

REQUEST FOR PROPOSALS  
(RFP)

**ISSUE DATE:** September 15, 2008

**TITLE:** Administrative Services and Fully Insured Health Benefits Plans

**Number:** OHB08-6

**ISSUING AGENCY:** Commonwealth of Virginia  
Department of Human Resource Management  
James Monroe Building, 13th Floor  
101 North 14th Street  
Richmond, Virginia 23219

**Contract Participation:** Under the authority of the Code of Virginia 2.2-4304. Cooperative Procurement, it is the intent of this solicitation and resulting contract(s) to allow for cooperative purchasing by Commonwealth of Virginia State Agencies. A list of all Commonwealth of Virginia State Agencies (Agencies) is available at [http://www.virginia.gov/cmsportal3/government\\_4096/state\\_website\\_list.html](http://www.virginia.gov/cmsportal3/government_4096/state_website_list.html)

Participation in this cooperative procurement is strictly voluntary, and does not preclude participating Agencies from using other contracts or competitive processes. The resultant contract(s) will be extended to the Agencies to purchase at contract prices in accordance with contract terms. The Contractor shall notify the Lead Agency in writing of all Agencies accessing the contract, and provide quarterly usage reports to the Lead Agency.

No modification of this contract or execution of a separate contract is required to participate. Participating Agencies shall place their own orders directly with the Contractor(s) and shall fully and independently administer their use of the contract(s) to include contractual disputes, invoicing and payments without direct administration from the Lead Agency. The Lead Agency shall not be held liable for any costs or damages incurred by any other participating Agencies as a result of any authorization by the Contractor to extend the contract. It is understood and agreed that the Lead Agency is not responsible for the acts or omissions of other Agencies and will not be considered in default of the Agreement no matter the circumstances.

**PERIOD OF CONTRACT:** From July 1, 2009 through June 30, 2011, with three one-year renewal options as described within.

Sealed proposals for furnishing services described herein will be received subject to the conditions cited herein until 2:00 p.m., October 16, 2008.

All Inquiries Must Be In Writing And Should Be Directed To:

Mr. Dan Hinderliter  
Department of Human Resource Management  
James Monroe Building, 13th Floor  
101 North 14th Street  
Richmond, Virginia 23219  
e-mail: dan.hinderliter@dhrm.virginia.gov

SEND ALL PROPOSALS DIRECTLY TO THE ISSUING AGENCY ADDRESS SHOWN ABOVE.

**Note: This public body does not discriminate against faith-based organizations in accordance with the Code of Virginia, § 2.2-4343.1 or against a bidder or offeror because of race, religion, color, sex,**

**national origin, age, disability, or any other basis prohibited by state law relating to discrimination in employment.**

In compliance with this Request for Proposals, and to all the conditions imposed therein and hereby incorporated by reference, the undersigned offers and agrees to furnish materials and services in accordance with the attached signed proposal or as mutually agreed upon by subsequent negotiation.

Name and Address of Firm:

_____	Date: _____
_____	By: _____
_____	(PRINTED NAME)
_____	_____
_____	(SIGNATURE IN INK)
_____ Zip Code: _____	Title: _____
Fax Number: _____ ( ) _____	Telephone: _____ ( ) _____

**PRE-PROPOSAL CONFERENCE:** A **Mandatory** pre-proposal conference will be held on Monday, September 29, 2008, at the James Monroe Building. (Reference Paragraph 5.9)

## INTRODUCTION

### 1.1 Purpose

The purpose of this Request for Proposals (RFP) is to secure an administrator for the statewide Medical/ Surgical and/or vision and hearing health benefits program for the Commonwealth of Virginia and The Local Choice (TLC). The TLC program is an optional health benefits program administered by the Department of Human Resource Management (DHRM) for political subdivisions of the Commonwealth. Please note that one statewide health benefit plan must be offered. Less than statewide plans may also be offered under this RFP, if they meet the criterion described in Section 2.2 below.

The medical/surgical vendor administers the current vision and hearing plan. Offerors are to submit a similar combined arrangement.

The entire health benefits program is being procured with four RFPs (See paragraph 1.3).

The objectives of the programs are to provide better than average benefits administered in a very cost-effective manner with excellent service to enrollees, so that state agencies and participating local jurisdictions can recruit and retain high quality employees. Within this context, the employee health benefits program would like to offer as many choices of medical/surgical plan administrators as may be feasibly cost-effective. The carve out plans (for dental, Mental Illness & Substance Abuse and prescription drug services) are being procured under the RFP entitled Administrative Services for benefit plans (*OHB08-4, OHB08-5 and OHB08-7*) issued at the same time as this RFP. The carved out benefits being procured under those RFPs will be included with all self-funded medical/surgical plans offered as a result of this RFP.

### 1.2 Background

The Department of Human Resource Management (the Department) is the authorized agent of the Governor in administering the state employee health benefits program. The program is delivered through approximately 250 state agencies to some 95,000 active, full-time employees, retirees not eligible for Medicare, and extended coverage (COBRA) enrollees, and to the dependents of these enrollees. Agencies distribute program materials, assist employees in applying for coverage or changes in coverage according to rules developed by the Department, payroll-deduct employee premiums, post eligibility information onto the Benefits Eligibility System (BES), and otherwise assist employees in accessing the program's benefits. To support employees and agencies' benefit personnel, the Department operates Employee Direct (E-Direct) which is a web-based system through which employees may make enrollment and coverage changes without the use of paper forms, and which serves as a portal to benefits related information including wellness and medical management sites.

The Department also has the responsibility for administering a health benefits program, The Local Choice (TLC), which is offered to localities statewide as a replacement option to other health benefits program choices. Any local government, school district, political subdivision, etc. may join this program. Presently there are 257 member groups covering approximately 27,000 employees. The Department offers a choice of plans to member

groups in addition to plan(s) offered to state employees. Currently the choices of plans include PPO, HDHP (HDHP) and HMO plans with some utilizing coinsurance rather than co-payments and deductibles.

The Department has developed plans and programs with the advice of consultants, vendors, employees and others, and has delivered benefits through Contractors, either insurers or third party administrators. The coverages currently available may be found on the state employees web site: [www.dhrm.virginia.gov/employeebenefits.html](http://www.dhrm.virginia.gov/employeebenefits.html) and on theLocal Choice web site: [www.thelocalchoice.state.va.us](http://www.thelocalchoice.state.va.us).

### 1.3 General Description

The Department currently offers one statewide self funded plan, a PPO called COVA Care and a regional fully insured HMO. It is anticipated that similar medical/surgical and HMO plans, both regional and state-wide and both fully insured and self funded will result from this RFP #OHB08-6. The Department also offers a statewide self funded High Deductible health Plan (HDHP), which is not part of this procurement. The Local Choice program currently offers six choices under the self-funded plan and is designed around a PPO called Key Advantage Expanded. Other TLC offerings include Key Advantage 200, 300 and 500, a regional fully insured HMO, as well as an HDHP, which is not included in this procurement. .. It is anticipated that there will always be a degree of choice in TLC to better meet the needs of the different groups and to ensure the program remains competitive in the marketplace.

Incorporated within all of these plans, and, possibly, other less than state wide self funded plans, are separately procured benefit plans of: a dental plan; a mental health and substance plan plan (MISA) including Employee Assistance Program (EAP) services; and a prescription drug plan. . This RFP # OHB08-6 provides offerors of Medical/Surgical including Vision and Hearing services the opportunity to provide the services on a statewide self-funded basis. One offeror will be selected using a competitive negotiation process. Less than statewide plans may also be offered under this RFP, if they meet the criteria described in Section 2.2 below.

The Department wishes to receive offers for the statewide plan on an Administrative Services Only (ASO), self-insured basis. It wishes to receive offers for less than statewide plans on a fully insured or self funded basis. The Department's preference for less than state-wide plans is for a self funded program; fully insured offers for less than statewide plans may be considered, but the Department is under no obligation to implement such a plan.

This RFP is divided into sections, such as this numbered Section 1.0, Introduction. A section is one of the principal divisions of this RFP. Within these sections, numbered paragraphs are the second principal division and normally contain the number of the section in which they are located, such as this paragraph numbered 1.3.

***It is imperative that offerors respond to all applicable requirements and complete all applicable schedules and exhibits described in the Form of Response, Section 6.*** Any offeror confusion about which sections and/or paragraphs may be applicable to a potential offeror should be clarified no later than the mandatory offerors' conference.

**This RFP does not embrace coverage for MISA, EAP, dental, or pharmacy benefits. For those plans, refer to the companion RFPs entitled Administrative Services for Dental Health Plans, Administrative Services for Prescription Drugs Benefits, Administrative Services for Mental Illness, Substance Abuse and EAP Benefits numbered OHB08-4, OHB08-5 and OHB08-7.**

**This RFP also does not address coverage for Medicare Retiree benefits. Benefits for the Medicare Retiree Program, including the Medicare Part D benefit, will be procured at a later date for an effective date of January 1, 2010.**

#### 1.4 Policy Regarding Participation of Small, Women, and Minority Owned Businesses

It is the policy of the Commonwealth of Virginia to contribute to the establishment, preservation, and strengthening of small businesses and businesses owned by women and minorities and to encourage their participation in state procurement activities. The Commonwealth encourages Contractors to provide for the participation of small businesses and businesses owned by women and minorities through partnerships, joint ventures, subcontracts, and other contractual opportunities. Submission of a report of past efforts to utilize the goods and services of such businesses and plans for involvement on this contract are required. By submitting a proposal, offerors certify that all information provided in response to this RFP is true and accurate. Failure to provide information required by this RFP will ultimately result in rejection of the proposal.

All information requested by this RFP on the ownership, utilization, and planned involvement of small businesses, women owned businesses, and minority owned businesses must be submitted. If an offeror fails to submit all information requested, the purchasing agency will require prompt submission of missing information after the receipt of vendor proposals in order for a non-compliance proposal to be considered. (See Exhibit TWO)

#### 1.5 Appendices

Appendix 1 is the current standard contract. Appendix 2 contains selected enrollment, cost, workload, demographic and utilization data for state employees. Appendix 3 contains a summary description of plans currently offered to TLC employees. Appendix 4 provides summary claims experience for mental health and substance abuse and EAP services. Appendix 5 gives information regarding the number of contracts and claims experience of TLC local employees covered under non-HMO contracts. Appendix 6 contains copies of certain forms currently in use. Appendix 7 contains a description of the state employee billing system. Appendix 8 contains a description of the enrollment and billing procedures and group renewal process for TLC. Appendix 9 contains the EDI payment procedures that are used for the state employee group.

#### 1.6 Attachments

Attachment 1 contains benefit descriptions. Attachment 2 contains the cost schedules and technical questionnaire that must be submitted with a proposal. In electronic form

(see 1.8 below) it also contains claim and eligibility data necessary to prepare a proposal. Attachment 3 provides report formats.

## 1.7 Exhibits

Exhibit **One** contains a sample HIPAA Privacy Business Associate Agreement (see paragraph 8.23). Exhibit **Two** contains the Small Business and Business Owned By Women and Minorities report that is required to be submitted under paragraph 6.6.

## 1.8 Electronic Data Files and Response Forms

Files containing claims, enrollment data and the Attachment 2 schedules you will need to prepare and submit a proposal are available in electronic form. To obtain the CD containing these MS Excel and Word files, you may pick them up at the Department or provide a mailing address for delivery. To arrange pick up or delivery, please contact [Dan Hinderliter](mailto:dan.hinderliter@dhrm.virginia.gov) by phone (804-371-7990) or e-mail (dan.hinderliter@dhrm.virginia.gov). Please note, these files are proprietary and available only to vendors of the services requested by this RFP.

## 2.0 MEDICAL BENEFIT SPECIFICATIONS, TASKS, AND MANDATORY QUALIFICATIONS

### 2.1 Statewide Medical Plans

The Department is required to offer at least one statewide benefit plan for the state employees program and for the TLC program. One contractor is used for both programs and the plan(s) are provided on a self-insured basis. The plans that are currently offered are described on the web sites provided in Section 1.2 above and encompass a variety of plan designs. The Department will continue the self-insured arrangements and the Contractor must have the ability to administer multiple plans. The Contractor must be able to assist the Department in changing plan designs during the term of this contract as situations change within the health care industry.

