

Arkansas Comprehensive Health Insurance Pool (“CHIP”)

Pre-Existing Condition Insurance Plan Administered By CHIP

**Request for Proposals to Act as Plan Administrator for CHIP and PCIP
Programs**

December 21, 2010

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Request for Proposals to Act as Plan Administrator for CHIP and PCIP Programs

December 21, 2010

1. General Information

1.1. **Introduction to the CHIP and PCIP Programs.** The Board of CHIP hereby issues a request for proposals (“RFP”) for Qualified Bidders to act as Plan Administrator for CHIP *and* PCIP for a three-year contract period beginning July 1, 2011 and ending June 30, 2014. The CHIP and PCIP programs are currently scheduled to end on December 31, 2013, with both programs being replaced as of January 1, 2014 by the health insurance exchanges and the individual health insurance mandate created pursuant to the Patient Protection and Affordable Care Act, as modified by the Health Care Education and Reconciliation Act (collectively “Affordable Care Act”). Accordingly, the last six (6) months of this Contract will consist of administering run-off claims and other close out functions on behalf of CHIP and PCIP. CHIP may extend the term of this Contract for additional three-month periods of performance, as necessary, to ensure the proper administration of close-out functions. In order to extend the period of performance beyond June 30, 2014, CHIP must provide written notice to the Selected Bidder no later than ninety (90) days prior to that date. This RFP and the Selected Bidder’s proposal will become part of the Contract between CHIP and the Selected Bidder.

1.1.1. **Arkansas Comprehensive Health Insurance Pool (“CHIP”).** CHIP operates as a nonprofit legal entity and political subdivision, instrumentality and body politic of the State of Arkansas. The Arkansas General Assembly first created CHIP in 1995 to provide insurance coverage for Arkansas residents with high-risk conditions who could not obtain coverage through the individual health insurance market. CHIP began selling coverage on July 28, 1996.

In 1997, the Arkansas General Assembly modified the law to make CHIP a “qualified high risk pool” under 45 Code of Federal Regulations (“C.F.R.”) §148.128 of the rules implementing HIPAA portability provisions, offering an alternative portability mechanism for Arkansas residents who exhaust their coverage options in the group market. In accordance with section 148.128, the Centers for Medicare and Medicaid Services (“CMS”) has certified CHIP as a qualified high risk pool in 1997, 2000, 2003, 2007 and 2009.

In the spring of 2003, the General Assembly authorized CHIP to offer coverage to a third category of Arkansas residents—persons eligible for the Health Coverage Tax Credit (“HCTC”) pursuant to the Trade Adjustment Assistance Act of 2002 and their qualifying family members (collectively, “HCTC Eligibles”), generally either persons who have lost their job because their employer has moved facilities overseas, or who have lost access to pension benefits. CHIP opened enrollment to HCTC Eligibles in August 2003, in conjunction with federal implementation of the Health Coverage Tax Credit Processing Center, which provides advances on tax credits to HCTC Eligibles to supplement CHIP premium payments. Participation in the HCTC program has been limited all over the country and Arkansas is no exception. Only a small number of Policyholders are enrolled in CHIP as HCTC Eligibles.

CHIP is governed by a seven-member Board of Directors appointed by the Commissioner of Insurance. By statute, the Board is composed of the following members:

- Two current or former employees of insurers licensed to do business in Arkansas;
- Two current or former employees of an Arkansas-licensed HMO;
- One who is from a health-related profession;
- One who is a Policyholder of the general public not associated with the medical profession, a hospital or an insurer;
- One who represents a group considered to be uninsurable.

In accordance with Arkansas Code Annotated (“A.C.A.”) §23-79-507, CHIP relies on two primary sources of revenue—(1) premiums collected from Policyholders and (2) assessments on Insurers doing business in Arkansas. CHIP premium rates are reviewed every six months and adjusted, if necessary, based on the experience of the CHIP population. Under section 23-79-507, CHIP rates can be no more than 150% of the standard risk rate in the Arkansas individual health insurance market. *See* A.C.A. §23-79-507(a)(2)(B).

Premiums are limited by statute to no more than 150% of the standard risk rate for individual health insurance in Arkansas do not typically cover the total medical costs of CHIP Policyholders and CHIP’s administrative expenses. Accordingly, CHIP’s Board is authorized to assess Insurers doing business in Arkansas to make up for any shortfall on revenue. “Insurers,” generally companies who provide health insurance or health maintenance organization coverage, and excess or stop loss coverage for self-funded plans, are defined in Subsection 1.3 of the RFP. On occasion, CHIP’s operations may be audited or reviewed by state authorities because Insurers assessed by CHIP are entitled to a premium tax credit by the state of Arkansas for the assessment period. *See* A.C.A. §23-76-507(c).

Over the past several years, CHIP also has obtained federal grant funds to offset operational losses and to fund disease management efforts. It is not known whether such grant funds will be available in the future.

In accordance with A.C.A. §23-79-504, CHIP is not subject to:

- State, county and local taxes;
- the Arkansas Procurement Law (A.C.A. §19-11-201, et seq.);
- the Arkansas Freedom of Information Act (A.C.A. §25-19-101, et seq.); or
- the Arkansas Administrative Procedure Act (A.C.A. §25-15-201, et seq.)

CHIP’s fiscal year begins July 1. The number of monthly enrollees as of July 1, 2009 through November 1, 2010 is included in **Exhibit A** to this RFP.

- 1.1.2. **Introduction to the Pre-Existing Condition Insurance Plan (“PCIP”)**. The Affordable Care Act, which became law in March 2010, created a new program – the Pre-Existing Condition Insurance Plan – to make health insurance available to

certain individuals denied coverage by private insurance companies because of a pre-existing condition. The statutory authority for PCIP is set out at section 1101(b) of the Affordable Care Act, which authorizes HHS to enter into contracts with non-profit entities such as CHIP to establish and operate PCIP to provide coverage for eligible individuals beginning in 2010 and ending on December 31, 2013.

PCIP is administered by CHIP pursuant to its contract with HHS that is attached hereto as **Exhibit B** (*With Proprietary and Confidential Documents Removed*). PCIP has approximately \$46 million in federal funds allotted to it over the projected lifetime of the program. Enrollment is currently limited to no more than to 2,500 individuals to ensure that funding lasts over the course of the program. PCIP benefits are designed in a manner very similar to CHIP's. Under the Affordable Care Act, PCIP premiums are set at 100% of the standard risk rate for individual health insurance in Arkansas. Expenses for PCIP above the level paid for through enrollee premiums will be paid for by the federal fund allotment. PCIP is not funded with Arkansas tax dollars.

As in the rest of the country, the PCIP program has begun slowly in Arkansas. Reasons for this slow start may relate to the eligibility requirement, prescribed by the Affordable Care Act, that an applicant must have been uninsured for at least six months. Because of this requirement, for example, no one currently enrolled in CHIP qualifies for enrollment in PCIP because such individuals have health insurance coverage. Another reason for the slow pace of enrollment may be that premiums may be considered unaffordable by many uninsured Arkansans, even though they are set at the standard risk rate for individual coverage in Arkansas. **Exhibit C** to the RFP sets forth the enrollment levels of PCIP during its first three months of its enrollment, September-November 2010.

1.2. **Qualified Bidders for this RFP.** Only Bidders qualified by statute and by this RFP may submit proposals to perform services for CHIP as Plan Administrator in response to this RFP. Qualifications and duties of the Plan Administrator are described in A.C.A. §23-79-508. **The Plan Administrator must be an Insurer as defined by this RFP and A.C.A. §23-79-503.** Criteria by which the Board shall evaluate Bidders who submit proposals in response to this RFP shall include the following:

- The Insurer's proven ability to handle large group accident and health benefit plans;
- The efficiency and timeliness of the Insurer's claim processing procedures and other administrative procedures of an accident and health insurer;
- The Insurer's provider network;
- The Insurer's cost proposal for administering CHIP's benefit plans;
- The Insurer's ability to apply effective cost containment programs and procedures and to administer the Plan in a cost effective manner; and
- The financial condition and stability of the Insurer.

