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		**Title**
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) on current and past three years for members exceeding 50% of the lowest deductible requested
- 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 Operations Begin?			**The Primary Sponsor is?**			
For Profit			**Non-Profit**			
Federal Qualified?	**Yes**	**No**	**If not Federal Qualified, 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-Services?			**Yes**		**No**	

Enrollment

Current enrollment as of: _____ is: _____
(Date) (Members)

Members	# of Members	Members	# of Members	Members	# of Members
Commercial		POS		Exchange	
Medicare Advantage		SNP		Medi-Medi (Dual)	
Medicaid		Medicaid Disabled		Medicaid Expansion	
Other (Define)					

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.)*		
Provider	**Risk Capitated**	**No. of Members Capitated**

PROVIDERS UNDER CONTRACT TO THE HMO			
PROVIDER	**YES/NO**	**PROVIDER**	**YES/NO**
Physicians/Primary Care		Urgent Care Centers	
Physicians/Specialty Care		Pharmacies	
Hospitals		X-Ray/Laboratories	
Ambulatory Surgery		Ambulance	
Hospital Emergency Room		Other (Define)	

MANAGEMENT UTILIZATION – 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	**$**	**Coinsurance:**	**Rate Per Member Per Month:**

REINSURANCE COVERAGE(S) DESIRED		
HOSPITAL OPTIONS	**PROFESSIONAL OPTIONS**	**COMBINED (HOSPITAL & PROFESSIONAL)**
$	**$**	**$**
$	**$**	**$**
$	**$**	**$**

COINSURANCE OPTIONS (Above Deductible):	90%	80%
INSOLVENCY?	Yes	No

CAPITATED MEMBERS: Is the HMO responsible for reinsurance on any capitated members; 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**

HMO CLAIMS REINSURANCE DETAIL LISTING – (Excel Spreadsheet Preferred)

For the current year and the prior (3) years (separated by policy period), provide details of each member who has incurred or is expected to incur total charges* in excess of fifty (50%) of your lowest requested deductible – PLEASE PROVIDE DETAILS

NOTE: Please provide paid through date for current policy period.

- **Patient ID/Name**
- **Type of Member (Commercial, POS, Exchange, Medicare Advantage, SNP, Medi-Medi (Dual), Medicaid, Medicaid Disabled, Medicaid Expansion**
- **Nature of Illness or Accident**
- **Dates of Service**
- **Provider Name**
- **Billed & Paid Charges**
- **Total Expected Charges for Current Year and Total Charges Separated for Past Three Years**
- **Reimbursement Received From Current Carrier (If any outstanding, show expected amount)**
- **Status of Member (Active, Terminated, Discharged)**
- **Prognosis**
- **Expected Charges for New Contract Year**

***Charges to include risk covered under the HMO Reinsurance Agreement, i.e. Hospital Charges – Inpatient, Subacute, LTAC, etc.**