Note: The carve out plans providing Dental, Pharmacy, and MISA benefits being procured on companion RFPs are incorporated within the framework of all statewide ASO plans being offered.

Note: The statewide medical plans include a vision and hearing benefit. The successful contractor will have the ability to provide these benefits as shown on the schedules of benefits on the Department's Web Site and in Appendix 3.

### 2.2 Less Than Statewide Plans: Health Maintenance Organizations (HMOs) and PPOs

An offeror may submit a proposal for a less than statewide plan under these conditions:

2.2.1 The plan has a managed care network (HMO; PPO)

2.2.2 The plan is licensed and the proposal covers a contiguous service area.

2.2.3 Self- and fully insured options will be considered.

2.2.4 A self insured plan will be considered if the plan is an existing network plan, covering a contiguous service area, and has at least 5000 members in the proposed area on January 1, 2009.

The benefit design for a less than statewide plan is up to the offeror, but should represent a distinctive choice when compared to the COVA Care options. More than one option may be proposed.

## 2.3 MEDICAL SURGICAL PLAN PROVIDER NETWORK

2.3.1. The statewide Contractor must offer a statewide network of providers who are expert and practiced and appropriately credentialed. The number of providers should permit employees to access the network for services within the standards described in paragraph 2.4.

2.3.2 The Contractor must:

- a. ensure that providers continue to meet the Contractor's criteria,
- b. ensure that sufficient liability insurance is maintained,
- c. ensure that provider contracts continue to remain in force,
- d. ensure that referral patterns and utilization of services are monitored continually,
- e. ensure that sufficient (in the Department's judgment) numbers of credentialed providers are available, and
- f. encourage providers to support and utilize electronic health records

2.3.3. The Department will consider local networks if the networks are properly credentialed and offer the specified benefits at capitated rates deemed advantageous to the Department.

2.3.4. The Contractor must develop, maintain and publish a directory of participating providers of services. Provider directories must be available to all group administrators and must be easily accessible by enrollees on the contractor's web site (see paragraph 8.15). The Contractor shall have and execute a plan for updating provider lists and communicating changes to benefits administrators and enrollees

## 2.4 MANDATORY QUALIFICATIONS FOR OFFERORS

2.4.1 All network-based plans shall demonstrate that sufficient access is available as demonstrated by the geo-access response in Attachment 2.

**Alternatively**, if the plan has a Certificate of Quality Assurance from the Center for Quality Health Services and Consumer Protection, the plan shall be deemed to have met the access requirement. If such certificates have not been issued by Dec.

15,2008, the Department may deem the Offeror's application for the Certificate to meet this requirement.

- 2.4.2 All network-based plans shall annually produce and submit a HEDIS (or department approved substitute), including the standard Member Satisfaction Survey, in accordance with the current requirements.
- 2.4.3 All network-based plans shall apply for NCQA certification *before* responding to this RFP. If rejected, regardless of the reason, the plan(s) shall re-apply at the earliest time permitted by NCQA.
- 2.4.4 To be awarded a contract, all plans must demonstrate the capability to provide the claims and eligibility files in a format required by the Department. Such demonstration will consist of submission and approval of a test file in the format provided by to finalists. The timing and other logistics involved with this process will be determined during the proposal evaluation negotiations. .
- 2.4.5 All plans must offer toll-free customer service telephone numbers at least three months before the effective date of the contract.
- 2.4.6 The network for the statewide plans shall provide access to participating providers outside of the Commonwealth of Virginia where desired by enrollees.

## 2.5 MEDICAL SURGICAL PLAN CLAIMS PROCESSING

- 2.5.1. Process all claims incurred during the life of this contract.
- 2.5.2. Receive, date and control claims within 24 hours of the day received.
- 2.5.3. Verify eligibility of claimant and period of coverage for every claim processed. Pay no claims for TLC employees whose premiums are not currently paid. Eligibility file must include each dependent by name and number together with the period during which coverage has been in force.
- 2.5.4. Examine the licensure and participation status of the provider of services.
- 2.5.5. Determine whether or not the services are covered.
- 2.5.6. Determine that the services provided were necessary.
- 2.5.7. Check claims history and prevent duplicate payments or payments that exceed contract limits
- 2.5.8. Price the services.
- 2.5.9. Generate and mail a check, as required, and an explanation of benefits (EOB) or denial notice. The forms of the EOB and denial notice are subject to the Department 's approval, however, the Department may consider an electronic EOB in luei of a paper EOB.. Payments and denial notices must be mailed or

generated within five business days of the date on which the claim was processed.

- 2.5.10 Deliver a summary paid claim listing to the Department in a form acceptable to the Department every week along with an invoice. Administrative costs are to be billed monthly.
- 2.5.11 Maintain a bank account for paying claims. Reconcile the account, and credit interest to the Department when interest on the float exceeds banking charges. The amount of interest will be determined by mutual agreement between Contractor and the Department.
- 2.5.12 Maintain a history of all claims paid. Not less than 18 months of claims history prior to the current calendar year shall be maintained on line.
- 2.5.13 Provide within ten (10) days of the end of each month an electronic file of claims paid during the previous month to Department's Consultant in format provided under Attachment 4.
- 2.5.14 Provide, on a schedule to be determined, an electronic claim file to a designate data warehouse, or to other vendors as needed to perform integrated disease management services.
- 2.5.15 As requested, provide "real-time" access to claim information to a third party vendor for purposes of performing consolidated customer service, health coaching and patient care coordination.

## 2.6 MEDICAL SURGICAL PLAN EMPLOYEE INQUIRES

Respond correctly and timely to inquiries received by telephone, by mail, e-mail or in person

## 2.7 MEDICAL SURGICAL BENEFITS ADMINISTRATION

- 2.7.a. The Contractor shall check the eligibility of claimants against the eligibility files that will be supplied electronically by the Department (for State employees) and a central eligibility file (for enrollees of The Local Choice) before authorizing benefits.
- 2.7.b. The Contractor shall develop employee communication materials, which fully and accurately describe, including any companion carve out benefits:
  - 1. the benefits of the program,
  - 2. how the program works,
  - 3. where, how, and when additional information can be obtained,
  - 4. how to access care,

5. what to do in an emergency,
6. how to appeal the determination of the Contractor with respect to a denial of benefits for any reason,
7. employee assistance services available,
8. such other information as would be required to meet the standards of a summary plan description as that term is defined in the Employee Retirement Income Security Act (ERISA), and
9. develop 2 articles per year for use by the Department in employee communications about various aspects of the plan.
10. develop ancillary communications materials as needed to focus on specific program components.

2.7.c Provide a legal defense against all claims arising out of this contract.

2.7.d Hold enrollees and covered dependents harmless with respect to services covered under this contract when such services are furnished by participating providers.

2.7.e The Contractor shall coordinate as closely as possible with the MISA and Prescription Drug Plan Administrators under which the employee is enrolled to integrate customer service, claims processing, disease/case management and data reporting.

2.7.f Participate as requested in HR Conferences, benefits fairs and wellness activities coordinated under the CommonHealth program or through the Department

## 2.8 Mandatory Qualifications for Medical Offerors

2.8.1 The plan shall demonstrate that the access to participating providers available to employees of the Commonwealth is acceptable to the Department.

2.8.2 A network-based plan shall annually produce and submit an approved Member Satisfaction Survey.

2.8.3 The plan must offer toll-free customer service telephone numbers at least three months before the effective date of the contract.

2.8.4 The plan must provide a web site available to state and TLC employees that is available for use by April 1, 2009.

2.8.5 Before issuing a contract, the plan must submit a paid claims test file containing at least 500 claims in a format that will be provided. The Department must be able to read and approve the file format. PLEASE NOTE: Standard vendor files are not acceptable to fulfill this requirement.

2.8.6 The plan shall cooperate with other vendors and designated consultants in data integration activities

2.8.7 The plan shall work with the Department and other vendors in the creation and distribution of a single, COVA-specific ID card.

### 3.0 STANDARDS OF PERFORMANCE

#### 3.1 General

The Contractor shall be solely responsible to the Department and liable for any delay or non-performance of any portion of the contract which results from this RFP, and for erroneous payments. The Contractor shall not be responsible for delay or non-performance if the non-performance is caused by the failure of the Commonwealth, covered persons, or non-network providers to provide information necessary for the Contractor to meet its contractual obligations.

Certain performance obligations are of such importance that a Contractor's failure to achieve the requirements found herein jeopardizes the value which the Department expected of the contract. In acknowledgment of this, and in consideration of the extra expenses and other damages incurred by the Department should the Contractor fail to fulfill specified contractual obligations, both parties agree that the Contractor shall pay to the Department the amount contained in the appropriate schedule of liquidated damages (see paragraphs 3.8) when the Contractor's performance fails to meet the specified standards of performance.

**It is expressly agreed that, unless otherwise specified, the determination of liquidated damages, if any, shall be determined annually by comparing the system generated reports in Attachment 2 and 3 to the related Schedules submitted by the Contractor.**

#### 3.2 Claims Must Be Paid Correctly

The goal is 100% accuracy.

Below Standard:

Total payment error rate in excess of 1% of benefit payments, where total payment error rate is the dollar amount of erroneous payments, including payments to an incorrect payee (any reason) or paid in an incorrect amount (any overpayment plus any underpayment) or any other payment error (including both incorrect payee and incorrect amount), divided by the total dollar amount of claims paid during the audit period, **OR**

Total error rate in excess of 5% of claims processed, where total error rate is the number of claims with any kind of error (including payment errors) divided by the total number of claims processed during the audit period.

Compliance with this standard shall be determined by internal audit, verified by external audit. Should the internal and external audits arrive at results which materially affect the amount of liquidated damages, the Contractor and the Department shall negotiate the actual amount of the damages. If these parties cannot reach an agreement through negotiation, they shall jointly pay for an independent audit whose determination shall be binding on both parties.

### 3.3 CORDINATION OF BENEFITS SAVINGS

Produce savings from coordination of benefits of at least 2% of non-Medicare paid claims per calendar year for the active employee-early retiree group. HMOs are exempt from this requirement.

Compliance with this standard shall be determined by audit as described in 3.2.

### 3.4 Access of Eligibility Files Updates

The Department will maintain current eligibility files for both the state employee group and the TLC program. Enrollee eligibility changes may be made electronically without restriction to time of day or day of week. The Department will move these changes automatically to an electronic file for pickup by the Contractors. It is expected that each Contractor pick up changes on a regularly working basis, and in all cases, at least once daily.

### 3.5 Reporting

Reports containing the requested true information shall be submitted timely. The submission of a materially inaccurate report does not constitute timely submission for the purposes of this section. NOTE: Timely reporting also includes the submission of accurate and readable weekly claims files, paid claims invoices, and monthly administration invoices.

The Department shall determine compliance with this standard by the date of receipt of reports.

### 3.6 INVOICE PROCESSING

Process 90% of TLC premium invoices within 3 business days of receipt of payment and 100% of premium invoices within 5 days of receipt.

Compliance with this standard shall be determined by audit as described in 3.2.

### 3.7 Premium Projections

If the total discount representing the Net Payment after Application of Your Reimbursement Method reported on Projected Savings Report (Attachment 2, schedule 2-2) is less than 95% of the total discount representing the Net Payment after Your Application of Reimbursement Method projected on the Projected Savings Schedule for the same fiscal year such that the amount paid for claims is higher than projected, then

1% of the Contractor's administrative fee shall be owing and due the Department as liquidated damages for each 0.1% by which the actual discount received is lower than 95% of the projected discount.

3.8 Patient Satisfaction

At least 90% of the covered persons responding to the Contractor's annual surveys (Paragraph 4.1.9) must rate their overall experience with the program as "satisfactory" or better.

3.8 Schedule of Liquidated Damages – General

This schedule of liquidated damages is mutually agreed in view of the difficulty and the cost of measuring the actual damages incurred from complaints, lost productive time, intrusion into other business, etc., as a result of under-performance in the areas noted.