Criteria for selecting the Plan Administrator are described more fully in Section 5 of the RFP.

Unless CHIP exercises its right to extend the term of the Contract pursuant to Subsection 1.1 of the RFP, the Plan Administrator shall serve for a period of three (3) years, subject to removal for cause and subject to the terms, conditions and limitations of the Contract entered

into between the Board and the Plan Administrator. Key duties of the Plan Administrator include:

- Determining eligibility for coverage;
- Establishing premium billing procedures and collection of premiums;
- Adjudication and timely payment of claims, including pharmacy claims;
- Responding to questions about benefits, premium payments, claims or other inquiries from prospective applicants, Policyholders, health care providers and other individuals;
- Regular reporting to the Board, in a manner determined by the Board;
- Implementation of cost containment procedures;
- Other services related to the above services.

Duties of the Plan Administrator are described further below in Section 3.

The Plan Administrator may subcontract administrative duties to another organization that is not an Insurer. A Qualified Bidder must identify and describe any such subcontracts in its proposal, as described further in Section 3 of the RFP.

1.3. **Definitions and Acronyms.**

- 1.3.1. **Bidder** means an entity that submits a proposal in response to this RFP.
- 1.3.2. **Board** means the CHIP Board of Directors, as described in Subsection 1.1.1
- 1.3.3. **CHIP** means the Arkansas Comprehensive Health Insurance Pool. When “CHIP is used in reference to coverage or a benefit plan, CHIP refers to the plans offered under the program described in Subsection 1.1.1 of the RFP.
- 1.3.4. **Commissioner** means the Arkansas Insurance Commissioner.
- 1.3.5. **Contract** means the agreement to be executed between the Selected Bidder and the Board. The Contract shall include this RFP, including all of its Exhibits, the Selected Bidder’s proposal response and a base contract to be negotiated between the Selected Bidder and the Board.
- 1.3.6. **Creditable Coverage** means coverage as defined under both section 2701(c)(1) of the Public Health Service Act before enactment of the Affordable Care Act and 45 CFR 146.113(a)(1).
- 1.3.7. **Federally Eligible Individual** means an Arkansas resident who is eligible for CHIP coverage because he or she has exhausted his or her coverage options in the group market in accordance with HIPAA and regulations implementing HIPAA.
- 1.3.8. **HCTC Eligible** means an individual who is eligible for CHIP coverage because he or she qualifies for a Health Coverage Tax Credit under the Trade Assistance Act of 2002 and applicable regulations.
- 1.3.9. **HIPAA** means Health Insurance Portability and Accountability Act of 1997.

- 1.3.10. **HITECH Act** means the Health Information Technology for Economic and Clinical Health Act of 2009.
- 1.3.11. **Insurer** means any entity that provides health insurance, including excess or stop-loss health insurance, in the State of Arkansas. In this RFP, Insurer includes an insurance company, a medical services plan, a hospital plan, a hospital medical service corporation, a health maintenance organization, a fraternal benefits society, or any other entity providing a plan of health insurance or health benefits subject to state insurance regulation.
- 1.3.12. **Network Provider** means a professional, institutional or other provider under contract with the Plan Administrator or a subcontractor of the Plan Administrator who has agreed to provide services to CHIP Policyholders at the in-network rate specified in the contract between the Network Provider and either the Plan Administrator; or a subcontractor of the Plan administrator.
- 1.3.13. **PCIP** means the Pre-Existing Condition Insurance Plan administered by CHIP pursuant to a contract between CHIP and the United States Department of Health and Human Services (“HHS”). When used in connection with a benefit plan, PCIP refers to the coverage offered pursuant to such contract between CHIP and HHS as described in subsection 1.1.2.
- 1.3.14. **Policyholder** means a Federally Eligible Individual, a HCTC Eligible or Resident Eligible Person who receives coverage through CHIP, or a Resident receiving coverage from PCIP.
- 1.3.15. **Qualified Bidder** means a Bidder described in Subsection 1.2 of this RFP.
- 1.3.16. **Resident** means an individual who is legally domiciled in Arkansas.
- 1.3.17. **Resident Eligible Person** means an Arkansas resident with a health condition or conditions that disqualifies the individual for coverage through the individual market, or only allows that person to obtain coverage through the individual market at rates substantially higher than CHIP rates (currently 50% higher).
- 1.3.18. **RFP** means this Request for Proposal for Plan Administrator services.
- 1.3.19. **Selected Bidder** means the Bidder that is selected by the Board as part of this RFP process and that executes a Contract with the Board to provide Plan Administrator services.

1.4. **Overview of CHIP & PCIP Eligibility Criteria.**

- 1.4.1. **CHIP Eligibility for Federally Eligible Individuals.** To enroll in CHIP, such an individual must:
- (1) Be a resident of Arkansas;

- (2) Have, as of the date on which the individual seeks CHIP coverage, an aggregate of 18 months of creditable coverage as defined by HIPAA regulations without a break in coverage of 63 days or more;
- (3) Have been covered most recently by creditable Coverage under group health insurance coverage offered by an insurer, a group health plan, a governmental plan, or a church plan (or health insurance coverage offered in connection with any such plans);
- (4) Not be currently covered by, or be eligible for coverage under:
 - (a) a group health plan;
 - (b) Part A or Part B of Medicare; or
 - (c) the Arkansas Medicaid program;
- (5) not have had his or her most recent creditable coverage terminated based upon a factor related to nonpayment of premiums or fraud;
- (6) have been offered a continuation of coverage option under COBRA or a similar state law continuation provision and, if the option was elected, have exhausted such coverage;
- (7) not have previously received CHIP benefits equaling \$1,000,000 or more;
- (8) not have his or her premium paid for or reimbursed:
 - (a) By one of the following in connection with a group health plan:
 - (i) The person's current employer;
 - (ii) If the person is retired, by the person's former employer; or
 - (iii) If the person is a dependent of an employee or retiree, by the current or former employer of the employee or retiree; or
 - (b) Under any government-sponsored program or by any government agency, foundation, health care facility, or health care provider except for premiums paid on behalf of:
 - (i) A trade adjustment assistance eligible person or a qualified trade adjustment assistance eligible person in accordance with section 35 of the Internal Revenue Code; or
 - (ii) An otherwise qualifying full-time employee or dependent of a qualifying full-time employee of a government agency, foundation, health care facility, or health care provider.

1.4.2. **CHIP Eligibility for Resident Eligible Individuals.** To enroll in CHIP, such an individual must:

- (1) have been a resident of Arkansas for *at least 90 days* and present evidence to the Administrator of:
 - (a) a notice of rejection or refusal by an insurer to issue substantially similar *individual* health insurance coverage by reason of the existence or history of a medical condition; or
 - (b) a refusal by an insurer to issue *individual* health insurance coverage except at a rate substantially in excess of (at least 50% greater than) the applicable premium rate under a comparable CHIP Policy;

or

- (2) have been a resident of Arkansas for *at least 30 days* and present evidence to the Administrator that he or she was covered under a high risk pool of another state qualified under federal HIPAA regulations, if such coverage ended no more than 63 days before the individual completed his or her CHIP application and the individual was not terminated by the other state's risk pool for reasons of fraud;

and

- (3) not be enrolled in or eligible for coverage through a Group Health Plan, Part A or B of Medicare or the Arkansas Medical Assistance Program (Medicaid and ARKids);
- (4) not be enrolled in any other health insurance coverage, *except that* if the individual provides the Administrator evidence required by either paragraph (1) or (2), above, and meets the requirements of paragraphs (5)-(8), below, the individual may maintain any existing health insurance coverage while he or she is satisfying the pre-existing condition waiting period under the CHIP Policy;
- (5) not have previously terminated CHIP coverage in the twelve (12) months prior to the date the individual applies for CHIP coverage;
- (6) not have previously received CHIP benefits equaling \$1,000,000 or more;
- (7) not be a resident of a public institution; and
- (8) not have premiums paid on the individual's behalf under any governmental sponsored program or by any government agency or health care provider, except premiums paid on behalf of an otherwise qualifying full time employee, or dependent of such employee, of a government agency or health care provider.

