Houston County Texas

REQUEST FOR PROPOSAL

Fully-Insured
Group Health, Dental and Life

Plan Year: 10/1/2023 to 9/30/2024

Proposal Due Date:
_____ at _____ P.M.

Prepared by:
Kris Dyches:

REQUEST FOR PROPOSAL FOR Houston County Texas COUNTY/ENTITY

FULLY INSURED GROUP MEDICAL COVERAGE

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Section I

Introduction & Timetable

Houston County Texas (hereinafter referred to as the County) is seeking proposals in response to this Request for Proposal (RFP) for a fully insured group medical program for employees, officials, and dependents from carriers qualified to provide these services and/or products for the County/Entity's benefits plan. This RFP is for the purpose of soliciting fully insured proposals in accordance with *Texas Local Government Code* Chapter 262.

Electronic proposals will be accepted via secured email or USB flash drive. Submissions must be clearly marked "GROUP MEDICAL PROPOSAL" and will be received no later than 3 p. m., Monday, June 12, 2023 p.m. Emailed proposals should be sent to **kdyches@co.houston.tx.us**

USB flash drives must be in a sealed envelope and may only be delivered in person, from U.S. Post Office or delivery service. The County will not be responsible for any lost or late deliveries. Address proposals to the County to the attention of:

Kris Dyches
Insurance Coordinator
401 E. Goliad Suite 201
Crockett, Texas, 75835
936-544-3255 ext. 355

Sealed proposals, one (1) original and (1) copy, must be clearly marked "GROUP MEDICAL PROPOSAL", and will be received no later than 3 p. m., Monday, June 12, 2023 p.m. Delivery may only be made in person, from U.S. Post Office or delivery service. The County will not be responsible for any lost or late deliveries. Address proposals to the County to the attention of:

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County requests proposals with and without broker/agent commissions and any commissions shall be fully disclosed

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Timetable for Proposals

Schedule	**Date**
Advertisement of Proposals on County Website:	6/1/2023
RFP Release Date:	6/1/2023
RFP Questions Due:	6/8/2023
Response to Questions:	6/13/2023
Proposal Due Date:	6/15/2023 – 4 pm
Targeted Proposal Award Date:	6/20/2023
Enrollment Meetings to be scheduled within:	8/21-8/25/2023
Plan Effective Date:	10/1/2023

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Houston County Information

Group: Houston County/Entity

Current Census: 112 Employees

Medical Premium Rate Structure: 4 tier rate basis: Employee Only, Employee & Spouse, Employee & Child(ren), Employee & Family

Health Benefits Plan History for the past 2 years:

Medical Carrier:	Coverage Date (s):	Dental Carrier:	Coverage Date (s):	Life/ AD&D Carrier:	Coverage Date (s):
Texas Association of Counties Health & Employees Benefits Pool - Blue Cross Blue Shield	10/1/2022-9/30/2023	N/A	N/A	Lincoln Financial Group	10/1/2022-9/30/2023

Waiting Period:
The County/Entity plan will have a waiting period of:

- New Enrollees – Effective First of the month following 60 days
- Elected Officials – Effective Date of Hire/no waiting period

Employer Contribution:
The County/Entity pays 100% of the cost for employees and 0 % for dependents.
Actual rates charged to the dependents will be determined by Commissioners Court.

Number of COBRA participants and benefit expiration date for each: None

Number of employees waiving coverage: 12 full time employees

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Retiree Medical Benefits**:**

Group Plan

- Pre-65 and Post-65 Retiree Benefits are requested

Medicare Supplement

- Request quote for Post-65 (Medicare Eligible) Supplemental Plan

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Section II

General Proposal Information

A. Requested Proposals

The County/Entity is seeking proposals on group medical benefits for retirees, eligible employees and their dependents.

Proposals shall include fully-insured PPO group medical plans from carriers qualified to provide these services and/or products for the County/Entity's benefit plan. All costs of proposal preparation shall be assumed by the proposer.