<u>Brief Reference</u>	<u>Liquidated Damage Award</u>
99% of benefit \$ paid correctly	3% of administrative costs for each 1% or fraction below standard
95% of claims paid without error	1% of administrative costs for each 1% or fraction below standard
Eligibility Files not picked up daily	\$100 per day, days 1-7, \$1,000 per day thereafter
COB savings of 2%	1% of administrative costs for each 1% or fraction below standard
Late/Missing Reports	\$100 per day, days 1-5; \$1,000 per day thereafter
Invoice Processing	\$500 per invoice not meeting standard
Inaccurate projections	1% of contracted administrative fee for each 0.1% of unrealized provider discount after 5%.
Patient Satisfaction	\$2000 for each percent or fraction thereof below standard

4.0 REPORTS AND DELIVERABLES

Generally, separate report sets are required for each separate group, including but limited to (1) TLC local governments, (2) TLC school jurisdictions, (3) TLC in total, (4) the state employee active employee group, (5) the state employee early retiree group, and (6) the state employee group in total. Attachments 2 and 3 also contain formats of some system-generated reports that will be used to assess Contractor performance and to determine the amount of liquidated damages due, if any. Report formats are generally contained in Attachments 2 and 3. Offerors are invited to suggest improvements or additional reports.

## 4.1 REPORTS

### 4.1.1 Rate and Administrative Expense Buildup Schedule

This form, which may be found in Attachment 2-1, must be submitted in accordance with paragraph 4.1.10 and 8.5.

### 4.1.2 Weekly Claims Report

The Weekly Claims Report is to be prepared in MS Excel format and E-mailed on the third business day after the close of the week. The format is contained in Attachment 3.

### 4.1.3 Weekly claims file

The format for the file will be provided to the finalist.

### 4.1.4 Administrative Fee Report

This report is used by all ASO plans to invoice administrative costs on a monthly basis. The format is contained in Attachment 3.

### 4.1.5 Monthly Service Report

This report discloses Contractor's results in meeting customer service and claims processing goals. The format can be found in Attachment 3.

### 4.1.6 TLC Monthly Income Report

The Monthly Income Report shows the premium income received from each local employer by plan and in total, with an indication of employer groups in default. The report is to be prepared in MS Excel format (see Attachment 3) and E-mailed on the 20<sup>th</sup> day after the close of the month.

### 4.1.7 Extended Coverage (COBRA) Transactions and Enrollment File

The specifications for this electronic file are found in Attachment 3. The two purposes of the report are (1) to report all changes (adds, deletes) to the previous month's Extended Coverage enrollment, and (2) to provide a file denoting the current Extended Coverage enrollment.

### 4.1.8 Monthly Utilization Management Report

This report discloses the contractor's assessment of its utilization management activities, including admission review, concurrent review and case management. The specifications for this electronic file are found in Attachment 3.

### 4.1.9 Annual HEDIS

The Contractor shall submit the latest appropriate version of the HEDIS (or Department-approved equivalent), including the standard Member Satisfaction Survey for the most recent calendar year, by July 1 or with the contractor's renewal, as appropriate.

#### 4.1.10 Annual Accounting and Renewal

On or before September 15, or such date as determined by the Department, after the completion of 12 months' operations under the contract, the Contractor shall submit specified IBNR lag triangle data in the required form to the Department Actuary.

On or before September 15, or such date as determined by the Department, after the completion of 12 months' operations under the contract, the Contractor shall submit a complete accounting of its operations for the fiscal year ended the last June 30, and shall propose a rate, using the Rate Buildup Schedule, for the fiscal year beginning the next July 1. The accounting and rate analysis should treat separately each major class of benefits, medical-surgical, mental illness and substance abuse, prescription drug, and dental.

In addition, the Annual Report shall contain:

- costs by employee, spouse and dependents (separately for active employees, retirees, and extended coverage enrollees),
- a list of the fifty highest cost cases (enrollees) with relevant detail on admissions, diagnoses, etc.,
- amounts paid to hospitals (including inpatient surgical per diem, inpatient acute medical per diem, inpatient acute obstetrical case rate, inpatient outlier minimum charge per case and inpatient outlier rate, and outpatient case rates for those procedures which comprise 50% of outpatient hospital reimbursement, or for the 25 procedures which have the highest total dollar impact together with an indication of the percentage of total outpatient reimbursement these 25 procedures represent),
- show the fifty professional providers of services receiving the largest payments, and
- claims in excess of \$100,000, if not previously reported.

Finally, the Annual Report shall provide a frequency distribution of contracts, claims and dollars paid in total and by type of benefit.

4.1.11 Such other reports as may be necessary to document the performance of the Contractor and its adherence to the contracted standards.

4.2 All Contractors: Utilization of Small Businesses and Businesses Owned by Women and Minorities.

UTILIZATION OF SMALL BUSINESSES AND BUSINESSES OWNED BY WOMEN AND MINORITIES

1. Periodic Progress Reports/Invoices. Within sixty days of each six months' operation under this contract, disclose the actual dollars contracted to be spent to-date with such businesses, and the total dollars planned to be contracted with such businesses on this contract. This information shall be provided separately for small businesses, women-owned businesses and minority-owned businesses.
2. Final Actual Involvement Report: The contractor will submit, prior to completion of the contract and prior to final payment, a report on the actual dollars spent with small businesses, women-owned and minority-owned businesses during the performance of this contract. At a minimum, this report shall include for each firm contracted with and for each such business class (i.e., comparison of the total actual dollars spent on this contract with the planned involvement of the firm and business class as specified in the proposal, and the actual percent of the total estimated contract value. A suggested format is as follows:

Business Class: Small, Women-Owned or Minority-Owned

<u>FIRM NAME, ADDRESS AND PHONE NUMBER</u>	<u>TYPE GOODS/SERVICES</u>	<u>ACTUAL DOLLARS</u>	<u>PLANNED DOLLARS</u>	<u>%OF TOTAL CONTRACT</u>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
TOTALS FOR BUSINESS CLASS		_____	_____	_____

#### 4.3 Other Deliverables

- 4.3.1 The Contractor agrees to furnish and warrants that the administrative charge quoted includes all enrollment materials, benefits booklets, and brochures describing plan benefits, applications, notices, claims forms, checks, remittance advices, two articles for employee publications, administrative manuals, provider networks, directories, forecasts, invoices, identification cards, criteria sets and such services and materials stated or implied anywhere in this RFP or the Contractor's response thereto.
- 4.3.2 The statewide medical surgical ASO contractor shall assist the Department with the ongoing operations of The Local Choice program by providing direct support with, but not limited to, the marketing; communications; underwriting; renewal and proposal preparation and delivery; group billing and collections; maintaining membership; and distributing ASO membership to other ASO carve-out products Contractors.

#### 5.0 PROCUREMENT PROCEDURES

##### 5.1 Method of Award

- 5.1.1 The Department shall select two or more Offerors deemed to be fully qualified and best suited among those Offerors submitting proposals, unless the Department has made a determination in writing that only one Offeror is fully qualified, or that one Offeror is clearly more highly qualified than the others under consideration. The selection of Offerors will be based on the evaluation factors included in this RFP. Negotiations shall be conducted with the selected Offeror(s). Price shall be considered when selecting finalists for negotiation, but shall not be the sole determining factor.
- 5.1.2 After negotiations have been conducted with each selected Offeror, the Department shall select the Offeror, which, in its opinion, has made the best proposal. The Department shall award the contract to that Offeror. The Department may cancel this RFP, or reject proposals at any time prior to an award. The Department is not required to furnish a statement of the reason why a particular Offeror was not deemed to have made the best proposal (Section 2.2-4359, Code of Virginia).
- 5.1.3. Should the Department determine in writing, and in its sole discretion, that only one Offeror is fully qualified, or that one Offeror is clearly more highly qualified than the others under consideration, a contract may be negotiated and awarded to that Offeror.
- 5.1.4 The contract will incorporate by reference all the requirements, terms and conditions of this RFP and the Contractor's proposal, except as either or both may be amended through negotiation. All statements and representations, written or verbal, relating to the award of this and renewal contracts must be construed to be consistent with the following submission instructions.

## 5.2 Submission of Written Proposals

- 5.2.1 All proposals must be in the form requested (See paragraph 6.0 and Attachment 2). The data required on the schedules submitted in response to this RFP are subject to verification. Material errors shall be a basis for rejecting such a proposal. An **Original**, a **Redacted** and six additional copies shall be delivered in a sealed container, and labeled as a proposal, with the words "**Do Not Open**" and **the type of benefit plan enclosed** prominently displayed on the outside. Proposals must be received no later than 2:00 p.m. on October 16, 2008, by:

Mr. Dan Hinderliter  
Department of Human Resource Management  
James Monroe Building, 13th Floor  
101 North 14th Street  
Richmond, Virginia 23219

Each copy of the proposal should be bound in a **loose-leaf notebook**. All documentation submitted with the proposal should be contained in that single volume. (If necessary, additional notebooks may be submitted in clearly marked and referenced sequence.) *Offerors are required to submit a CD containing their response in MS Excel and Word format, as directed by the Attachment 2 schedules, along with each copy of the proposal.*

5.2.2 Ownership of all data, materials and documentation originated and prepared for the Department pursuant to the RFP shall belong exclusively to the Department and be subject to public inspection in accordance with the Virginia Freedom of Information Act. Trade secrets or proprietary information submitted by an offeror shall not be subject to public disclosure under the Virginia Freedom of Information Act; however, the offeror must invoke the protections of Section 2.2-4342 of the Code of Virginia, in writing, at the time the data or other material is submitted. The written notice must specifically identify the data or materials to be protected and state the reasons why protection is necessary. The proprietary or trade secret material submitted must be identified as required and must indicate only the specific words, figures, or paragraphs that constitute trade secrets or proprietary information. The Department, in its sole discretion, may not consider proposals with unduly broad requests for protection against disclosure.

### 5.3 Modification of Proposals

Any changes, amendments or modifications of an offeror's proposal prior to the deadline for receipt of proposals must be in writing and submitted in the same manner as the original proposals. All modifications must be labeled conspicuously as a change, amendment, or modification of the previously submitted proposal. Changes, amendments, or modifications of proposals will not be considered after the deadline for receipt of proposals, except when the Department requests modifications.

### 5.4 Oral Presentation

Offerors who submit a proposal in response to this RFP may be required to give an oral presentation of their proposal to the Department. This provides an opportunity for the offeror to clarify or elaborate on the proposal. This is a fact finding and explanation session only and does not include negotiation. The Department will schedule the time and location of these presentations. Oral presentations are an option of the Department and may or may not be conducted.

### 5.5 Inquiries Concerning the RFP

Any communication concerning this RFP or any resulting contracts must be addressed in writing to:

Mr Dan Hinderliter  
Department of Human Resource Management  
James Monroe Building, 13th Floor  
101 North 14th Street  
Richmond, Virginia 23219  
E-mail: [dan.hinderliter@dhrm.virginia.gov](mailto:dan.hinderliter@dhrm.virginia.gov)

### 5.6 Public Inspection of Procurement Records

Proposals will be subject to public inspection only in accordance with Section 2.2-4342 of the Code of Virginia.

## 5.7 Clarification of Proposal Information

The Department reserves the right to request verification, validation or clarification of any information contained in any of the proposals. This clarification may include checking references and securing other data from outside sources, as well as from the offeror.

## 5.8 Reference To Other Materials

The offeror cannot compel the Department to consider any information except that which is contained in its proposal, or which is offered in response to a request from the Department. The offeror should rely solely on its proposal. The Department, however, reserves the right, in its sole discretion, to take into consideration its prior experience with offerors and information gained from other sources.

## 5.9 Mandatory Pre-Proposal Conference

A **mandatory** pre-proposal conference will be held at 11:00 a.m. September 29, 2008, in the James Monroe Building, Conference Room C, 1<sup>st</sup> Floor, 101 North 14th Street, Richmond, Virginia. The purpose of this conference is to allow potential offerors an opportunity to present questions and to obtain clarification relative to any facet of this procurement.

