McPhee
& ASSOCIATES, INC.
Managed Care Insurance

REQUEST FOR PROPOSAL

HMO REINSURANCE QUESTIONNAIRE

THE INFORMATION CONTAINED IN THIS REQUEST AND TRANSMITTED WITH IT IS TO BE USED ONLY FOR THE UNDERWRITING OF STOP-LOSS INSURANCE. IT WILL BE HELD IN THE STRICTEST OF CONFIDENCE AND WILL NOT BE RELEASED TO ANY PARTIES OTHER THAN THE APPROPRIATE INSURANCE CARRIERS FOR THE PURPOSE OF GETTING QUOTES.

GENERAL INFORMATION

Name of HMO	
Street Address	
City, State, Zip	
Executive Director	
Finance Director	
Submitted By	
Phone | Fax	PH: F:
Email Address	

DOCUMENTS TO ACCOMPANY THIS APPLICATION

The following documents and information are requested in order to process your request.

- Copy of current benefit plan in use (summary of benefits can also be used)
- Provider/Contractual Arrangements with Hospitals and other providers (summary can be used for payment arrangement, outliers/stop-loss provisions should be shown)
- Current reinsurance agreement
- Claims details listing (form attached) or current and past three years
- Pending or potential claims
- Audited financial statements for the past 3 years – ***if requesting insolvency coverage***
- Latest NAIC quarterly statement – ***if requesting insolvency coverage***

BACKGROUND

When did operation begin? _______________ **The primary sponsor is?** ____________________________

We are: ☐ For profit ☐ Non-profit

Federally Qualified: ☐ Yes ☐ No **If not, do you plan to be?** ☐ Yes ☐ No

Type of Plan: ☐ Network ☐ Staff ☐ Group ☐ IPA

Does the HMO offer or is the HMO planning to offer point-of-service? ☐ Yes ☐ No

Enrollment

Current enrollment as of: ______________________ **is**: _________________________
(**Date**) (**Members**)

Members			Percentage			Number of Members		
Commercial	POS	Exchange						
Medicare Advantage	SNP	Medi-Medi (Dual Eligible)						
Medicaid	Medicaid Disabled	Medicaid Expansion						
Other (i.e. Medi-Medi)								

THE FOLLOWING DATA IS TO BE ON A REINSURANCE YEAR BASIS

Data is for the annual period from: _______________________ **to**: ___________________________

INDIVIUDAL AND GROUP MEMBERS				
YEAR	BED DAYS PER 1,000	NUMBER OF HOSPITAL STAYS PER 1,000	AVERAGE PER DIEM	MEMBER MONTHS
Current Year				
Previous Year				
Two Years Ago				
Three Years Ago				
Projected for Next Year				

MEDICARE MEMBERS				
YEAR	BED DAYS PER 1,000	NUMBER OF HOSPITAL STAYS PER 1,000	AVERAGE PER DIEM	MEMBER MONTHS
Current Year				
Previous Year				
Two Years Ago				
Three Years Ago				
Projected for Next Year				

MEDICAID MEMBERS				
YEAR	BED DAYS PER 1,000	NUMBER OF HOSPITAL STAYS PER 1,000	AVERAGE PER DIEM	MEMBER MONTHS
Current Year				
Previous Year				
Two Years Ago				
Three Years Ago				
Projected for Next Year				

LIST CONTRACTED HOSPITALS WITH THEIR PER DIEM OR DISCOUNT ARRANGEMENTS. INCLUDE OUTLIER (STOP-LOSS) PROVISIONS, IF ANY, ON A SEPARATE SHEET.

HOSPITAL	MED/SURG	ICU	NICU	UTILIZATION PERCENTAGE

List where services for the following are done and the contractual arrangement including any outlier provisions

TYPE	HOSPITAL	CONTRACTUAL ARRANGEMENT
Transplants		
Level IV NICU		
Burns		

CAPITATION AGREEMENTS

(Only list capitated providers who are assuming full liability for all expenses for the member.)

Hospital	No. of Members

Capitated Physicians? ☐ Yes ☐ No Number of Members: _________________

PROVIDERS UNDER CONTRACT TO THE HMO

PROVIDER	FINANCIAL RISK		CAPITATED	
	YES	NO	YES	NO
Physicians/Primary Care				
Physicians/Specialty Care				
Hospitals				
Ambulatory Surgery				
Urgent Care Centers				
Pharmacies				
X-Ray/Laboratories				
Ambulance				
Hospital Emergency Room				

MANAGEMENT/UTILIZATION

Does the HMO have its own staff or is the management responsibility contracted out to a separate entity? Please explain:

____

____

What techniques are used to…?

Control over utilization:

Control excessive length of stay in hospital:

Provide Peer Review:

PRESENT COVERAGE DETAILS	
Present Reinsurer	
Contract Period	
Deductible Per Member	**$**
Rate Per Member Per Month	**$**
Coinsurance	% after Deductible is met
	% on transplants

REINSURANCE COVERAGE(S) DESIRED			
DEDUCTIBLE OPTIONS (Per member Per Contract Year):			
HOSPITAL	**$**	**$**	**$**
PROFESSIONAL	**$**	**$**	**$**
COMBINED (HOSPITAL & PROFESSIONAL)			
COINSURANCE OPTIONS (Above Deductible):			
80% YES NO		**90% YES NO**	
INSOLVENCY:			
YES		**NO**	

CAPITATED MEMBERS: Is the HMO responsible for reinsurance on any capitated member; if so, are they to be covered under this reinsurance agreement?

Hospital: ___YES ___NO Number of Members: ________________

Professional: ___YES ___NO Number of Members: ________________

The information contained in this request and transmitted with it constitutes the data upon which a proposal will be based. In submitting this proposal request, the undersigned warrants that he or she has made a diligent effort to verify the information contained herein; and that, to the best of their knowledge and belief, such information accurately represents the facts; and that no pertinent information has been omitted or altered.

Signature Date

Signature Date

2441 HONOLULU AVENUE, SUITE 180 | MONTROSE, CA 91020 | PH: (818) 541-7900 | F: (818) 541-7903 | LIC.#0688132

HMO REINSURANCE DETAIL LISTING

HOSPITALIZATION CHARGES: For the current year and the prior (3) years, provide details of each member who has incurred or is expected to incur total hospital charges in excess of fifty (50%) of your lowest requested deductible.

NOTE: Data should be completed up through (10) ten months of the current year.

Patient ID: Patient type- Commercial Medicare, etc.	Nature of Illness or Accident	Dates of Hospital Stays	Hospital charges to Date-HMO Liability	Total Expected Charges for Current Contract Year	Reimbursement received from Current Carrier	Status/Data Discharged-Prognosis	Expected charges for New Contract Year

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Rev. 09/2017