1.4.3. **CHIP's HCTC Eligibles.** Per requirements of federal law, HCTC Eligible Persons are divided into the following four categories, as further defined below: (1) HCTC Qualified Eligible Person; (2) HCTC Qualified Eligible Family Member; (3) HCTC Standard Eligible Person; and (4) HCTC Standard Eligible Family Member.

(1) **HCTC Qualified Eligible Person.** In order to be eligible for coverage under the CHIP Policy as a HCTC Qualified Eligible Person, an individual must:

- (a) have, as of the date the individual completes and submits an application for CHIP coverage, an aggregate of at least three (3) months of creditable coverage without a break in such coverage of sixty-three (63) days or more;
- (b) be legally domiciled in Arkansas;
- (c) present to CHIP a letter or other written notice from the Health Coverage Tax Credit Program that the individual is or may be eligible for the Health Coverage Tax Credit (HCTC);
- (d) not be incarcerated by a federal state or local authority;
- (e) not be eligible for coverage for, or enrolled in, Part A or B of Medicare;
- (f) not be enrolled in:
 - (i) the Arkansas Medical Assistance Program (Medicaid or ARKids);
 - (ii) a federal employee health plan;
 - (iii) a U.S. military health plan (TRICARE/CHAMPUS);
 - (iv) a health plan provided through the person's, or the person's spouse's, current or former employer, if the employer contributes more than 50% of the family's cost of coverage; or
 - (v) a plan provided through the person's, or the person's spouse's, current or former employer, if the employer provides the coverage in lieu of cash or other benefits under a cafeteria plan.

(2) **HCTC Qualified Eligible Family Member.** An individual may be enrolled for coverage as a HCTC Qualified Eligible Family Member if:

- (a) the individual is the spouse or dependent for federal income tax purposes of a HCTC Qualified Eligible Person;
- (b) the individual is:
 - (i) not eligible for coverage for, or enrolled in, Part A or B of

Medicare;

- (ii) not enrolled in:
 - (A) the Arkansas Medical Assistance Program (Medicaid or ARKids);
 - (B) a federal employee health plan;
 - (C) a U.S. military health plan (TRICARE/CHAMPUS);
 - (D) a health plan provided through the person's, or the person's spouse's, current or former employer, if the employer contributes more than 50% of the family's cost of coverage; or
 - (E) a plan provided through the person's, or the person's spouse's, current or former employer, if the employer provides the coverage in lieu of cash or other benefits under a cafeteria plan; and
- (iii) the HCTC Qualified Eligible Person applies for coverage for the spouse or dependent at the same time he or she applies for coverage, or within 31 days after the spouse or dependent family member first qualifies for coverage under subsections (i) and (ii), above.

(3) **HCTC Standard Eligible Person.** In order to be eligible for coverage under the Policy as a HCTC Standard Eligible Person, the individual must:

- (a) be legally domiciled in Arkansas;
- (b) present to CHIP a letter or other written notice from the Health Coverage Tax Credit Program that the individual is or may be eligible for the Health Coverage Tax Credit (HCTC);
- (c) not be incarcerated by a federal, state or local authority;
- (d) not be eligible for coverage for, or enrolled in, Part A or B of Medicare or the Arkansas Medical Assistance Plan (Medicaid and ARKids First);
- (e) not be enrolled in:
 - (i) a federal employee health plan;
 - (ii) a U.S. military health plan (TRICARE/CHAMPUS);
 - (iii) a health plan provided through the person's, or the person's

spouse's, current or former employer, if the employer contributes more than 50% of the family's cost of coverage; or

- (iv) a plan provided through the person's, or the person's spouse's, current or former employer, if the employer provides the coverage in lieu of cash or other benefits under a cafeteria plan;
- (f) not be enrolled in *or eligible for* any other health insurance coverage, including the coverage described in paragraph (e), above, if the coverage is substantially similar to or more comprehensive than the CHIP policy, except that:
 - (i) a person may maintain other coverage for the period of time such person is satisfying any pre-existing condition waiting period under the Policy; and
 - (ii) a person may maintain coverage under this Policy for the period of time such person is satisfying a pre-existing condition waiting period under another Health Insurance Coverage, Group Health Plan, or other coverage intended to replace the Policy;
- (g) not:
 - (i) have previously terminated CHIP coverage unless twelve (12) months have elapsed since the termination of the CHIP coverage;
 - (ii) have received benefits under a prior CHIP policy of \$1,000,000 or more in Covered Expenses or benefits of any kind;
 - (iii) be a resident of a public institution;
 - (iv) fail to pay the required premium under the CHIP Policy; or
 - (v) have premium paid on the person's behalf under any governmental sponsored program or by any government agency or health care Provider, except premiums paid:
 - (A) as advance payment on the Health Coverage Tax Credit; or
 - (B) on behalf of an otherwise qualifying full time employee, or Dependent of such employee, of a government agency or health care provider; and

- (h) provide evidence to the CHIP administrator:
 - (i) of a notice of rejection or refusal by an insurer to issue substantially similar individual Health Insurance Coverage by reason of the existence or history of a medical condition *(a rejection or refusal by a group health plan or by an insurer offering only excess or stop loss coverage, or contracts, agreements, or other arrangements for reinsurance coverage with respect to the an applicant shall not be sufficient evidence under this subsection)*;
 - (ii) of a refusal by an insurer to issue individual health insurance coverage except at a rate which CHIP determines is substantially in excess of the applicable premium rate under this Policy; or
 - (iii) that the Applicant was covered under a high risk pool of another state qualified under federal HIPAA regulations, provided that the coverage terminated no more than sixty-three (63) days prior to the date CHIP received the Applicant's completed application, and the other state's risk pool did not terminate the applicant's coverage due to fraud.

- (4) **HCTC Standard Eligible Family Member.** An individual may be enrolled for coverage as a HCTC Standard Eligible Family Member if:
 - (a) the individual is the spouse or dependent for federal income tax purposes of a HCTC Standard Eligible Person;
 - (b) the individual is:
 - (i) not eligible for coverage for, or enrolled in, Part A or B of Medicare;
 - (ii) not enrolled in:
 - (A) the Arkansas Medical Assistance Program (Medicaid or ARKids);
 - (B) a federal employee health plan;
 - (C) a U.S. military health plan (TRICARE/CHAMPUS);
 - (D) a health plan provided through the person's, or the person's spouse's, current or former employer, if the employer contributes more than 50% of the family's cost of coverage; or
 - (E) a plan provided through the person's, or the person's

spouse's, current or former employer, if the employer provides the coverage in lieu of cash or other benefits under a cafeteria plan; and

- (c) the HCTC Standard Eligible Person applies for coverage for the spouse or dependent at the same time he or she applies for coverage, or within thirty-one (31) days after the spouse or dependent Family Member first qualifies for coverage under subsections (a) and (b), above.