Attendance at this conference is a prerequisite to submitting a proposal. Offerors who intend to submit a proposal are **required** to attend. Any changes resulting from this conference will be issued in a written addendum to the RFP. Attendance at the conference will be documented by the representative's signature on the attendance roster. Offerors should bring a copy of this RFP to the conference

**It is requested that any known questions regarding the RFP be sent by e-mail to DanHinderliter prior to date of conference to facilitate the conference. See E-mail address in paragraph 5.5.**

## 5.10 Timetable

RFP Published	September 15, 2008
Mandatory Pre-Proposal Conference	September 29, 2008
Proposals Due, 2:00 P.M.	October 16, 2008
Notice of Intent to Award	November 17, 2008

## 6.0 FORM OF RESPONSE AND CRITERIA

### General

A separate proposal is required for each plan type (PPO, HMO, etc), or if less than state wide for each area for which you are proposing. A proposal for the statewide ASO plan must include provisions for vision and hearing services. Attachment 2 contains the schedules required to complete a proposal. Please review Attachment 2 carefully and complete those section(s) that apply to the plan being offered.

Each proposal shall be in the form of a loose-leaf binder tabbed to point to each section below. Before the first tab:

- Place the executed RFP Cover Sheet followed by a statement defining those sections of your proposal which may not be released because they are proprietary. Each page so designated shall also be marked “Confidential: Proprietary Information,” and, if not so marked, shall not be protected.
- Following the executed Cover Sheet and statement of confidentiality, if any, place a properly completed Proposal Checklist which will be provided to attendees of the Pre-Proposal Conference.

An original proposal and six copies are required. The original shall contain a Cover Sheet bearing an original signature signed in BLUE ink and be labeled on the cover as “Original”.

#### 6.1 Redline RFP noting demurrals (Tab 1)

Include a copy of the RFP. Using the *Track Changes* and *Highlight Changes* MS Word tools, annotate in redline **any and all** demurrals or deviations to the requirements of the RFP. You may also enter any substantive comments on the RFP provisions, but please restrict such to issues that are necessary to clearly understand your proposal. Information required in the tabs below need **NOT** be repeated in this tab. Also, affirmations or confirmations of compliance to RFP requirements are unnecessary in this tab and are **NOT** to be included.

#### 6.2 Legally Correct Description of Benefits (Tab 2)

6.2.1 For the statewide employees program, itemize any benefit changes to current plans.

6.2.2 For the TLC program, itemize any benefit changes to current plans (1) utilizing Co-Pays and hospital deductibles and (2) utilizing the coinsurance benefits. If you intend to duplicate the current program in its entirety, you may simply so note.

#### 6.3 Benefits Brochure (Tab 3)

The offeror shall submit a model brochure containing supplemental information for employees to help them understand how the plan works.

6.3.1 The brochure shall consist of the information required by the monthly service report (see paragraph 4.1), and all of the following available or applicable to the type plan offered.

6.3.1.1 the plan's NCQA certification status,

6.3.1.2 selected HEDIS (or Department approved substitute) information on

- plan membership
- effectiveness of care

- PCP availability
- physician turnover
- disenrollment
- rate trends

6.3.1.3 highlights from the HEDIS (or Department approved substitute) Member Satisfaction Survey, including

- overall satisfaction
- overall quality of care and services
- access
- recommendation to family and friends

6.3.1.4 a brief summary of the report, which describes the plan's adherence to the access standards, found in paragraph 2.3, subparagraph 1.

6.3.1.5 a brief discussion of the criteria used to admit institutional and professional providers into the network and the bases on which the plan pays the providers.

6.3.1.6 optionally, the plan may include practice guidelines covering those outpatient procedures representing about one-half of outpatient professional costs.

#### 6.4 Technical Questionnaire (Tab 4)

Attachment 2 contains the Technical Questionnaire, which constitutes the technical proposal. It must be completed in accordance with the instructions contained in the Questionnaire. In addition to the hard copy contained in this tab, the electronic file must be provided with your response as requested in the Questionnaire.

#### 6.5 Cost Proposal (Tab 5)

Attachment 2 contains the schedules which, along with the offeror's latest certified audit report, constitute the cost proposal. Include in this tab, a copy of the audited report for the most recently completed fiscal year and a hard copy of the schedules. Also, the schedules must be submitted in Excel as directed in Attachment 2 instructions.

The attachment also contains schedules that provide the following cost proposal detail:

6.5.1 A firm, fixed price per contract month for the first contract year.

6.5.2 A firm, fixed price per contract month for the second contract year. This price may not be indexed to the price of the first contract year.

6.5.3 A guaranteed interest rate for funds in the operating account or an index which will constitute a minimum guarantee. (Offerors of insured plans are exempt from this subparagraph 6.5.4.)

6.5.4 A cost summary page

6.6 Participation of Small, Women, and Minority Owned Businesses (Tab 6)

Complete the information required on Exhibit TWO.

6.7 MEDICAL SURGICAL CRITERIA

Proposals will be evaluated on six criteria:

Offeror's organization and financial stability (10)

Qualifications of staff (5)

Network service and quality (20)

Administrative capability (20)

Benefit cost management and administrative cost (25)

Small, women owned and minority owned businesses (20).

7.0 GENERAL TERMS AND CONDITIONS

7.1 VENDOR'S MANUAL

This solicitation is subject to the provisions of the Commonwealth of Virginia Vendor's Manual and any revisions thereto, which are hereby incorporated into this contract in their entirety. A copy of the manual is normally available for review at the Department's office on the 13th floor of the James Monroe Building. In addition, a copy can be obtained from the Department of General Services' Division of Purchases and Supply by calling (804) 786-3842.

7.2 APPLICABLE LAWS AND COURTS

This solicitation and any resulting contract shall be governed in all respects by the laws of the Commonwealth of Virginia, and any litigation with respect thereto shall be brought in the courts of the Commonwealth. The Contractor shall comply with all applicable federal, state, and local laws, rules, and regulations.

7.3 ANTI-DISCRIMINATION

By submitting their proposals, Offerors certify to the Commonwealth that they will conform to the provisions of the Federal Civil Rights Act of 1964, as amended, as well as the Virginia Fair Employment Contracting Act of 1975, as amended, where applicable, the Virginians with Disabilities Act, the Americans with Disabilities Act, and Section 2.2-4311 of the Virginia Public Procurement Act.

In every contract over \$10,000 the provisions in 1 and 2 below apply:

1. During the performance of this contract, the Contractor agrees as follows:
  - a. The Contractor will not discriminate against any employee or applicant for employment because of race, religion, color, sex or national origin, or disabilities, except where religion, sex or national origin is a bona fide occupational qualification reasonably necessary to the normal operation of the Contractor. The Contractor agrees to post in conspicuous places, available to employees and applicants for employment, notices setting forth the provisions of this nondiscrimination clause.
  - b. The Contractor, in all solicitations or advertisements for employees placed by or on behalf of the Contractor, will state that such Contractor is an equal opportunity employer.
  - c. Notices, advertisements, and solicitations placed in accordance with federal law, rule, or regulation shall be deemed sufficient for the purpose of meeting these requirements.
2. The Contractor will include the provisions of 1 above in every subcontract or purchase order over \$10,000, so that the provisions will be binding upon each sub contractor or vendor.

#### 7.4 ETHICS IN PUBLIC CONTRACTING

By submitting their proposals, Offerors certify (1) that their proposals are made without collusion or fraud and that they have not offered or received any kickbacks or inducements from any other Offeror, supplier, manufacturer, or sub contractor in connection with their proposal, and (2) that they have not conferred on or promised, any public employee having official responsibility for this procurement transaction, any payment, loan, subscription, advance, deposit of money, services, or anything of more than nominal value, unless consideration of substantially equal or greater value was exchanged.

#### 7.5 IMMIGRATION REFORM AND CONTROL ACT OF 1986

By submitting their proposals, Offerors certify that they do not and will not, during the performance of this contract, employ illegal alien workers or otherwise violate the provisions of the federal Immigration Reform and Control Act of 1986.

#### 7.6 DEBARMENT STATUS

By submitting their proposals, Offerors certify that they are not currently debarred by the Commonwealth of Virginia from submitting proposals for the type of goods or services covered by this solicitation, nor are they an agent of any person or entity that is currently so debarred.

## 7.7 ANTITRUST

By entering into a contract, the Contractor conveys, sells, assigns, and transfers to the Commonwealth of Virginia all rights, title, and interest in and to all causes of the action it may now have or hereafter acquire under the antitrust laws of the United States and the Commonwealth of Virginia, relating to the particular goods or services purchased or acquired by the Commonwealth of Virginia under said contract.

## 7.8 MANDATORY USE OF STATE FORM AND TERMS AND CONDITIONS

Failure to submit a proposal on the official state form provided for that purpose may be a cause for rejection of the proposal. Modification of or additions to the General Terms and Conditions of the solicitation may be cause for rejection of the proposal; however, the Commonwealth reserves the right to decide, on a case by case basis, in its sole discretion, whether to reject such a proposal.

## 7.9 CLARIFICATION OF TERMS

If any prospective Offeror has questions about the specifications or other solicitation documents, the prospective Offeror should contact William G. Gregory in writing no later than five working days before the due date. Any revisions to the solicitation will be made only by addendum issued by the Department.

## 7.10 PAYMENT

### 1. To Prime Contractor:

- a. Invoices for items ordered, delivered and accepted shall be submitted by the Contractor directly to the payments address shown on the purchase order/contract. All invoices shall show the state contract number and/or purchase order number; social security number (for individual Contractors) or the federal employer identification number (for proprietorships, partnerships, and corporations).
- b. Any payment terms requiring payments in less than 30 days will be regarded as requiring payment 30 days after invoice or delivery, whichever occurs last. This shall not affect offers of discounts for payment in less than 30 days, however.
- c. All goods or services provided under this contract or purchase order, that are to be paid for with public funds, shall be billed by the Contractor at the contract price, regardless of which public agency is being billed.
- d. The following shall be deemed to be the date of payment: the date of postmark in all cases where payment is made by mail, or the date of offset when offset proceedings have been instituted as authorized

under the Virginia Debt Collection Act.

2. To Subcontractors:

- a. A Contractor awarded a contract under this solicitation is hereby obligated:
  - (1) To pay the subcontractor(s) within seven (7) days of the Contractor's receipt of payment from the Commonwealth for the proportionate share of the payment received for work performed by the subcontractor(s) under the contract; or
  - (2) To notify the agency and the subcontractor(s) in writing, of the Contractor's intention to withhold payment and the reason.
- b. The Contractor is obligated to pay the subcontractor(s) interest at the rate of one percent per month (unless otherwise provided under the terms of the contract) on all amounts owed by the Contractor that remain unpaid seven (7) day following receipt of payment from the Commonwealth, except for amounts withheld as stated in (2) above. The date of mailing of any payment by U.S. Mail is deemed to be payment to the addressee. These provisions apply to each sub-tier Contractor performing under the primary contract. A Contractor's obligation to pay an interest charge to a subcontractor may not be construed to be an obligation of the Commonwealth.

7.11 PRECEDENCE OF TERMS

Paragraphs 7.1 - 7.10 of these General Terms and Conditions shall apply in all instances. In the event there is a conflict between any of the other General Terms and Conditions and any Special Terms and Conditions in this solicitation, the Special Terms and Conditions shall apply.

7.12 QUALIFICATIONS OF OFFERORS

The Commonwealth may make such reasonable investigations as deemed proper and necessary to determine the ability of the Offeror to perform the services and the Offeror shall furnish to the Commonwealth all such information and data for this purpose as may be requested. The Commonwealth reserves the right to inspect Offeror's physical facilities prior to award to satisfy questions regarding the Offeror's capabilities. The Commonwealth further reserves the right to reject any proposal if the evidence submitted by, or investigations of, such Offeror fails to satisfy the Commonwealth that such Offeror is properly qualified to carry out the obligations of the contract and to provide the services contemplated therein.

7.13 TESTING AND INSPECTION

The Commonwealth reserves the right to conduct any test/inspection it may deem advisable to assure supplies and services conform to the specification.

#### 7.14 ASSIGNMENT OF CONTRACT

A contract shall not be assignable by the Contractor in whole or in part without the written consent of the Commonwealth.