Proposed medical plan should duplicate current benefits as closely as possible. Alternate plans may be considered but differences should be fully disclosed.

B. Proposed Coverage Period

The EFFECTIVE DATE of coverage is specified in Section I. Proposed rates shall remain in effect and be guaranteed for at least 12 months. Rates shall be firm, except for changes in census data and number of participants, at the time proposal is due. All underwriting shall be completed by due date.

County/Entity reserves the right to terminate contract at any time with a 30-day written notice. It is the intention of the County/Entity to continue coverage for at least 12 months.

Proposals may be withdrawn, in writing, prior to the due date specified in Section I. All offers will remain open and guaranteed for at least 90 days after the due date.

C. Period of Contract

The initial period of this contract and any resulting renewals shall be for a one (1) year period.

D. Proposal Deadline

Original and copies of the proposal must be submitted no later than PROPOSAL DUE DATE (Refer to Section I).

Proposals received after PROPOSAL DUE DATE may be returned.

E. Company Eligibility

All proposals must include the name of the insurance carrier, which should have a current general policyholder rating of "A-" published by AM Best or be registered with the Texas Department of Insurance as a non-profit company or a Pool in accordance with the *Texas Local Government Code* Chapter 172. If a quoting company has a lower rating or is ineligible for a rating, evidence supporting the financial stability and service capabilities of the company should be submitted.

The Insurance Carrier must pay claims in Texas for at least 10,000 employee lives.

F. Reservation of Rights

The County/Entity reserves the right to reject all proposals, in whole or in part, waive any technicalities, and to accept the proposal which in its judgment is in the best interest of the county/entity and its employees.

G. Award Consideration

Selection will be based on the following evaluation criteria. There are 100 total points available, and the system is weighted so that important aspects such as price and network availability/effectiveness are given more value. This weighing system is typical of the evaluation criteria that many local governments use in order to comply with the Texas Local Government Code; however, it may be adapted to reflect the priorities of the County/Entity.

Scoring System:

Benefits	20%
Network	25%
Total cost	25%
Financial stability	15%
Service	15%

H. Participant Eligibility Criteria

All full-time (not temporary) employees and their dependents covered by the current plan will receive immediate coverage as of the effective date. Coverage for current participants will be covered with no pre-existing condition limitations according to HIPAA. Proposal must also cover COBRA participants who opt to continue coverage.

Eligible participants:

1. Full time Employees (not temporary) working 40 hours per week
2. Elected and Appointed Officials
3. Eligible Retirees

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I. Requests for Additional Information

Requests for additional information may be submitted in writing via e-mail until June 5, 2023 to: **kdyches@co.houston.tx.co.**

Please note the County/Entity believes the information contained in this RFP to be correct. Proposers must assume ultimate responsibility for ensuring its accuracy.

Responses will be forwarded to all known proposers by date shown in Section I.

J. Legal

All proposers are expected to comply with all federal, state, and local laws and regulations relative to the preparation and submission of insurance proposals.

K. Confidentiality

The information contained in this RFP is confidential and may be used solely for the purpose of preparing proposals for the County/Entity. This includes all information relating to the medical condition of persons covered by county's benefit program. **The contents of proposals shall also remain confidential during the review process.**

L. Continuity of Coverage

All employees, COBRA participants, and covered dependents on the current plan are to be administered on a "no-loss/ no gain" basis by the insurance coverage. "Actively At Work" provisions must not apply to persons covered under the plan on the EFFECTIVE DATE (refer to Section I).

In fulfilling the continuity of coverage requirements, full credit must be allowed for all or any part of the major medical deductibles, coinsurance and preexisting conditions satisfied under the current program.

M. Census

The current census is provided. For proposing purposes, rates must be based on the participation figures provided in the census.