1.5.4. **Eligibility for PCIP Coverage.** To enroll in the PCIP program, an individual must:

- (a) have been without health insurance coverage for six (6) months before he or she applies for coverage;
- (b) have been recently rejected for coverage, or offered limited coverage, in the commercial market because of a pre-existing condition; and
- (c) reside in Arkansas and be a U.S. citizen, national or an alien who is lawfully present in the country.

1.5.5 **Additional eligibility criteria as of January 1, 2011 for individuals age 0-18 (All CHIP and PCIP eligibility categories).** For applications received on or after January 1, 2011, the CHIP Board voted to add an eligibility criterion to CHIP, and to recommend the same criterion to HHS for PCIP, for applicants age 0-18. HHS agreed to the CHIP Board's recommendation, and the new criterion is being applied to both the CHIP and PCIP programs for applications received on or after January 1, 2011. The new criterion will allow an applicant under 18 or his or her parent or legal guardian to show evidence of uninsurability in the individual market by providing evidence of the existence of certain medical conditions established by the CHIP Board. The age 0-18 applicant may demonstrate the existence of such a condition in lieu of providing evidence of a rejection by a health insurance carrier in the Arkansas individual market. The list of conditions, which will apply to age 0-18 applicants in the same manner for both the CHIP and PCIP programs, is attached to this RFP as **Exhibit D.**

1.6. **Description of Current CHIP Plans.**

CHIP offers all persons eligible for its coverage the same options of benefit plans, although Resident Eligible Persons, HCTC Standard Eligible Persons and HCTC Standard Eligible Family Members are subject to a six-month pre-existing condition exclusion unless they qualify and purchase a pre-existing condition waiver in accordance with terms specified in the CHIP policies. A copy of the two policy forms currently approved by the Commissioner and in effect as of the issuance of this RFP, and the riders or endorsements in effect in regard to such policies, are attached to this RFP as **Exhibits E and F.**

Enrollees may choose between four different levels of deductibles -- \$1,000, \$1,250 (qualifies *only* for use with a Health Savings Account, or "HSA"), \$5,000 and \$10,000. A current summary

of coverage appears below. For a complete list of covered benefits, limitations, and exclusions, please see the policies attached as **Exhibits E and F** to the RFP.

COVERAGE SUMMARY

Lifetime Maximum Benefit Aggregate Lifetime	\$1,000,000
Calendar Year Deductible	[\$1,000/ \$1,250 (Health Savings Account (HSA)- qualified)/ \$5,000/ \$10,000]
In Network - Out of Pocket Maximum*	[\$1,000 + Calendar Year Deductible ("CYD")/ \$2,000 + CYD (HSA-qualified)/ \$5,000 + CYD/ \$10,000 +CYD

Does **not include Pre-Certification Penalty. Does not include either charges for Mental or Nervous Disorders or for Chemical or Drug Dependency (except in HSA-qualified plan).*

Out of Network – Out of Pocket Maximum	Unlimited
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Out of Network facilities/providers may bill for balances over the CHIP payment level in addition to the deductible & coinsurance amount.

	<u>Coinsurance</u>	
	<u>In-Network</u>	<u>Out-of-Network</u>
Hospital, Physical Illness	80%	60%
Prescription Drugs	80%	80%
Mental or Nervous Disorders*	50%	50%
Chemical or Drug Dependency*	50%	50%
All Other Types Of Covered Expenses	80%	60%

**For HSA-qualified plans (\$1,250 deductible), covered services for mental or nervous disorders, and for chemical and drug dependency, are covered at 80% in-network and 60% out-of-network.*

<u>Wellness Care</u>	<u>In-Network</u>	<u>Out-of-Network</u>
Routine Physical, Well Child or Well Baby Exam (<i>Limit 1 per year</i>)	\$25 copayment	Not Covered
Routine Mammography Screening (<i>Limit 1 for women ages 35-39, 1 every 2 years for women ages 40-49, and 1 per year for women ages 50 and older</i>)	\$25 copayment	Not Covered
Routine Pap Smear (<i>Limit 1 per year for women age 18 or older</i>)	\$25 copayment	Not Covered
Routine Prostate Exam Screening (<i>Limit 1 per year for men age 50 and older</i>)	\$25 copayment	Not Covered

Vaccinations.

(In dose and frequency recommended by the Advisory Committee on Immunization Practices (ACIP) of the federal CDC for a person of like age and health status of the Insured Person, including two (2) seasonal and H1N1 flu vaccination). No copayment Not Covered

Wellness Care charges are not subject to the Calendar Year Deductible.

PRE-ADMISSION CERTIFICATION REQUIRED OR ADMISSIONS TO HOSPITALS AND ALL OTHER INPATIENT FACILITIES. FAILURE TO PRE-CERTIFY MAY RESULT IN A MONETARY PENALTY BEING APPLIED.

1.7 Description of Current PCIP Plan.

PCIP offers all persons eligible for its coverage the same option of benefits, which are not subject to any preexisting condition exclusions. A copy of the policy forms currently approved by HHS and in effect as of the issuance of this RFP, and the riders or endorsements in effect in regard to such policies, are attached to this RFP as **Exhibit G**.

PCIP enrollees have only one level of deductible -- \$1,000. A current summary of coverage appears below. For a complete list of covered benefits, limitations, and exclusions, please see the policy attached as **Exhibit G**.

COVERAGE SUMMARY

Lifetime Maximum Benefit		
Aggregate Lifetime		\$1,000,000
Calendar Year Deductible		\$1,000
In-Network - Out of Pocket Maximum		\$1,000 + Calendar Year Deductible
<i>Does not include Pre-Certification Penalty or any services subject to a copayment.</i>		
Out-of-Network - Out of Pocket Maximum		Unlimited
<i>Out-of-Network facilities/providers may bill for balances over the CHIP payment level in addition to the deductible and Co-Insurance amount.</i>		
Co-Insurance	<u>In-Network</u>†	<u>Out-of-Network</u>†
Hospital, Physical Illness	80%	60%
Mental or Nervous Disorders	80%	60%
<i>Subject to \$4,000 annual limit</i>		
Chemical or Drug Dependency	80%	60%
<i>Subject to \$4,000 annual limit</i>		
All Other Types of Covered Expenses	80%	60%

† After In-Network Out-of-Pocket Maximum met, In-Network Co-Insurance is paid at 100% and Out-of-

Network Coinsurance is paid at 80% for the remainder of the calendar year.

Wellness Care*	<u>In-Network</u>	<u>Out-of-Network</u>
Routine Physical, Well Child or Well Baby Exam <i>(Limit one per year)</i>	\$25 copayment	Not Covered
Routine Mammography Screening <i>(Limit one for women age 35-39, one every two years for women age 40-49, and one per year for women age 50 and older)</i>	\$25 copayment	Not Covered
Routine Pap Smear <i>(Limit one per year for women age 18 and older)</i>	\$25 copayment	Not Covered
Routine Prostate Exam Screening <i>(Limit one per year for men age 50 and older)</i>	\$25 copayment	Not Covered
Vaccinations. <i>(In dose and frequency recommended by the Advisory Committee on Immunization Practices (ACIP) of the federal CDC for a person of like age and health status of the Insured Person, including two (2) seasonal and H1N1 flu vaccination).</i>	No copayment	Not Covered

Prescription Drugs*

copayment: \$10 for generic; \$30 for preferred; \$70 for non-preferred.

* Charges for Wellness Care and Prescription Drugs are not subject to the Calendar Year Deductible.

PRE-ADMISSION CERTIFICATION REQUIRED OR ADMISSIONS TO HOSPITALS AND ALL OTHER INPATIENT FACILITIES. FAILURE TO PRE-CERTIFY MAY RESULT IN A MONETARY PENALTY BEING APPLIED.

2. Instructions for Submitting Proposals

The following describes the anticipated bid process. Please note that the Board reserves the right to accept or reject any and all proposals, to waive any technicalities or irregularities therein, to award contracts, or to withdraw the RFP without awarding a contract.