#### 7.15 CHANGES TO THE CONTRACT

Changes can be made to the Contract in any one of the following ways:

1. The parties may agree in writing to modify the scope of the contract. An increase or decrease in the price of the contract resulting from such modification shall be agreed to by the parties as a part of their written agreement to modify the scope of the contract.
2. The Department may order changes within the general scope of the contract at any time by written notice to the Contractor. Changes within the scope of the contract include, but are not limited to such things as services to be performed, the method of packing or shipment and the place of delivery or installation. The Contractor shall comply with the notice upon receipt. The Contractor shall be compensated for any additional costs incurred as the result of such order and shall give the Department a credit for any savings. Said compensation shall be determined by one of the following methods:
  - a. By mutual agreement between the parties in writing; or
  - b. By agreeing upon a unit price or using a unit price set forth in the contract, if the work to be done can be expressed in units, and the Contractor accounts for the number of units of work performed, subject to the Department's right to audit the Contractor's records and/or to determine the correct number of units independently; or
  - c. By ordering the Contractor to proceed with the work and to keep a record of all costs incurred and savings realized. A markup for overhead and profit may be allowed if provided by the contract. The same markup shall be used for determining a decrease in price as the result of savings realized. The Contractor shall present the Department with all vouchers and records of expenses incurred and savings realized. The Department shall have the right to audit the records of the Contractor as it deems necessary to determine costs or savings. Any claim for an adjustment in price under this provision must be asserted by written notice to the Department within thirty (30) days from the date of receipt of the written order from the Department. If the parties fail to agree on an amount of adjustment, the question of an increase or decrease in the contract price or time for performance shall resolve in accordance with the procedures for resolving disputes provided by the Disputes Clause (paragraph 8.12) of this contract and in accordance with the disputes provisions of the

Commonwealth of Virginia's Vendor's Manual. Neither the existence of claim or a dispute resolution process, litigation or any other provision of this contract shall excuse the Contractor from promptly complying with the changes ordered by the Department or with the performance of the contract generally.

#### 7.16 DEFAULT

In case of failure to deliver goods or services in accordance with the contract terms and conditions, the Commonwealth, after due oral or written notice, may procure them from other sources and hold the Contractor responsible for any resulting additional purchase and administrative costs. This remedy shall be in addition to any other remedies which the Commonwealth may have.

#### 7.17 INSURANCE

By signing and submitting a bid or proposal under this solicitation, the bidder or offeror certifies that if awarded the contract, it will have the following insurance coverages at the time the contract is awarded. The bidder or offeror further certifies that the contractor and any subcontractors will maintain these insurance coverages during the entire term of the contract and that all insurance coverages will be provided by insurance companies authorized to sell insurance in Virginia by the Virginia State Corporation Commission.

##### INSURANCE COVERAGES AND LIMITS REQUIRED:

1. Worker's Compensation - Statutory requirements and benefits.
2. Employee Liability - \$100,000
3. Commercial General Liability - \$500,000 combined single limit. Commercial General Liability is to include Premises/Operations Liability, Products and Completed Operations Coverage, and Independent Contractor's Liability or Owner's and Contractor's Protective Liability. The Commonwealth of Virginia must be named as an additional insured when requiring a Contractor to obtain Commercial General Liability coverage.

#### 7.18 ANNOUNCEMENT OF AWARD

Upon the award or the announcement of the decision to award a contract as a result of this solicitation, the purchasing agency will publicly post such notice on the Agency's web site, <http://www.dhrm.virginia.gov/rfps/rfpmain.html> , for a minimum of 10 days.

#### 7.19 DRUG-FREE WORKPLACE

During the performance of this contract, the contractor agrees to (i) provide a drug-free workplace for the contractor's employees; (ii) post in conspicuous places, available to employees and applicants for employment, a statement notifying employees that the unlawful manufacture, sale, distribution, dispensation,

possession, or use of controlled substance or marijuana is prohibited in the contractor's workplace and specifying the actions that will be taken against employees for violations of such prohibition; (iii) state in all solicitations or advertisements for employees placed by or on behalf of the contractor that the contractor maintains a drug-free workplace; and (iv) include the provisions of the foregoing clauses in every subcontract or purchase order of over \$10,000, so that provisions will be binding upon each subcontractor or vendor.

For the purposes of this section, "drug-free workplace" means a site for the performance of work done in connection with a specific contract awarded to a contractor, the employees of whom are prohibited from engaging in the unlawful manufacture, sale, distribution, dispensation, possession or use of any controlled substance or marijuana during the performance of the contract.

## 7.20 NONDISCRIMINATION OF CONTRACTORS

A bidder, offeror, or contractor shall not be discriminated against in the solicitation or award of this contract because of race, religion, color, sex, national origin, age, or disability or against faith-based organizations. If the award of this contract is made to a faith-based organization and an individual, who applies for or received goods, services, or disbursements provided pursuant to this contract objects to the religious character of the faith-based organization from which the individual receives or would receive the goods, services, or disbursements, the public body shall offer the individual, within a reasonable period of time after the date of his objection, access to equivalent goods, services, or disbursements from an alternative provider.

## 7.21 eVA BUSINESS-TO-GOVERNMENT VENDOR REGISTRATION

The eVA Internet electronic procurement solution, web site portal [www.eva.state.va.us](http://www.eva.state.va.us), streamlines and automates government purchasing activities in the Commonwealth. The portal is the gateway for vendors to conduct business with state agencies and public bodies.

All vendors desiring to provide goods and/or services to the Commonwealth shall participate in the eVA Internet e-procurement solution either through the eVA Basic Vendor Registration Service or eVA Premium Vendor Registration Service, and complete the Ariba Commerce Services Network registration.

- a. eVA Basic Vendor Registration Service: \$25 Annual Fee plus a Transaction Fee of 1% per order received. The maximum transaction fee is \$500 per order. eVA Basic Vendor Registration Service includes electronic order receipt, vendor catalog posting, online registration, and electronic bidding, as they become available.
- b. eVA Premium Vendor Registration Service: \$200 Annual Fee plus a Transaction Fee of 1% per order received. The maximum transaction fee is \$500 per order. eVA Premium Vendor Registration Service includes all benefits of the eVA Basic Vendor Registration Service plus automatic email or fax notification of solicitations and amendments, and ability to research

historical procurement data, as they become available.

- c. Ariba Commerce Services Network Registration. The Ariba Commerce Services Network (ACSN) registration is required and provides the tool used to transmit information electronically between state agencies and vendors. There is no additional fee for this service.

**Note: Vendors are strongly encouraged to register your company prior to submitting a bid or offer. Failure to register will result in your bid or offer being found non-responsive and rejected. All vendors must register in both the eVA and the Ariba Commerce Services Network Vendor Registration Systems.**

## 8.0 SPECIAL TERMS AND CONDITIONS

### 8.1 COST LIMITS

The Contractor is responsible for all the costs of implementing and administering the program. The Department is responsible for ensuring that the Contractor receives payment of all fees that are established pursuant to the contract which results from this RFP. Any cost incurred by the Contractor to address the tasks and responsibilities identified in this RFP which exceeds the contractually established fees is the risk of the Contractor.

### 8.2 RENEWAL OF CONTRACT

The term of this contract is two years with three one-year renewal options. For the one-year renewal options, the contract may renew annually subject to the following.

- 8.2.1 The Contractor shall advise the Department in writing no later than 2:00 PM on the last business day before September 16 that the insurer is willing to renew the contract on the same terms and conditions as currently in force or as modified pursuant to a request from the Department. This advice shall be in the form of a proposal which meets the requirements of Section 6, except that the submission of tabs 1 and 2 are necessary only to the extent that there are changes from the original proposal. Selected tab 5 detail is required with each renewal.
- 8.2.2 All Contractors require a finding by the Department that the Contractor's performance has been satisfactory. Such findings are within the sole discretion of the Department but will be based on materially important issues such as the plan's accreditation status (if applicable), employee satisfaction, and the amount of liquidated damages due the Department because of failure of the Contractor to meet standards.
- 8.2.3 If the Commonwealth elects to exercise the option to renew the contract for an additional one-year period, the contract price for the additional one year shall not exceed the contract price of the original increased/decreased by more than the percentage increase/decrease of the services category of the CPI-W

section of the Consumer Price Index of the United States Bureau of Labor Statistics for the latest twelve months for which statistics are available.

- 8.2.4 If during any subsequent renewal periods, the Commonwealth elects to exercise the option to renew the contract, the contract price for the subsequent renewal period shall not exceed the contract price of the previous renewal period increased/decreased by more than the percentage increased/decreased of the services category of the CPI-W section of the Consumer Price Index of the United States Bureau of Labor Statistics for the latest twelve months for which statistics are available.

### 8.3 Termination, Suspension and Cancellation of Contract

Either party may terminate this contract for its sole convenience effective July 1 of any year by delivery of written notice at least nine months prior to the effective date of cancellation, that is, by the previous September 1. Some school groups in the Local Choice program have plan years ending on September 30<sup>th</sup>. Therefore, it is agreed that for any Contractor having enrollment in one or more of these school groups, the termination of this contract as applied to the particular school group will be effective September 30 following the July 1 termination date of the contract.

If the Department determines, in its sole discretion, that limiting additional enrollment would enhance the administration of this contract, the Department may limit enrollment or suspend entirely new enrollments by a written order to the Contractor.

Furthermore, in the event of emergency requirements or significant changes in the Contractor's financial or organizational status which could not have reasonably been foreseen, the Department reserves the right to cancel and terminate this contract, in part or in whole without penalty, upon 60 days written notice to the Contractor.

Any contract cancellation notice shall not relieve the Contractor of the obligation to deliver and/or perform on all outstanding orders issued prior to the effective date of cancellation.

### 8.4 Payments and Interest

- 8.4.1 State Employee Program - The Department will send or make available (through the internet) to the Contractor an electronic file of changes in eligible enrollees and eligible dependents in a form to be mutually agreed upon on a daily or other basis as may be mutually agreeable. Contractor agrees that BES shall be the only official source for any eligibility file maintained by the Contractor for any claims payment made by the Contractor, unless the Department agrees to changes in writing.

If the plan is an insured plan, the Department will provide a premium payment sufficient to pay for the coverage of persons determined to be eligible by the Department will be made to the contractor no later than the tenth business day

of the month for which coverage is effective. The premium payment will reflect appropriate retroactive adjustments. The contractor will pay claims or provide services only for persons determined to be eligible by the Department.

- 8.4.2 The Local Choice Program - Bills for premiums shall be submitted to each local employer which has one or more enrollees in the plan by the twentieth day of the month prior to the month for which coverage is billed. Contractor agrees to submit bills in a form acceptable to the Department. Employers will reconcile bills and attach thereto applications effecting changes in coverage. Contractor will receive reconciled bills, applications and payments. Payments shall be made generally by the tenth of the month for which coverage is billed. Contractor agrees to reconcile bills timely, and update membership files and issue membership cards promptly. The plan will pay claims or provide services only for persons whose premiums are paid when due.

Note: The Contractor will provide the ability for large (as determined by the Department) TLC groups to pay their monthly premiums utilizing wire transfers or other electronic transfers of funds.

- 8.4.3 The Contractor will bill the Department for claims payments on a weekly basis and for administrative costs on a monthly basis. The Department will pay, subject to verification, the Contractor for services rendered. The form of the bills and the schedule of payments shall be acceptable to both parties. The plan will pay claims or provide services only for persons determined to be eligible by the Department.
- 8.4.4 The standard form of payment utilized by the Commonwealth is by EDI (See Appendix 9 for description). Unless a different method is agreed upon through negotiations, each Contractor must complete the EDI agreements required by the Department of Accounts.

#### 8.4.5 Retroactive Adjustments

Where the Department discovers an error in enrollment for which the Contractor has no responsibility, Contractor agrees to correct such an error retroactively up to a period of eighteen months from the date on which the error is discovered.

#### 8.4.6 COBRA Eligibles and Direct Bill Retirees

For all state employee groups, contractor agrees to track eligibility and bill Extended Coverage (COBRA) enrollees and certain retirees designated by the Department (that is, those retirees whose retirement checks are too small to pay for premiums through payroll deduction) for premiums. Insured plans shall submit a listing of any status changes to these enrollees during each month to the Department by the 15<sup>th</sup> of the following month reflecting changes by date and identified by social security number. ASO plans shall report those collections on the Monthly Income Report.

The above paragraph does not apply to Local Choice enrollees. Each TLC

member groups is responsible for administering COBRA eligibility for their group and the collection of premiums for all of their enrollees, including COBRA and retirees.