N. Negotiated Proposals

This RFP and any negotiations shall be made in compliance with the Texas Local Government Code Chapter 262.030.

During this portion of the process, if selected, proposers may be provided with an opportunity to change pricing or benefit provisions to become more competitive or in response to more current medical claims information.

O. Disqualification and Rejection of Proposals

Proposals shall conform to the attached specifications and any deviations may be grounds for rejection of

the proposal. Benefit options will be allowed, if clearly and specifically identified and explained. The County/Entity reserves the right to disqualify proposers who fail to comply with the provisions of this RFP. Any deviations must be clearly noted.

P. Reports / Renewal

The Insurance carrier guarantees to provide complete annual claims information. This information must include paid claims and detailed information on all claims over $10,000 (in accordance with the Health Insurance Portability and Accountability Act- HIPAA). The Insurance Carrier further agrees to deliver the complete renewal no later than 60 days prior to renewal date.

Q. Enrollment Meetings

Selected carrier will conduct initial employee meetings to explain new program benefits and be responsible for enrollment materials.

R. Proposal Questionnaire

Each proposal must include a completed Proposal Questionnaire. The questionnaire is provided in Section III of the RFP. Proposers electing not to answer certain questions should explain the reasons for not responding.

S. Submission Forms

Each proposal must include a completed Rate Submission Form for each plan quoted. The form is provided in Section IV.

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SECTION III

Medical Questionnaire

About the Insurance Company

1. Provide insurance carrier's name, location, and contact person

2. What is the current AM Best rating for your company?

3. Is your company regulated by the Texas Department of Insurance? ☐ Yes ☐ No

   If no, describe the kind of arrangement and guarantee provided to ensure payment of claims if the company becomes insolvent.

4. Please indicate number of covered employees and length of time firm has been in business in this capacity.

5. Are there a minimum number of participants required? ☐ Yes ☐ No

   If so, what is that number percentage of eligible employees?

6. Have any lawsuits been filed against your organization related to any of your health care products or administrative services in the last three years? Please describe the nature of any lawsuits, dates, and outcomes.

7. Provide three (3) governmental entity references, including contact name and phone number, for which your company provides group health insurance services. Include groups of similar size if possible.

8. Describe your proposal's wellness programs including all events, programs, nurse related services and condition management efforts.

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Plan Implementation

9. Do you agree to a no-loss/no-gain takeover of all benefits? ☐ Yes ☐ No

10. Will credit be given for deductible and coinsurance accumulations upon the initial plan takeover? ☐ Yes ☐ No

11. Does your plan include a deductible carryover into a subsequent year? ☐ Yes ☐ No
    What is the carryover period?

Account and Customer Services

12. Will our account to be handled by one main contact person or team? Please provide the contact person or team leader's name and contact information.

13. Is there a toll-free customer service number available to plan participants to verify benefit information, claims questions, and for providing referrals? ☐ Yes ☐ No

COBRA

14. Please include the cost for using your company for COBRA services and describe the services provided.

Deviations

15. Describe any deviations from the requirements of this RFP. The company providing this proposal is liable for the addition, including the costs, of differences not clearly noted in this question.

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SECTION IV

EXHIBITS

1. Copy of Newspaper Advertisement
2. Benefit Plan Design - past 2-3 years (if changed between years) for medical, Rx, dental & life(Delete benefits that are not being requested)
3. Current Census- including gender, DOB, tier description (EO, EC, ES, EF), status (active, retiree, COBRA, waive) for medical, Rx, dental, & life (Delete benefits that are not being requested)
4. Claims History – 2 years (3 years preferable) of monthly claims, premiums & enrollment for medical, Rx, dental & life (Delete benefits that are not being requested)
5. High Claimants Report ($10,000+) including diagnosis with last date of service & prognosis if available.
6. Current Billing Invoice(s)
7. Prior Year Renewal Rates or copy of an invoice from previous year
8. Census Summary (Attached for group to complete)
9. Employer Contribution Summary (Attached for group to complete)
10. Rate Submission Form (Proposer to complete)

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Census Summary

Proposals shall be based on the county/entity's current enrollment. Census attached. Below is a summary of how many employees are in each tier.