2.1. Bid and Selection Schedule.

Schedule of Events:

Event	Date
Release of RFP	December 21, 2010
Proposal Receipt Date	February 21, 2011
Proposal Evaluation	February 21, 2011- March 15, 2011
Contract Award Date	March 15, 2011
Contract Execution Date	On or about April 1, 2011
Operations Start Date	July 1, 2011

2.2. Format of Proposal.

2.2.1. **Technical Specifications.** Bidders must respond to all questions and requests for information contained in Section 3 of the RFP, which response shall comprise the Bidder's technical proposal.

2.2.2. **Cost Proposal.** Bidders must respond to all questions and requests in Section 4 of this RFP, which response shall comprise the Bidder's cost proposal.

2.2.3. **Non-Responsiveness.** Failure to respond to any requirement of Sections 3 or 4 shall be sufficient basis for rejection of a proposal as non-responsive. The Board reserves the right to accept or reject any and all proposals.

2.3. **Confidentiality.** All proposals remain entirely confidential until the Board awards a Contract. Thereafter, CHIP will not consider any information in a proposal to be confidential unless the Bidder marks the information as confidential under state or federal law and specifies in the transmittal letter submitted under Subsection 3.1.1 of the RFP the legal justification for the assertion of confidentiality. A Bidder may not copyright its entire proposal. The proposal of the

Successful Bidder will be available to the public following the award of the Contract. CHIP is not subject to the Arkansas Freedom of Information Act.

2.4. **Costs of preparing proposal, protest or negotiating Contract.** Neither the State of Arkansas nor CHIP shall be liable for any costs incurred by any Bidder in its preparation or response to this RFP, protest of award of the Contract, or negotiations of a Contract by a Successful Bidder.

2.5. **Questions and Inquiries.**

2.5.1. **Format of questions or inquiries.** All requests for additional information or explanations relating to the RFP must be submitted in writing to the Board either in care of :

Charles B. Cliett, Jr.
Mitchell, Williams, Selig, Gates & Woodyard, P.L.L.C.
425 West Capitol Avenue, Suite 1800
Little Rock, AR 72201

or via electronic mail to: drawford@mwlaw.com
with a cc to: jharriman@mwlaw.com and ccliett@mwlaw.com

All questions submitted, and CHIP's responses to all questions, shall be sent to each Bidder in accordance with Subsection 2.5.3.

2.5.2. **Deadline for submission of questions or inquiries.** To assure a timely response is made to every Bidder, questions or inquiries relating to the RFP must be received no later than fifteen (15) days before the proposal receipt date specified in subsection 2.1 of the RFP.

2.5.3. **CHIP's responses to questions or inquiries.** CHIP shall use best efforts to respond to all questions submitted within five (5) business days after the deadline for questions specified in Subsection 2.5.2. CHIP will send each question asked, and CHIP's response to each question, via e-mail to each Bidder via the contact person identified in response to Subsection 3.1.2.

2.6. **Mandatory Response Format/Distribution.** Bidders must submit proposals in a sealed package or box containing an original and three (3) copies of the technical submission in response to Section 3 of this RFP, including all attachments and exhibits to the technical submission. Bidders shall submit an original and three (3) copies of the cost proposal in response to Section 4 of this RFP in the same package or box as the technical submission, but the cost proposal must be sealed in its own envelope or other package and clearly marked "Cost Proposal."

The bid documents will be considered only if they are received by CHIP as indicated in this RFP no later than 4 p.m. Central Time on February 21, 2011, at the address indicated below. Any proposal received after this time and date will not be considered. Sufficient time for mail delivery should be allowed. Proposals will be publicly opened at 4:30 p.m. Central time at the address indicated below on February 21, 2011.

The street and mailing address for delivery of the proposals submitted in response to this RFP and for the opening of the bids shall be:

Charles B. Cliett, Jr.
Mitchell, Williams, Selig, Gates & Woodyard, P.L.L.C.
425 West Capitol Avenue, Suite 1800
Little Rock, AR 72201

- 2.7. **Oral Presentation.** Upon ten (10) days notice from the Board, a Bidder shall present an oral presentation of the proposal to the Board, at the expense of the Bidder.
- 2.8. **Grievance and Protest Procedure relating to RFP.** Any Bidder wishing to object to the award of the RFP or other processes relating to the RFP shall submit in writing a protest within ten (10) calendar days after announcement of the Board's award of the Selected Bidder. The written protest shall be submitted to the same address as specified above in Subsection 2.6, directed to Board Chair, Michael Wilkinson, to the attention of Charles B. Cliett, Jr. The Chair shall make the protest available to all Board members. The protest shall contain the aggrieved Bidder's specific contentions as to errors in the evaluation or any other improprieties of the bid and selection process. A special meeting of the Board may be called to review the written protest. The Board shall render a majority decision on the protest and the Board Chair shall render a written decision to the aggrieved party. All decisions of the Board regarding the protest shall be final and conclusive. This grievance and protest procedure shall be the exclusive remedy for any aggrieved Bidder in regard to this RFP.

3. Technical Proposal

The following information is mandatory for the purpose of evaluating the Bidder's ability to perform the work required.

3.1. General Information.

3.1.1. **Transmittal letter.** The first item in a Bidder's proposal shall be a transmittal letter:

- Signed by an individual authorized to legally bind the Bidder in regard to all matters relating to the Proposal;
- Stating that the Bidder is the prime contractor and an Insurer as defined by this RFP;
- Identifying any and all subcontractors that will be responsible for fulfilling the requirements of this RFP;
- Stating that no attempt has been made or will be made by the Bidder to induce any other person or firm to submit or not to submit a proposal in response to the RFP;
- Confirming that no cost or pricing information has been included in the Transmittal Letter or the Technical Proposal, but only in the Cost Proposal;
- Authorizing CHIP to contact clients and references listed by the Bidder in its response to Subsection 3.1.6 of the RFP;
- Confirming that the Technical Proposal and Cost Proposal are valid for a minimum of ninety (90) days from the proposal due date;
- Confirming that the Bidder will agree to execute and fulfill a contract according to the conditions and negotiate in good faith, terms specified in this RFP on or about April 1, 2011;
- If applicable, justifying why the Bidder believes any portion of its proposal is proprietary or otherwise confidential under state or federal law; and
- Confirming that the Bidder will negotiate in good faith and execute a Business Associate Agreement as required by HIPAA privacy and security rules and by the federal HITECH Act .

3.1.2. **Key personnel: RFP Proposal and Contract negotiations.** Provide name, title, corporate address, telephone number and e-mail address of the primary contact person for the Bidder and for any other personnel of Bidder authorized to conduct Contract negotiations.