#### 8.4.7 Settlement and Payment of Liquidated Damages

There shall be an annual settlement between the Contractor and the Department on or before November 30<sup>th</sup>, unless both parties agree to an extension. The settlement agreement shall provide for the final settlement of contract expenses, including liquidated damages. It is mutually agreed that liquidated damages, if any, shall be determined by reference to claims incurred for the fiscal year in settlement and paid through the 30<sup>th</sup> of September following the close of that year. Amounts owed to either party shall be paid within 30 days of settlement. Late payments by either party are subject to interest at 1% per month on the unpaid balance, such that interest is due and payable on the 31<sup>st</sup> day following the date of settlement for the 30 days the balance would have remained unpaid. The settlement agreement shall specify the last business day on which timely payment may be made.

#### 8.4.8 Interest

An ASO Contractor shall pay the Department interest on all funds held by the Contractor for the Department, including check float. The Department will bargain in good faith with respect to the total structure of the financial arrangements such that the Contractor and the Department are both protected against the untimely payment of amounts due, including weekly claims reimbursements.

8.4.9 The Contractor shall deliver only those services actually ordered by the Department. The Department will accept and pay only for those services which have been fully rendered. The Contractor shall invoice the Department each month for services provided during the prior month. Payment will be made by the Department within 30 days of receipt of an approved invoice by the Commonwealth's EDI payment method.

### 8.5 Premiums

The Offerors shall propose premiums using the Premium Buildup form referenced in paragraphs 4.1. The Department retains the right to establish premiums for each ASO plan. In establishing such premiums, the Department will consider the Contractor's proposal, the costs of the Department in the administration of the employee health benefits program, and in the costs of activities which benefit the insureds of all plans, such as the annual enrollment and CommonHealth, the Department's work site health promotion program. All rate projections should include a surcharge of 2% to recognize these costs.

8.5.1 Insured plans shall establish premiums in accordance with their own

procedures. Notice of any change in premiums shall be accomplished using the Premium Buildup form referenced in sub-paragraph 1 of paragraph 4.1.

8.5.2 ASO plans shall propose premiums using the Premium Buildup form referenced in sub-paragraph 1 of paragraph 4.1. The Department retains the right to establish premiums for each ASO plan. In establishing such premiums, the Department will consider the contractor's proposal, the age, gender, and, as may be feasible, the health risks of the enrolled population, the administrative costs of the Department, the relative efficiency of the plan's provider networks, the prices the plan pays for services, the plan's administrative costs, and such other factors as may be relevant.

### 8.5.3 Surcharges

All plans shall participate in the costs of the Department in the administration of the employee health benefits program, and in the costs of activities which benefit the insureds of all plans, such as the annual enrollment and CommonHealth, the Department's work site health promotion program. All rate projections should include a surcharge of 2% to recognize these costs.

Insured plans may be subject to premium adjustments based on the age and gender of their enrollees.

For the state employee group plans, all insured plans will be paid 98% of the agreed upon premium, plus/minus, if applicable, any premium adjustments based upon the demographic adjustment.

For The Local Choice program, all insured plans will be paid the total monthly premium by each group having enrollees under the insured plan. If applicable, a monthly for each enrolled group will be required to be filed with the Department within 20 days of the last day of the coverage month, which will be used to transmit the 2% surcharge plus/minus any premium adjustments based upon the demographic adjustment. This form and method of adjustment may be replaced by an automated computation performed by the Department should the Department determine that such a process becomes feasible for this program.

## 8.6 AUDITS

Some standards of performance under this contract shall be measured by audits. Results of claims audits shall be extrapolated to the universe of claims being audited, and the Contractor's performance with respect to the universe of claims shall be deemed to be the same as the Contractor's performance on the sample of claims, provided that the audit sample was randomly drawn and statistically valid (+/-3% error rate at 95% confidence level).

The Contractor shall assist the Department and the Department's auditors, who may be employees of the Department, employees of other Contractors, or agents of the Department, in the conduct of audits. This assistance shall include the

provision of secure, quiet office space, including furnishings and telephones needed by the auditors.

The Contractor agrees to retain all books, records, and other documents relative to the contract which results from this RFP for five (5) years after final payment, or until the conclusion of any audit by the Commonwealth, whichever is sooner. The Department, its authorized agents, and State Auditors, shall have full access to, and the right to examine, any of the Contractor's materials relevant to the contract which results from this RFP.

#### 8.7 CONTRACT REPRESENTATIVES

Both the Department and the Contractor shall appoint a contract representative who shall ensure that the provisions of this contract are adhered to. The Department hereby appoints the Director, Office of Contracts and Finance.

The Contractor shall provide the full name and address of their contract representative including telephone and fax number. In the event of a change in contract representatives, an official written notice shall be provided within 15 days of the change.

#### 8.8 CERTIFIED CORPORATE ANNUAL REPORTS

Within 120 days of the close of its fiscal year, the Contractor shall furnish to the Department an annual report of its consolidated operations. This report shall be certified by an independent auditor.

#### 8.9 CONFIDENTIALITY OF INFORMATION

The Contractor shall treat all information utilized in its performance of the contract as confidential, personal information. The Contractor shall handle all confidential information in accordance with the Virginia Privacy Protection Act, Virginia Code Section 2.1-377 et seq.. All files, computer data bases and other records developed or maintained pursuant to the execution of the contract are the property of the Department, and shall be delivered to the Department upon demand. The Contractor merely serves as the custodian of the files, and acts as agent for the Department in the payment for services and the performance of other assigned tasks, including assisting the Department with requests under the Virginia Freedom of Information Act.

#### 8.10 COMMISSIONS AND BROKERAGE FEES

The Contractor agrees that, in the performance of this contract, no payments shall be made to brokers or sales persons who are not employees of the Contractor.

#### 8.11 SEVERABILITY

In the event any portion of the contract shall be determined by a court of competent jurisdiction to be invalid or unenforceable, such provision shall be

deemed void and the remainder of the contract shall continue in full force and effect.

#### 8.12 ELIGIBILITY

The Department shall determine who is eligible for the employee Health Benefits program.

#### 8.13 EMPLOYER CONTRIBUTIONS TOWARDS PREMIUMS

The Department shall set the employer contribution for all plans. Generally, the employer shall contribute the same percentage of the total premium which the employer contributes to the state wide PPO plan or the actual dollar amount, whichever is less, further adjusted to account for the age and sex of employees actually enrolled in other plans and the Department's cost of administering all plans.

#### 8.14 FORCE MAJEURE

Neither party shall be deemed to be in default of any of its obligations hereunder, if, and so long as, it is prevented from performing such obligations by an act of war, hostile foreign action, nuclear explosion, earthquake, hurricane, tornado, or other catastrophic natural event or act of God.

#### 8.15 INTERNET SITE

Contractor agrees to maintain an Internet site with a section or page devoted to enrollees covered under the employee health benefits program or TLC. As a minimum, the site shall contain the following.

8.15.1 a link to the Contractor's current provider directory with a capability to locate providers by geographic locations and type of practice

8.15.2 the data specified in paragraph 6.3.

8.15.3 an outline of coverage

8.15.4 other information about the plan

#### 8.16 SUBCONTRACTING

The Contractor is fully responsible for all work performed under the contract. The Contractor may not assign, transfer, or subcontract any interest in the contract, without prior written approval of the Department. The Contractor shall require all subcontractors to comply with all provisions of this RFP. The Contractor will be held liable for contract compliance for all duties and functions whether performed by the Contractor or any subcontractor.

#### 8.17 DISPUTES

In accordance with section 2.2-4363 of the Code of Virginia, disputes arising out of the contract, whether for money or other relief, may be submitted by the Contractor for consideration by the Department. Disputes must be submitted in writing, with all necessary data and information, to the Director of the Department of Human Resource Management at the James Monroe Building, 12<sup>th</sup> Floor, 101 North 14<sup>th</sup> Street, Richmond, Virginia 23219. Disputes will not be considered if submitted later than sixty (60) days after the final payment is made by the Department under the contract. Further, no claim may be submitted unless written notice of the Contractor's intention to file the dispute has been submitted at the time of the occurrence or at the beginning of the work upon which the dispute is based. The Department shall render a final written decision regarding the dispute not more than ninety (90) days after the dispute is submitted, unless the parties agree to an extension of time. If the Department does not render its decision within 90 days, the Contractor's sole remedy will be to institute legal action, pursuant to section 2.2-436411-70 of the Code of Virginia. The Contractor shall not be granted relief as a result of any delay in the Department's decision. During the time that the parties are attempting to resolve any dispute, each party shall proceed diligently to perform its duties.

#### 8.18 CONTRACTOR AFFILIATION

If an affiliate (as defined below in this paragraph) of the Contractor takes any action which, if taken by the Contractor, would constitute a breach of the contract, the action taken by the affiliate shall be deemed a breach by the Contractor. "Affiliate" shall mean a "parent," subsidiary or other company controlling, controlled by, or in common control with the Contractor, sub Contractor or agents of the Contractor.

#### 8.19 TRANSFER OF FILES

If for any reason the Department decides to no longer contract with the Contractor, the Contractor agrees to transfer to the party designated by the Department, at no cost, all data, records, computer files, other files, and materials of any sort that were maintained for the Commonwealth. The Contractor agrees to assist the Department in understanding, using, and transferring all files and records, including those maintained in computer language.

#### 8.20 ADVERTISING

In the event a contract is awarded as a result of this RFP, the Contractor shall not advertise that the Commonwealth of Virginia, or any agency or institution of the Commonwealth, has purchased, or uses its products or services.

#### 8.21 INDEMNIFICATION

The Contractor agrees to indemnify, defend, and hold harmless the Commonwealth of Virginia, its officers, agents, and employees from any claims, damages, and actions of any kind or nature, whether at law or in equity, arising

from or caused by the use of any services of any kind or nature furnished by the Contractor, provided that such liability is not attributable to the sole negligence of the Department.

## 8.22 ANNUAL ENROLLMENT

The Department will provide employees an annual opportunity to change health benefits plans or types of membership. Contractor agrees to follow all instructions of the Department with respect to the conduct of the annual enrollment, including and especially the form and content of information supplied to eligible persons. The Contractor agrees to supply to agencies and TLC employers sufficient quantities of benefits booklets and brochures for the orderly conduct of annual enrollment activities. Annual enrollment expenses are the responsibility of the Contractor and are to be absorbed in its administrative costs. There will be no special recognition of annual enrollment expenses without the prior agreement of the Department.

Enrollment and changes in the state employee group is currently accomplished online by the state employees through the Department's Web based enrollment and change system which is referred to as Employee Direct or E-Direct. Changes through E-Direct are updated live time to the Department's Benefits Eligibility System (BES) which serves as the sole source of all enrollment information to Contractors, except for those enrollees (COBRA and retirees whose premiums cannot be deducted from annuities). See Appendix 7 for more detail. Agency benefit administrators may key changes directly to BES, however the spring 2008 enrollment reflected almost 70% usage of E-Direct by employees making changes. The Department has implemented a personal identification number for members, which is not a Social Security number.

The local employers currently conduct enrollment in the Local Choice program each May prior to the new fiscal year (July 1). The plans offered by each employer are group specific to that employer with the completed forms returned to the medical/surgical carriers by early June to allow for delivery of ID cards by the July 1 effective date. The TLC procedures are discussed in greater detail in Appendix 8.

## 8.23 HIPAA PRIVACY BUSINESS ASSOCIATES AGREEMENT

The Contractor agrees to be bound by the HIPAA Privacy Business Associates Agreement. This agreement must be executed prior to any contract award. See Exhibit ONE.

## 8.24 CHANGES IN PARTICIPATING PROVIDERS

The Plan shall require, among other things, that the provider will abide by the provisions of the agreement with the Plan for a full contract year with respect to State and TLC employees, except for such changes as retirement, abandonment of practice, etc. As an alternative, the Plan may represent that enrollees through any provider participating on July 1 of any contract year for a period of 12 months, regardless of any subsequent change in the participating status of the provider

during that time. This provision does not apply to staff/group type HMOs. Note well that the end of the contract year for many, but not most, TLC groups is September 30, not June 30.