HEALTH	Active	COBRA	Retiree under 65	Retiree over 65	Total
Employee Only	100				
Employee & 1 Child (if applicable)					
Employee & Children	8				
Employee & Spouse	3				
Employee & Family					
Total HEALTH	111				

DENTAL	Active	COBRA	Retiree under 65	Retiree over 65	
Employee Only	20		N/A	N/A	
Employee & Family	5				
Total DENTAL	25				

LIFE and AD&D	Active	COBRA	Retiree under 65	Retiree over 65	
Employee Only	118	N/A	N/A	N/A	
Total LIFE					

VISION	Active	COBRA	Retiree under 65	Retiree over 65	
Employee Only	57	N/A	N/A	N/A	
Employee & Family	10				
Total VISION	67				

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Employer Contribution Summary

Listed below are current contribution amounts (or percentages) for each benefit.

(County/Entity completes each blank below) Delete any tiers not applicable.

		Amount Employer Pays		Amount Employee Pays		Amount Retiree pays (if applicable)
Health:						
Employee Only:	$	859.02	$	0.00	$	0.00
Employee + 1 Child:	$	0.00	$	279.54	$	279.54
Employee + Children	$	0.00	$	588.84	$	588.84
Employee + Spouse	$	859.02	$	963.90	$	963.90
Employee + Family	$	859.02	$	1,156.78	$	1,156.78
Vision:						
Employee Only:	$	0.00	$	6.20	N/A	
Employee + Children	$	0.00	$	12.44	N/A	
Employee + Spouse	$	0.00	$	11.80	N/A	
Employee + Family	$	0.00	$	18.28	N/A	
Dental:						
Employee Only:	$	0.00	Dependent on Plan		N/A	
Employee + 1 Child:	$	0.00	Dependent on Plan		N/A	
Employee + Children	$	0.00	Dependent on Plan		N/A	
Employee + Spouse	$	0.00	Dependent on Plan		N/A	
Employee + Family	$	0.00	Dependent on Plan		N/A	

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		Amount Employer Pays		Amount Employee Pays	Amount Retiree pays (if applicable)
Life:					
Group life & AD&D:	$	19.75	$	0.00	N/A
Additional Life:		N/A		N/A	N/A
LTD/STD:		N/A		N/A	N/A

Current Term Life Benefit Plan: Please duplicate current benefits as closely as possible. Alternate plans may be considered

Term Life Volume per covered person

Basic Life	$ 50,000
AD&D	$ 50,000
Retiree Life	$ N/A

Voluntary Dependent

Volume – Spouse	$ N/A
Volume – Child (ren)	$ N/A

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Rate Submission Form

Proposer must fill out this form.

MEDICAL	RATES PER MONTH
Employee Only	**$**
Employee & 1 Child (if applicable)	**$**
Employee & Children	**$**
Employee & Spouse	**$**
Employee & Family	**$**
Broker commission included?	☐ Yes* ☐ No

*Rates shown above include an approximate broker commission of $_____Annually.

DENTAL	RATES PER MONTH
Employee Only	**$**
Employee & Family	**$**
Broker commission included?	☐ Yes* ☐ No

*Rates shown above include an approximate broker commission of $_____Annually.

VISION	RATES PER MONTH
Employee Only	**$**
Employee & Family	**$**
Broker commission included?	☐ Yes* ☐ No

*Rates shown above include an approximate broker commission of $_____Annually.

LIFE	RATES PER MONTH
Volume Amount Quoted:	$
Term Life per $1000	**$**
AD&D per $1000	**$**
Broker commission included?	☐ Yes* ☐ No

*Rates shown above include an approximate broker commission of $_____Annually.