3.1.3. **Key personnel: Contract implementation and administration.**

- Provide resumes for key personnel who will be responsible for implementation and administration of the contract.
 - If a subcontractor or subcontractors have been identified in the transmittal letter, identify the key personnel of the subcontractor who shall have responsibility for implementation and administration of the contract.
 - Provide an organizational chart for your company (and, if applicable, your subcontractor(s)) and the name, title and qualifications of individuals (professional and technical) who will be assigned to this project.
- 3.1.4. **Subcontractor(s).** To the extent that the Bidder intends on relying on a subcontractor or subcontractors to perform duties under the Contract with CHIP, Bidder must clearly delineate throughout its proposal between the Bidder's experience, expected performance and areas of responsibility and the subcontractor's experience, expected performance and areas of responsibility.
- 3.1.5. **Bidder's Experience.** Include a brief history of the Bidder and its experience over the past five (5) years, especially in providing comprehensive administrative services similar to those required in this RFP and particularly for a government health program such as CHIP or PCIP. The response should include, but not be limited to:
- Names and types of programs;
 - Specific dates and length of contracts or renewals;
 - Scope of your involvement;
 - Number of clients/customers served; and
 - Important milestones reached in the program.
- 3.1.6. **Representative Client List and References.** Bidder shall provide a list of at least six (6) current clients that it believes are generally representative of its current business operations, with name and contact information. Bidder shall list at least three (3) references with name and contact information, which can come from this list of clients, or from former clients or other persons knowledgeable about Bidder's business and capabilities to do the work described by this RFP.
- 3.1.7. **Arkansas Insurer.** Provide evidence that Bidder is an Insurer as defined by this RFP.
- 3.1.8. **Arkansas Office.** Bidder shall confirm that it has, or will establish, an office within the State of Arkansas for purposes of conducting business. The bid must identify all locations of offices and facilities that Bidder or its subcontractor(s) intend to use to perform the duties of Plan Administrator.
- 3.1.9. **CHIP Property.** Bidder shall confirm that all records, files and reports associated with this program that are obtained, assembled and maintained by the Plan Administrator are and remain the property of the Board, subject to a Board retention policy, shall be kept confidential by the Plan Administrator, shall not be used by the Plan Administrator for any purpose unrelated to the administration of

CHIP and PCIP, and are to be turned over to the Board and/or a successor Plan Administrator. Bidder shall provide the Board or its designee with access to all such records for audit purposes during normal working hours.

- 3.1.10. **Right to Audit.** Bidder shall confirm that the Board shall have the right to audit, upon commercially reasonable notice, all records maintained by the Plan Administrator that relate to services provided by the Plan Administrator and all functions under the Contract.
- 3.1.11. **Hold Harmless.** The proposal shall contain a statement that indicates the Bidder, if awarded the Contract as Plan Administrator, shall hold harmless and indemnify the Board and the Policyholders in regard to the policies and procedures instituted by the Plan Administrator for all its services, duties and responsibilities described in this RFP, and any subsequent developed documents related to the Plan administration.
- 3.1.12. **Insurance.** The proposal shall describe all the types and levels of insurance maintained by the Bidder that will cover its actions as Plan Administrator, such as directors, officers and employees liability, umbrella general liability or errors and omission coverage. Bidder shall further provide evidence:
- That such levels of insurance are commercially reasonable and will be adequate for Bidder's work as Plan Administrator; and
 - That the insurance maintained by Bidder will also cover the actions of any subcontractor(s) proposed, or that any subcontractor contains its own commercially reasonable coverage that will insure its actions as subcontractor for CHIP and PCIP's Plan Administrator.
- 3.1.13. **Anti-Discrimination Laws.** The proposal shall contain a statement of agreement that if the Bidder is awarded a Contract as Plan Administrator, it will be at all times fully compliant with the requirements set forth in Title VI of the Civil Rights Act and all other laws requiring the Bidder to operate in a non-discriminatory manner.
- 3.1.14. **Description of record-keeping capabilities.** Describe how CHIP and PCIP records will be maintained and the Bidder's ability to segregate CHIP files from PCIP files, and to segregate both CHIP and PCIP files from other business of Bidder.
- 3.1.15. **Coordination of CHIP and PCIP records with other business and confidentiality laws.** Bidder shall discuss how CHIP and PCIP records will be maintained in a confidential manner, in compliance with both federal HIPAA privacy and security regulations, the federal HITECH Act and Arkansas Rule and Regulation 74 implemented in response to the Gramm Leach Bliley Act.
- 3.1.16. **Disaster Recovery.** Bidder shall summarize and provide a copy of its disaster recovery plan. Such plan must be sufficient to demonstrate that key program operations will remain operational in the event of major systems failures or other disaster.

3.1.17 **Fraud, waste and abuse procedures.** Bidder shall describe procedures it will use to prevent, detect and report incidences of fraud, waste and abuse.

3.2. **Financial Information.** Bidder shall submit the following information:

3.2.1. **Financial Statements.** Bidder shall submit copies of Bidder's audited financial statements for the past three (3) fiscal years. If Bidder plans to use subcontractor(s) for any part of the work performed under the Contract, Bidder also should submit the subcontractor's audited financial statements for the past three (3) fiscal years.

3.2.2. **Segregation of Costs.** A description of methods to be used to segregate the costs associated with this program from the cost of the organization's normal book of business to ensure that the Board is only paying for those expenses actually related to the program.

3.3. **Key Administrative Functions.** Bidder shall describe its capabilities in performing each of the following key administrative functions of the Plan Administrator. Bidder shall assume that Plan Administrator bears all costs for production of any materials required and relating to such functions, including, but not limited to costs of development and printing of application forms, of policy forms and endorsements, of claim forms, costs of stationery and postage, administrative fees of mass mailings relating to rate changes, policy amendments, general communications to each agent and Policyholder, mailing, investigating and corroboration of costs, all subject to Board approval.

3.3.1. **Receipt of applications and eligibility determination; reverification.** The Plan Administrator must perform all eligibility determinations and applications processing functions for CHIP. The Plan Administrator also shall be responsible for annual reverification of Policyholder eligibility.

3.3.1.1. **Application processing and initial eligibility determination.** The Bidder shall describe its ability to perform application processing and initial eligibility determinations, including, but not limited to, the following functions:

- Assist CHIP and PCIP in development of application forms and other forms necessary for an enrollment packet, such as an outline of coverage and other informational materials;
- Production and printing of application forms and other forms necessary for an enrollment packet and disseminating such information upon requests to prospective applicants, agents or other persons who request such materials;
- Receipt of applications from new applicants;
- Review received applications for completeness and correspond with applicants to obtain any additional documentation or other information necessary to determine eligibility;
- Determination of eligibility for coverage and any conditions on eligibility, such as whether a pre-existing condition exclusion will

- apply to the individual;
- Maintain copies of all applications received and maintain an electronic system for tracking application status and resolution; and
- Revise processes as necessary if CHIP or PCIP revises eligibility categories or adds new categories.

3.3.1.2. **Reverification of eligibility.** Bidder must describe its ability to maintain continued systematic eligibility verification on all CHIP and PCIP Policyholders, at the direction of CHIP but no more frequently than annually, including securing updated proof of Arkansas residency, and to assist CHIP in development and production of a questionnaire to determine if a Policyholder has obtained other insurance coverage or otherwise has experienced a change in circumstances impacting the Policyholder's continued eligibility for CHIP or PCIP coverage.

3.3.2. **Payment of agent commission.** Bidder shall describe its ability to pay an agent's referral fee as established by the Board to each agent who refers an applicant to CHIP or PCIP, if the applicant is accepted, from moneys received as CHIP or PCIP premiums, respectively. Plan Administrator must produce IRS Form 1099 or other tax documents required by law to be submitted to agents annually evidencing referral fees earned from CHIP or PCIP.

Bidders should note that selling or marketing of CHIP or PCIP policies may not be limited to Plan Administrator or agents associated with the Plan Administrator.

3.3.3. **Billing and collecting premiums.** The Bidder shall describe its ability to establish a premium billing and collection procedure regarding CHIP and PCIP Policyholders, including, but not limited to, its ability to meet the standards below:

3.3.3.1. **Generally.** Billings shall be made on a periodic basis, as determined by the Board. Currently, Policyholders are billed either monthly or quarterly, at the choice of the Policyholder, unless a certain billing period is required by circumstances described in Subsections 3.3.3.2 and 3.3.3.3, below. Bidder shall describe its processes for all stages in the billing and collection process, including, but not limited to:

- issuance of premium notices to Policyholders;
- posting payments to Policyholder files;
- issuing premium lapse and cancellation notices as appropriate, and following up on non-sufficient fund payments and partial payments;
- issuing premium refunds, as appropriate; and
- maintenance of security and audit procedures to account for all premium payments received.