#### 8.25 MAILINGS AND NOTICES

Contractor agrees to notify retirees and extended coverage enrollees annually in a form acceptable to the Department of changes in premiums and benefits or other contract amendments in a form acceptable to the Department. All notices shall be mailed first class. Contractor agrees to supply group administrators with all necessary forms and supplies.

Contractor will strictly limit the content and form of mailings and notices, other than premium bills and claims related transactions, to the benefits booklet and brochure cited in paragraphs 6.2 and 6.3 and an approved cover letter. Benefits booklets and brochures shall be printed in black ink on plain white paper, grade number 3, 50 pound offset, without any illustrations except graphs to illustrate HEDIS data. Under no circumstances will any communication of the contractor, written or verbal, compare its cost, benefits, or performance with that of another plan in the employee health benefits program. The logo of the Department and the title of the document shall be the most prominent features on the first page of each document.

#### 8.26 IDENTITY THEFT:

The Contractor assures that any and all personal information and data obtained as a result of performing contractual duties associated with this contract shall be held in strict confidence. Such information shall not be divulged without written permission from the individual and this Agency.

1. All personal information whether electronic or hard copy shall be stored in a manner that will prevent intrusion by unauthorized persons.
2. All intrusions or suspicion of intrusion into secured files containing personal information shall be reported to the Agency within 24 hours of detection.
3. All remedies suggested by the Contractor shall be approved by the Agency prior to being implemented.

Exhibit One

Office of State Health Benefits Programs  
of the  
Department of Human Resource  
Management

H I PAA Privacy  
Business Associate  
Agreement  
With  
(Insert Company Name)

Effective Date:  
(Insert Date)

## 1. PREAMBLE

Pursuant to the Health Insurance Portability and Accountability Act ("HIPAA") of 1996, and its implementing regulation, the Standards for Privacy of Individually Identifiable Health Information, 65 Fed. Reg. Section 84,462 et seq. (Dec. 28, 2000) and all subsequent provisions and Federal guidance ("HIPAA Privacy Rule"), the Commonwealth of Virginia's Office of Health Benefits Programs ("Covered Entity"), and (name of the Business Associate), a (state) corporation, ("Business Associate"), (jointly "the Parties"), wish to enter into this Business Associate Agreement ("Agreement") that addresses the requirements of the HIPAA Privacy Rule with respect to "business associates" as that term is defined in that Rule.

This Agreement is intended to ensure that the Business Associate will establish and implement appropriate safeguards (including certain administrative requirements) for "Protected Health Information" (as defined in the HIPAA Privacy Rule and copied below) that the Business Associate may create, receive, use, or disclose in connection with certain functions, activities, or services (collectively "Services") to be provided by Business Associate to Covered Entity. These Services are identified in a separate agreement between the Parties entitled (RFP# OHBXX-XX) and dated (Insert date) ("Service Agreement").

The Parties acknowledge and agree that in providing Services, Business Associate will create, receive, use, or disclose Protected Health Information. In connection with Business Associate's creation, receipt, use, or disclosure of Protected Health Information, Business Associate, and Covered Entity hereby agree as follows:

## II. DEFINITIONS

- (a) *General definitions.* All capitalized terms used but not otherwise defined in this Agreement shall have the same meaning as those terms in 45 CFR §§ 160.103 and 164.501.
- (b) *Specific definitions.*
- (i) *Individual.* "Individual" shall have the same meaning as the term "individual" in 45 CFR § 164.501 and shall include a person who qualifies as a personal representative in accordance with 45 CFR § 164.502(g).
  - (ii) *Privacy Rule.* "Privacy Rule" shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 CFR Part 160 and Part 164, Subparts A and E.
  - (iii) *Protected Health Information.* "Protected Health Information" ("PHI") shall mean individually identifiable health information maintained and transmitted in any form or medium, including, without limitation, all information (including demographic, medical, and financial information), data, documentation, and materials that is created or received by a health care provider, health plan, employer, or health care clearinghouse, and relates to: (A) the past, present, or future physical or mental health or condition of an individual; (B) the provision of health care to an individual; or (C) the past, present, or future payment for the provision of health care to an individual, and that identifies or could reasonably be used to identify an individual. Protected Health Information does not include health information that has been de-identified in accordance with the standards for de-identification provided for in the Privacy Rule.
  - (iv) *Designated Record Set.* "Designated Record Set" shall mean a group of records maintained by or for the Covered Entity that is:
    - (A) The enrollment, payment, claims adjudication, and case or medical management record systems maintained by or for a health plan; or
    - (B) Used, in whole and in part, by or for the Covered Entity to make decisions about individuals.

For purposes of this paragraph, the term record means any item, collection, or grouping of information that includes Protected Health Information and is maintained, collected, used, or disseminated by or for the Covered Entity.

(v) *Data Aggregation*. "Data Aggregation" shall mean, with respect to Protected Health Information created or received by the Business Associate in its capacity as the Business Associate of the Covered Entity, the combining of such Protected Health Information by the Business Associate with the Protected Health Information received by the Business Associate in its capacity as business associate of another entity to permit data analyses that relate to the health care operations of the respective entities.

(vi) *Required By Law*. "Required By Law" shall have the same meaning as the term "required by law" in 45 CFR § 164.501.

(vii) *Secretary*. "Secretary" shall mean the Secretary of the Department of Health and Human Services ("HHS") or his designee.

### **III. OBLIGATIONS AND ACTIVITIES OF BUSINESS ASSOCIATE**

- (a) Business Associate agrees to not use or further disclose Protected Health Information other than as permitted or required by the Agreement or as Required By Law.
- (b) Business Associate agrees to use appropriate safeguards to prevent use or disclosure of the Protected Health Information other than as provided for by this Agreement.
- (c) Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to the Business Associate of a use or disclosure of Protected Health Information by Business Associate in violation of the requirements of this Agreement.
- (d) Business Associate agrees to report to Covered Entity within five (5) business days any use or disclosure of Protected Health Information (whether by itself or by its subcontractors) not permitted for by this Agreement.
- (e) Business Associate agrees to ensure that any agent, including a subcontractor, to whom it provides Protected Health Information received from, or created or received by Business Associate on behalf of, Covered Entity agrees to the same restrictions and conditions that apply through this Agreement to Business Associate with respect to such information.
- (f) Business Associate agrees to provide access, at the request of Covered Entity, and in the time and manner designated by Covered Entity, to Protected Health Information in a Designated Record Set, to Covered Entity or, as directed by Covered Entity, to an Individual in order to meet the requirements under 45 CFR § 164.524.
- (g) Business Associate agrees to make any amendment(s) to Protected Health Information in a Designated Record Set that the Covered Entity directs or agrees to pursuant to 45 CFR § 164.526 at the request of Covered Entity or an Individual, and in the time and manner designated by Covered Entity.
- (h) Business Associate agrees to make internal practices, books, and records relating to the use and disclosure of Protected Health Information received from, or created or received by Business Associate on behalf of, Covered Entity available to the Covered Entity, or at the request of the Covered Entity to the Secretary, in a time and manner designated by the Covered Entity or the Secretary, for purposes of the Secretary determining Covered Entity's compliance with the Privacy Rule.

- (i) Business Associate agrees to document such disclosures of Protected Health Information and information related to such disclosures as would be required for Covered Entity to respond to a request by an Individual for an accounting of disclosures of Protected Health Information in accordance with 45 CFR § 164.528.
- (j) Business Associate agrees to provide to Covered Entity or an Individual, in the time and manner designated by Covered Entity, information collected in accordance with Section III (i) of this Agreement, to permit Covered Entity to respond to a request by an individual for an accounting of disclosures of Protected Health Information in accordance with 45 CFR § 164.528.
- (k) Business Associate agrees to: (i) implement the administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic Protected Health Information that it creates, receives, maintains, or transmits on Covered Entity's behalf; (ii) Ensure that any agent, including a subcontractor, to whom it provides such information agrees to implement reasonable and appropriate standards to protect the information; and (iii) agrees to report to Covered Entity any security incident of which it becomes aware that involves the information. Business Associate agrees that that the obligations set forth in Section III (k) shall be implemented by the final compliance date for the Security Standards to the extent required by law.

#### **IV. PERMITTED USES AND DISCLOSURES BY BUSINESS ASSOCIATE**

- (a) *General Uses and Disclosures.* Business Associate agrees to create, receive, use, or disclose Protected Health Information only in a manner that is consistent with this Agreement or the Privacy Rule and only in connection with providing Services to the Covered Entity identified in the Service Agreement, provided that such use or disclosure would not violate the Privacy Rule if done by Covered Entity. In providing Services, Business Associate, for example, will be permitted to use and disclose Protected Health Information for "treatment, payment and health care operations" in accordance with the Privacy Rule.
- (b) *Other Uses and Disclosures:*
  - (i) Except as otherwise limited in this Agreement, Business Associate may use Protected Health Information for the proper management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate.
  - (ii) Except as otherwise limited in this Agreement, Business Associate may disclose Protected Health Information for the proper management and administration of the Business Associate, provided the disclosures are Required By Law or the Business Associate obtains reasonable assurances from the person to whom the information is disclosed that it will remain confidential and used or further disclosed only as required by law or for the purpose for which it was disclosed to the person, and the person notifies the Business Associate of any instances of which it is aware in which the confidentiality of the information has been breached.
  - (iii) Except as otherwise limited in this Agreement, Business Associate may use Protected Health Information to provide Data Aggregation services to Covered Entity as permitted by 42 CFR § 164.504(e)(2)(i)(B).

#### **V. OBLIGATIONS OF THE COVERED ENTITY**

- (a) *Provisions for Covered Entity to Inform Business Associate of Privacy Practices and Restrictions:*

- (i) Covered Entity shall provide Business Associate with the notice of privacy practices that Covered Entity produces in accordance with 45 CFR § 164.520, as well as any changes to such notice.
  - (ii) Covered Entity shall provide Business Associate with any changes in, or revocation of, permission by Individual to use or disclose Protected Health Information, if such changes affect Business Associate's permitted or required uses and disclosures.
  - (iii) Covered Entity shall notify Business Associate of any restriction to the use or disclosure of Protected Health Information that Covered Entity has agreed to in accordance with 45 CFR § 164.522.
- (b) *Permissible Requests by Covered Entity.* Covered Entity shall not request Business Associate to use or disclose Protected Health Information in any manner that would not be permissible under the Privacy Rule if done by Covered Entity, except Protected Health Information for those activities performed by the Business Associate in accordance with the provisions of the Service Agreement between the parties.

## **VI. TERM AND TERMINATION**

- (a) *Term.* The Term of this Agreement shall be effective as of April 1, 2003, and shall terminate when all of the Protected Health Information provided by Covered Entity to Business Associate, or created or received by Business Associate on behalf of Covered Entity, is destroyed or returned to Covered Entity, or, if it is infeasible to return or destroy Protected Health Information, protections are extended to such information, in accordance with the Termination provisions in this Section.
- (b) *Termination for Cause.* Upon Covered Entity's knowledge of a material breach by Business Associate, Covered Entity shall provide an opportunity for Business Associate to cure the breach or end the violation. If Business Associate does not cure the breach or end the violation within the time agreed to by the Parties, or if Business Associate has breached a material term of this Agreement and cure is not possible, Covered Entity may terminate this Agreement [and the applicable Sections of the Service Agreement] upon written notice to Business Associate.
- (c) *Effect of Termination:*
- (i) Except as provided in paragraph (c)(ii) of this Section IV, upon Termination of this Agreement for any reason, Business Associate shall return or destroy all Protected Health Information received from Covered Entity, or created or received by Business Associate on behalf of Covered Entity. This provision shall apply to Protected Health Information that is in the possession of subcontractors or agents of Business Associate. Business Associate shall retain no copies of the Protected Health Information.
  - (ii) In the event that Business Associate determines that returning or destroying the Protected Health Information is infeasible, Business Associate shall provide to Covered Entity notification of the conditions that make return or destruction infeasible. Upon mutual agreement of the Parties that return or destruction of Protected Health Information is infeasible, Business Associate shall extend the protections of this Agreement to such Protected Health Information and limit further uses and disclosures of such Protected Health Information to those purposes that make the return or destruction infeasible, for as long as the Business Associate maintains such Protected Health Information.

