORS AND SUBCONTRACTORS MUST REGISTER WITH AND USE THE E-VERIFY SYSTEM TO VERIFY THE WORK AUTHORIZATION STATUS OF ALL NEWLY HIRED EMPLOYEES.

THIS FORM MUST BE COMPLETED AND SUBMITTED WITH THE BID/PROPOSAL. FAILURE TO SUBMIT THIS FORM AS REQUIRED MAY DEEM YOUR SUBMITTAL NONRESPONSIVE.

The affiant, by virtue of the signature below, certifies that:

1. The Contractor and its Subcontractors are aware of the requirements of Florida Statute 448.095.
2. The Contractor and its Subcontractors are registered with and using the E-Verify system to verify the work authorization status of newly hired employees.
3. The Contractor will not enter into a contract with any Subcontractor unless each party to the contract registers with and uses the E-Verify system.
4. The Subcontractor will provide the Contractor with an affidavit stating that the Subcontractor does not employ, contract with, or subcontract with unauthorized alien.
5. The Contractor must maintain a copy of such affidavit.
6. The City may terminate this Contract on the good faith belief that the Contractor or its Subcontractors knowingly violated Florida Statutes 448.09(1) or 448.095(2)(c).
7. If this Contract is terminated pursuant to Florida Statute 448.095(2)(c), the Contractor may not be awarded a public contract for at least 1 year after the date on which this Contract was terminated.
8. The Contractor is liable for any additional cost incurred by the City as a result of the termination of this Contract.

_____
Authorized Signature

_____
Printed Name

_____
Title

_____
Name of Entity/Corporation

STATE OF _____

COUNTY OF _____

The foregoing instrument was acknowledged before me by means of ☐ physical presence or ☐ online notarization on, this _____ day of _____, 20____, by _____ (name of person whose signature is being notarized) as the _____ (title) of _____(name of corporation/entity), personally known _____, or produced _____ (type of identification) as identification, and who did/did not take an oath.

_____
Notary Public

_____
Printed Name

My Commission Expires: _____
NOTARY SEAL ABOVE

SECTION VI: Attachments

Note: All attachments in this RFP will be via released via secure email by the City's Agent of Record: Gehring Group.

ATTACHMENT 1 ..... FULL POPULATION CENSUS
ATTACHMENT 2 ..... MEDICAL INSURANCE CENSUS
ATTACHMENT 3 ..... EMPLOYEE ASSISTANCE PROGRAM CENSUS
ATTACHMENT 4 ..... MEDICAL CLAIMS EXPERIENCE & ENROLLMENT DATA
ATTACHMENT 5 ..... EMPLOYEE ASSISTANCE PROGRAM UTILIZATION DATA
ATTACHMENT 6 ..... MEDICAL PROVIDER DISRUPTION DATA
ATTACHMENT 7 ..... PHARMACY FORMULARY DISRUPTION DATA
ATTACHMENT 8 ..... MEDICAL BENEFIT SUMMARY
ATTACHMENT 8 ..... MEDICAL SBC
ATTACHMENT 9 ..... STOP LOSS POLICY
ATTACHMENT 10 ..... MEDICAL ASO AMENDMENT
ATTACHMENT 11 ..... EMPLOYEE ASSISTANCE PROGRAM BENEFIT SUMMARY
ATTACHMENT 12 ..... CITY & GEHRING GROUP AGREEMENT (AOR)
ATTACHMENT 13..... CITY INSURANCE REQUIREMENTS
ATTACHMENT 14..... CITY STANDARD TERMS & CONDITONS