3.3.3.2. **Electronic Funds Transfer (EFT).** The Plan Administrator must allow the capability for Policyholders to pay premiums via EFT. Bidder may limit this method of payment to monthly, or may describe its ability to allow EFT payments on either a monthly or quarterly basis.

- 3.3.3.3. **HCTC Eligibles.** For HCTC Eligibles, the Plan Administrator must coordinate with the federal Health Care Tax Credit Processing Center, which is set up to pay a portion of HCTC Eligibles' premium payments in the form of advances on tax credits.
- 3.3.4. **Customer service.** The Plan Administrator must provide customer services to prospective and current Policyholders, as well as providers, insurance companies, agents, CHIP, PCIP and its Board and other members of the public who need information or assistance. Bidder shall describe its customer service capabilities including, but not limited to, the following criteria:
- 3.3.4.1. Training and in-service programs for customer service staff;
- 3.3.4.2. Receiving and responding to telephone, mail, e-mail and walk-in inquiries;
- 3.3.4.3. Maintenance of sufficient toll-free lines, for applicant, Policyholder and provider inquiries;
- 3.3.4.4. Description of standards Bidder expects to meet or exceed regarding:
- Average length of time a caller must wait before being connected to customer service;
 - Average number of calls dropped per day;
 - Average number of calls handled per day;
 - Percentage of inquiries resolved with initial telephone call;
 - Percentage of inquiries resolved through initial written response to letter or e-mail.
- 3.3.4.5. Description of system used to monitor, document and verify customer service performance, including a description of how telephone calls are monitored or recorded and how inquiries or complaints and customer services responses to such inquiries and complaints are logged or otherwise documented for future reference in case of complaints, audits or other inquiries.
- 3.3.5. **Adjudication and timely payment of claims.** The Bidder shall describe its ability to perform all necessary functions to assure timely payment of claims to Policyholders or Network Providers, in accordance with the benefit plans in CHIP and PCIP policies then in effect (currently the policies attached to this RFP as **Exhibits E, F and G**). The narrative in the proposal shall provide detail about the claims payment system, including the amount of automation built into the system. Proper performance of claims adjudication shall include, but not necessarily be limited to, the following:
- 3.3.5.1. Making available information relating to the proper manner of submitting a claim for benefits under the Plan and distributing forms upon which submissions shall be made;
- 3.3.5.2. The ability to fully comply with HIPAA regulations regarding accepting and sending standard transactions and code sets;

- 3.3.5.3. Evaluating the eligibility of each claim for payment under the CHIP and PCIP policies;
 - 3.3.5.4. Notifying each claimant within thirty (30) days after receiving a properly completed and executed proof of loss, whether the claim is accepted, rejected, or if further information is needed to make such determination;
 - Bidder shall state its cumulative average turnaround time from receipt to payment of clean claims for its commercial business.
 - 3.3.5.5. Paying claims expenses from the premium payments received from, or on behalf of, CHIP or PCIP Policyholders, to the extent that premiums cover claim expenses;
 - 3.3.5.6. Notifying CHIP, in the manner directed by the Board, if additional funds are needed for the Plan Administrator to pay claims, so that CHIP may transfer funds for payment from other sources, which, as previously stated in this RFP, consist primarily of assessments paid by Insurers doing business in Arkansas for CHIP and which consists of federal funds for PCIP;
 - 3.3.5.7. Tracking and implementing procedures to apply preexisting condition exclusion limitations, out-of-pocket maximums and other provisions of the CHIP and PCIP policies to the adjudication of claims;
 - 3.3.5.8. The ability to correct overpayments or underpayments detected through audits, the provider or Policyholder appeals processes or other means;
 - 3.3.5.9. Coordinating benefits to the extent a Policyholder has or obtains other coverage (under limited circumstances, a Policyholder may have other coverage that may need to be coordinated with CHIP or PCIP);
 - 3.3.5.10. Pursuing subrogation (either directly or through a subcontractor) by reviewing claims on a regular basis to determine whether third party liability or workers compensation liability may exist, contacting Policyholders to determine applicability of subrogation, evaluating the economic feasibility of recovery and attempting to recover on behalf of CHIP or PCIP where subrogation is appropriate, in consultation with CHIP counsel and the Board; and
 - 3.3.5.11. Self-monitoring claim adjudication performance through internal audits.
- 3.3.6. **Grievance and Appeals Processes.** The Bidder shall describe its proposed processes for handling the grievances and appeals. The narrative shall include what types of grievances are referred to committees and any special procedures for handling difficult or complex grievances. The description shall incorporate appeal of grievances to the Grievance Committee of the Board. The Board's Grievance Committee policy and process is included in **Exhibit H** to the RFP.
- 3.3.6.1. By applicants, Policyholders and former Policyholders and other

individuals who have a grievance with CHIP, PCIP or the Plan Administrator;

3.3.6.2. By Network Providers and other providers regarding claims and regarding all matters other than claims. Provider disputes regarding utilization review decisions shall be discussed more specifically in response to Subsection 3.4.1.11 of the RFP.

3.3.7. **Reports to the Board.** The Selected Bidder must be willing and capable of submitting regular reports to the Board regarding the operation of CHIP and PCIP, in a manner, content and frequency determined by the Board. Reports shall include:

- Monthly reports on Plan Administrator duties as described in this RFP, to be negotiated between CHIP and the Selected Bidder;
- Monthly reports to HHS on the PCIP program as required by HHS, the current format of which is specified in **Exhibit I** of this RFP;
- Administrator's reports at Board meetings regarding duties described in this RFP, as directed by the Board;
- End-of year reports regarding performance during the previous calendar year, as determined by the Board; and
- Ad hoc reports as requested by the Board.

3.3.8 **Wind-down plan.** Bidder shall describe how it will effectively administer the winding down of operations in the CHIP and PCIP programs between January 1 and June 30, 2014.

3.3.9. **Other Administrative Functions.** Bidder shall describe any other administrative functions not specifically referenced above that Bidder believes could improve the efficiency of operations of the CHIP and PCIP programs.

3.4. **Key Managed Care Functions.** Based upon the type of eligible participants who will enroll in the program and their current health status, it is essential for the Board to act in the most judicious manner possible to ensure the financial viability of CHIP and PCIP.

3.4.1. **Utilization Management/Case Management.** Please describe the proposed process for each of the following:

3.4.1.1. Pre-Admission Review of inpatient stay;

3.4.1.2. Guidelines or source material to be used to determine appropriate hospital utilization and length of stay;

3.4.1.3. Concurrent admission review for inpatient stay;

3.4.1.4. Second surgical opinion waiver/pre-procedure review;

3.4.1.5. Continued stay review;

- 3.4.1.6. Discharge planning;
- 3.4.1.7. Retrospective review;
- 3.4.1.8. Mental or nervous disorder/drug or chemical dependency substance abuse review program;
- 3.4.1.9. Case management;
- 3.4.1.10. Disease management; and
- 3.4.1.11. Utilization review appeal process (please identify your approach if a pre-admission, continued stay or pre-procedure review is denied).

3.4.2. **HMO/PPO/Provider Networks.** The Bidder must propose a network of providers that offers accessible and available care throughout the state of Arkansas, recognizing that there are fewer providers available in more rural areas of the state. A Bidder may propose alternate provider networks and alternate cost proposals under Section 4 based on such alternate networks.

3.4.2.1. The Bidder shall identify its current network capabilities in Arkansas, including the number of current contracts that have access to the network(s) and the service area covered by these agreements.

