McPhee & ASSOCIATES, INC.

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)
- Claims details 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		Medi-Medi (D-SNP)		Medicare C-SNP	
Medicare I-SNP		Medicaid Non-SPD		Medicaid SPD	
Medicaid Expansion		Other			

THE FOLLOWING DATA IS TO BE ON A REINSURANCE YEAR BASIS

Data is for the annual period from: _____ to: _____

TYPE	CURRENT POLICY PERIOD # of Months ____	PREVIOUS POLICY PERIOD	PROJECTED FOR NEXT YEAR
Commercial			
POS			
Exchange			
Medicare Advantage			
Medi-Medi (D-SNP)			
Medicare C-SNP			
Medicare I-SNP			
Medicaid Non-SPD			
Medicaid Disabled (SPD)			
Medicaid Expansion			
Other (Define)			

CAPITATION AGREEMENTS (Only list capitated providers who are assuming full risk for all expenses for the member)		
PROVIDER	**RISK CAPITATED**	**NO. OF MEMBERS CAPITATED**

MANAGEMENT UTILIZATION – What Techniques are used to…?
Control over-utilization:
Control excessive length of stay in hospital:
Provide Peer Review:

UTILIZATION STATISTICS (EXCLUDING SUBACUTE & PSYCH)

COMMERCIAL			
YEAR	BED DAYS PER 1,000	# OF HOSPITAL STAYS PER 1,000	AVERAGE PER DIEM
Current Year			
Previous Year			
Two Years Ago			

MEDICARE (SPLIT BETWEEN MA, D-SNP, C-SNP AND I-SNP IF POSSIBLE)			
YEAR	BED DAYS PER 1,000	# OF HOSPITAL STAYS PER 1,000	AVERAGE PER DIEM
Current Year			
Previous Year			
Two Years Ago			

MEDICAID (SPLIT BETWEEN MEDICAID NON-SPD, SPD AND EXPANSION IF POSSIBLE)			
YEAR	BED DAYS PER 1,000	# OF HOSPITAL STAYS PER 1,000	AVERAGE PER DIEM
Current Year			
Previous Year			
Two Years Ago			

CONTRACTS

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

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 and separated by member type – Commercial/POS, Exchange, Medicare Advantage, SNP, Dual, Medicaid, SPD, Expansion***), 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.