3.4.2.2. The Bidder shall submit geo-access maps demonstrating relative access throughout Arkansas to:

- general acute care hospitals;
- primary care providers for both adults and children (e.g., general practice physicians, internal medicine physicians);
- primary care providers for children only;
- high-volume specialists, such as general surgeons and cardiologists;
- radiology centers;
- labs; and
- pharmacies.

3.4.2.3. The Bidder shall submit a provider directory evidencing the current network.

- If a provider is not seeing new patients, this should be noted in the provider directory or otherwise specified in the proposal.
- If a provider has age limitations in addition to standard limitations for pediatricians (e.g., if provider only sees children of a certain age), the Bidder should specify this limitation in the provider directory or otherwise specify it in the proposal.

3.4.3. **Managing out-of-network costs.** Bidder shall provide a description of how it determines usual and customary or reasonable charges to pay out-of-network providers for services, including guidelines or source materials referenced for such determination.

- 3.4.4. **Quality assurance program.** Bidder shall describe its procedures for ensuring that the quality of care being provided to Policyholders is being monitored and reviewed. Bidder shall identify any national certification bodies that have evaluated its quality assurance program and submit a summary of its quality assurance plan with its proposal.
- 3.4.5. **Other managed care strategies.** Bidder shall discuss any cost containment or other managed care strategies not referenced above that Bidder would implement as Plan Administrator to control costs and improve the quality of the CHIP and PCIP programs.
- 3.5. **Proposed performance standards.** Bidders shall propose performance standards for the Plan Administrator in relation to the scope of work described in this Section 3 of the RFP and shall also propose penalties related to non-compliance with such standards, which penalties shall be expressed in reduction of the administrative fee. Bidders shall not be scored on their responses to this Subsection and the Board may accept the Selected Bidder's recommendation, in whole or in part, or reject them and negotiate different standards.
- 3.6. **Value-added services or discounts.** The Bidder shall describe any value-added services or discounts it is willing to offer to CHIP and PCIP Policyholders such as access to wellness or other health-related services at a discounted rate. The Bidder shall not include the cost of such services or discounts in its cost proposal submitted in response to Section 4 of the RFP.
- 3.7. **Transition plan.** If Bidder is not the incumbent Plan Administrator, the Bidder must describe a plan for transitioning work from the current Plan Administrator to the Bidder, should Bidder be chosen as the Selected Bidder. The Bidder must agree to cooperate in transition of the Plan Administrator functions and provide a detailed timeline that establishes July 1, 2011 as the "go-live" date, minimizes disruption to CHIP and PCIP Policyholders and provides key conversion dates for files. The Selected Bidder further must commit in its response to this Subsection to execute a contract with CHIP on or about April 1, 2011. Finally, in responding to this Subsection, each Bidder, including, if applicable, the current Plan Administrator, shall acknowledge the Bidder's commitment to cooperate with and facilitate any future transition of Plan Administrator duties from the Selected Bidder to a future Plan Administrator. CHIP reserves the right to accept all or part of a Selected Bidder's transition plan or negotiate a different plan. If the Board and the Bidder tentatively selected as the Selected Bidder cannot reach agreement on a transition plan, the Board reserves the right to choose the next highest scoring Bidder under Section 5, or to reissue a new RFP.

4. Cost Proposal

- 4.1. **Submit separately in sealed envelope.** Bidder shall submit its cost proposal under this Section separately in a sealed envelope. The Board will not evaluate a Bidder's cost proposal until it has completed evaluation of the Bidder's technical proposal under Section 3 of the RFP.
- 4.2. **Year 1 Proposal.** Bidder shall provide the following information regarding the proposed fee for administering the program in the first year of operation:
- 4.2.1. Monthly fee per participant;
 - CHIP
 - PCIP
 - 4.2.2. Cost per policy issued in the month;
 - CHIP
 - PCIP
 - 4.2.3. Monthly cost per policy in force (or issued in the month); and
 - CHIP
 - PCIP
 - 4.2.4. Cost per claim processed.
 - CHIP
 - PCIP
- 4.3. **Year 2-3 Proposals.** For each of the categories and sub-categories in Subsection 4.2, above, indicate the cost for the second and third years of operation. For the last half of year 3, the Bidder should take into account the anticipated wind-down mode of operations.

5. Criteria for Selection

- 5.1. **CHIP Board selects the Selected Bidder.** The Board will evaluate the responses to this RFP and may retain outside evaluators to recommend an award to the Board. The final decision for selecting the Selected Bidder, however, rests with the Board.
- 5.2. **Basis for evaluating proposals.** Any contract resulting from this RFP shall be awarded to the Bidder providing the best value to the Board. After determining responsiveness, proposals will be evaluated in accordance with the following categories and respective weight criteria:
- 5.2.1. **Response to General Information on Experience (Subsection 3.1), Financial Information (Subsection 3.2) and Key Administrative Functions (Subsection 3.3):**
Up to 300 points
- 5.2.2. **Responses to Key Managed Care Functions (Subsection 3.4):**
Up to 300 points
- 5.2.3. **Cost Proposal (Section 4):**
Up to 400 points
- 5.2.4. **Adjustments based on Oral Presentation.** The Board reserves the right to adjust initial scores of proposals up to 10% based on information clarified or otherwise explained in the oral presentations described in Subsection 2.7. Nothing in this Subsection mandates the Board to hold such oral presentations, which are solely at the Board's option.
- 5.3. **Historic Information.** The Board reserves the right to consider historic information and facts in the evaluation process, whether gained from the Bidder's proposal, question and answer conferences, references, or any other source.
- 5.4. **Bidder's responsibility to submit information.** The Bidder is cautioned that it is the Bidder's sole responsibility to submit information pertinent to the evaluation and that the Board is under no obligation to solicit additional information not referenced in this RFP. Failure to submit such information may cause an adverse impact on the evaluation of the Bidder's proposal.
- 5.5. **Point Selection Evaluation Form**
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- 5.5.1 **Response to General Information on Experience (Subsection 3.1), Financial Information (Subsection 3.2) and Key Administrative Functions (Subsection 3.3).**

Up to 300 points

_____ 300 OUTSTANDING (Far exceeds CHIP's expectation)

_____ 270 GOOD (Meets or slightly exceeds CHIP's expectation)

- _____ 240 ACCEPTABLE (Adequate, but not quite up to CHIP's expectation)
- _____ 210 POOR (Well below CHIP's expectation)
- _____ 0-209 UNACCEPTABLE OR UNRESPONSIVE

5.5.2. Responses to Key Managed Care Functions (Subsection 3.4):

Up to 300 points

- _____ 300 OUTSTANDING (Far exceeds CHIP's expectation)
- _____ 270 GOOD (Meets or slightly exceeds CHIP's expectation)
- _____ 240 ACCEPTABLE (Adequate, but not quite up to CHIP's expectation)
- _____ 210 POOR (Well below CHIP's expectation)
- _____ 0-209 UNACCEPTABLE OR UNRESPONSIVE

5.5.3 Response to Cost Proposal (Section 4):

Lowest total proposal cost that is responsive in regard to the technical proposal submitted in response to Section 3 of the RFP will receive 400 points. For evaluation, items will be considered individually and combined to determine the cost most advantageous to the CHIP and PCIP programs.

Remaining proposals that are responsive in regard to the technical proposal submitted in response to Section 3 of the RFP shall receive points in accordance with the following formula:

$$(a/b)(c) = d$$

a = the lowest cost proposal

b = the second (third, fourth, etc.) cost proposal

c = the maximum number of points allowed for cost (400 points)

d = the number of points allocated to respective proposals

- 5.6. **Right to reject proposals.** CHIP reserves the right to reject any proposal, regardless of cost, that does not achieve at least an acceptable score in both the technical proposal components of the scoring (see Subsections 5.5.1 and 5.5.2 for a description of an "acceptable" score).