## **VII. MISCELLANEOUS**

- (a) *Regulatory References.* A reference in this Agreement to a section in the Privacy Rule means the section as in effect or as amended and for which compliance is required.
- (b) *Amendment.* The Parties agree to take such action as is necessary to amend this Agreement from time to time as is necessary for Covered Entity to comply with the requirements of the Privacy Rule and the Health Insurance Portability and Accountability Act, Public Law 104-191.

- (c) *Survival.* The respective rights and obligations of Business Associate under Section VI(c)(i)&(ii) of this Agreement shall survive the termination of this Agreement.
- (d) *Interpretation:*
- (i) Any ambiguity in this Agreement shall be resolved in favor of a meaning that permits Covered Entity to comply with the Privacy Rule.
  - (ii) In the event of an inconsistency between the provisions of this Agreement and the Privacy Rule, as may be amended from time to time, as a result of interpretations by HHS, a court, or another regulatory agency with authority over the Parties, the interpretation of HHS, such other court or regulatory agency shall prevail.
  - (iii) In the event provisions of this Agreement differ from those mandated by the Privacy Rule but are nonetheless permitted by the Rule, the provisions of this Agreement shall control.
- (e) *Complete Integration.* This Agreement constitutes the entire agreement between the parties and supersedes all prior negotiations, discussions, representations, or proposals, whether oral or written, unless expressly incorporated herein, related to the subject matter of the Agreement. Unless expressly provided otherwise herein, this Agreement may not be modified unless in writing signed by the duly authorized representatives of both parties. If any provision or part thereof is found to be invalid, the remaining provisions shall remain in full force and effect.
- (f) *Successors and Assigns.* This Agreement will inure to the benefit of and be binding upon the successors and assigns of Covered Entity and Business Associate. However, this Agreement is not assignable by either party without the prior written consent of the other party, except that Business Associate may assign or transfer this Agreement to any entity owned or under common control with Business Associate.
- (g) *Limitation of Liability.* Except as otherwise provided for in the Privacy Rule, neither party shall be liable for other party's loss of profits, attorney's fees or interest, or for any incidental, indirect, special, or consequential damages as a result of this Agreement.
- (h) *No Third Party Beneficiaries.* Except as expressly provided for in the Privacy Rule, there are no third party beneficiaries to this Agreement. Business Associate's obligations are to Covered Entity only.
- (i) *Confidentiality.* Except as otherwise provided for in the Privacy Rule or this Agreement, neither party will disclose the terms of this Agreement to any third party without the other party's written consent.
- (j) *Counterparts.* This Agreement may be executed in two or more counterparts, each of which may be deemed an original.

**VIII. ACKNOWLEDGEMENT AND SIGNATURES**

THE PARTIES ACKNOWLEDGE THAT THEY HAVE READ THIS AGREEMENT,  
UNDERSTAND IT, AND AGREE TO BE BOUND BY ITS TERMS.

For :

For

By:

By:

Print Name:

Print Name:

Title:

Title: Director

Date:

Date:

## Exhibit Two

### Small Business Subcontracting Plan

#### Definitions

**Small Business:** "Small business " means an independently owned and operated business which, together with affiliates, has 250 or fewer employees, or average annual gross receipts of \$10 million or less averaged over the previous three years. Note: This shall not exclude DMBE-certified women- and minority-owned businesses when they have received DMBE small business certification.

**Women-Owned Business:** Women-owned business means a business concern that is at least 51% owned by one or more women who are citizens of the United States or non-citizens who are in full compliance with United States immigration law, or in the case of a corporation, partnership or limited liability company or other entity, at least 51% of the equity ownership interest is owned by one or more women who are citizens of the United States or non-citizens who are in full compliance with United States immigration law, and both the management and daily business operations are controlled by one or more women who are citizens of the United States or non-citizens who are in full compliance with the United States immigration law.

**Minority-Owned Business:** Minority-owned business means a business concern that is at least 51% owned by one or more minority individuals or in the case of a corporation, partnership or limited liability company or other entity, at least 51% of the equity ownership interest in the corporation, partnership, or limited liability company or other entity is owned by one or more minority individuals and both the management and daily business operations are controlled by one or more minority individuals.

**All small businesses must be certified by the Commonwealth of Virginia, Department of Minority Business Enterprise (DMBE) by the due date of the solicitation to participate in the SWAM program. Certification applications are available through DMBE online at [www.dmbe.virginia.gov](http://www.dmbe.virginia.gov) (Customer Service).**

Offeror Name: \_\_\_\_\_

Preparer Name: \_\_\_\_\_

Date:

#### Instructions

- A. If you are certified by the Department of Minority Business Enterprise (DMBE) as a small business, complete only Section A of this form. This shall not exclude DMBE-certified women-owned and minority-owned businesses when they have received DMBE small business certification.
- B. If you are not a DMBE-certified small business, complete Section B of this form. For the offeror to receive credit for the small business subcontracting plan evaluation criteria, the offeror shall identify the portions of the contract that will be subcontracted to DMBE-certified

small business in this section. Points will be assigned based on each offeror's proposed subcontracting expenditures with DMBE certified small businesses for the initial contract period as indicated in Section B in relation to the offeror's total price.

**Section A**

If your firm is certified by the Department of Minority Business Enterprise (DMBE), are you certified as a (**check only one below**):

- Small Business
- Small and Women-owned Business
- Small and Minority-owned Business

Certification number: \_\_\_\_\_ Certification Date: \_\_\_\_\_

**Section B**

Populate the table below to show your firm's plans for utilization of DMBE-certified small businesses in the performance of this contract. This shall not exclude DMBE-certified women-owned and minority-owned businesses when they have received the DMBE small business certification. Include plans to utilize small businesses as part of joint ventures, partnerships, subcontractors, suppliers, etc.

**B. Plans for Utilization of DMBE-Certified Small Businesses for this Procurement**

Small Business Name & Address  DMBE Certificate #	Status if Small Business is also: Women (W), Minority (M)	Contact Person, Telephone & Email	Type of Goods and/or Services	Planned Involvement During Initial Period of the Contract	Planned Contract Dollars During Initial Period of the Contract

<b>Totals \$</b>					

## **List of Appendices**

- Appendix 1 Current Standard Contract
- Appendix 2 Summary Description of All Plans Offered to COVA and TLC Groups
- Appendix 3 Summary Description of All ASO Plans Offered to COVA and TLC Groups
- Appendix 4 Summary Claims Experience MISA and EAP
- Appendix 5 Enrollment and Claims Experience for TLC
- Appendix 6 State Employee and TLC Current Forms
- Appendix 7 State Employee Billing System
- Appendix 8 Adoption, Enrollment, Billing and Renewal – TLC
- Appendix 9 EDI

# Appendix 1

## DEPARTMENT OF HUMAN RESOURCE MANAGEMENT

### STANDARD CONTRACT

This contract is entered into \_\_\_\_\_, 2008, by \_\_\_\_\_, hereinafter called "Contractor" and the Commonwealth of Virginia, Department of Human Resource Management, hereinafter called "Purchasing Agency."

WITNESSETH that the Contractor and the Purchasing Agency, inconsideration of the mutual covenants, promises and agreements herein contained, agree as follows:

**SCOPE OF SERVICES:** The Contractor shall provide the services to the Purchasing Agency as set forth in the Contract Documents.

**PERIOD OF CONTRACT:**

**COMPENSATION AND METHOD OF PAYMENT:** The Contractor shall be paid monthly according to the terms of its accepted proposal.

**CONTRACT DOCUMENTS:** The Contract Documents shall consist of this signed Contract; the Request for Proposals; proposal submitted by the contractor dated \_\_\_\_\_, \_\_\_\_\_; the general conditions, special conditions, specifications, and other data contained in the Request for Proposals.

Any contractual claims shall be submitted in accordance with the contractual dispute procedures set forth in the Request for Proposals.

In witness whereof, the parties have caused this Contract to be duly executed intending to be bound thereby.

**CONTRACTOR:**

**PURCHASING AGENCY:**

BY: \_\_\_\_\_

By: \_\_\_\_\_

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Print Name

Title: \_\_\_\_\_

Title: \_\_\_\_\_

Date: \_\_\_\_\_

Date: \_\_\_\_\_

### **Selected Enrollment, Cost, Workload, Demographic and Utilization for State Employees**

- A. Self Insured (ASO) Claims and Enrollment Data – Available in electronic form on a CD. To obtain the CD containing these MS Excel and Word files, you may pick them up at the Department or provide a mailing address for delivery. To arrange pick-up or delivery, please contact Dan Hinderliter by phone (804-371-7990) or e-mail (dan.hinderliter@dhrm.virginia.gov). Please note, these files are proprietary and available only to vendors of the services requested by this RFP

## Summary Description of All Plans Offered to COVA and TLC Groups

**Please access the web addresses shown for summary benefit descriptions of plans**

1. COVACare:

[www.dhrm.virginia.gov/hbenefits/cova/covacare.html](http://www.dhrm.virginia.gov/hbenefits/cova/covacare.html)

click on “Plan Summary of Benefits”

2. The Local Choice
  - a. Key Advantage Expanded
  - b. Key Advantage 200
  - c. Key Advantage 300
  - d. Key Advantage 500

[www.thelocalchoice.state.va.us/compareofbenefits/compofbenefitstoc.htm](http://www.thelocalchoice.state.va.us/compareofbenefits/compofbenefitstoc.htm)

Click on “2008-2009 Plan Year”

**Appendix 4**

**Employee Assistance (EAP)**

**Summary Claims Information  
COVA and The Local Choice**

<b>MISA</b>	<b>COVA</b>		<b>TLC</b>	
	<b>7/1/06 - 6/30/07</b>	<b>7/1/07- 6/30/08</b>	<b>7/1/06 - 6/30/07</b>	<b>7/1/07- 6/30/08</b>
<b>Place of Treatment</b>				
<b>Inpatient</b>				
# of Units	3,970	4,642	867	987
covered charges	\$5,884,234	\$6,961,163	\$1,179,260	\$1,325,852
<b>Partial Hospital</b>				
# of units	2,051	2,190	465	248
covered charges	\$964,400	\$1,174,015	\$216,259	\$120,136
<b>Intensive outpatient</b>				
# of units	1,953	2,059	122	196
covered charges	\$418,692	\$484,213	\$23,164	\$50,166
<b>Outpatient</b>				
# of units	97,769	100,664	16,651	18,848
covered charges	\$9,451,009	\$9,852,054	\$1,479,273	\$1,638,972
<b>All levels of care</b>				
# of units	105,743	109,555	18,105	20,279
covered charges	\$16,718,335	\$18,472,409	\$2,897,957	\$3,135,126
<b>EAP</b>				
# of members	2,211	2,292	279	261
covered charges	\$421,232	\$445,318.00	\$54,477	\$50,680

**Appendix 5**

**Enrollment and Claims Experience for The Local Choice**

<b>7/1/07 - 6/30/08</b>	<b>Key Advantage Expanded</b>	<b>Key Advantage 200</b>	<b>Key Advantage 300</b>	<b>Key Advantage 500</b>
Average monthly enrollment	15,567	5,301	2,949	1,745
Claims ((non-discounted)				
Medical				
facility	\$ 130,234,743	\$ 36,687,293	\$ 14,661,072	\$ 7,710,762
professional & other	\$ 36,795,454	\$ 10,163,416	\$ 4,343,651	\$ 2,202,619
Prescription Drug	\$ 38,206,106	prescription drug experience is blended across all TLC plans		
Dental	\$ 10,193,954	dental experience is blended across all TLC plans		

<b>7/1/07 - 6/30/08</b>	<b>Key Advantage Expanded</b>	<b>Key Advantage 200</b>	<b>Key Advantage 300</b>	<b>Key Advantage 500</b>
Average monthly enrollment	14,640	5,780	3,045	1,530
Claims ((non-discounted)				
Medical				
facility	\$ 109,546,678	\$ 37,057,393	\$ 13,141,262	\$ 7,603,752
professional & other	\$ 32,402,061	\$ 5,912,661	\$ 3,667,016	\$ 1,834,792
Prescription Drug	\$ 33,098,000	prescription drug experience is blended across all TLC plans		
Dental	\$ 9,371,965	dental experience is blended across all TLC plans		

## Appendix 6

## **State Employee and TLC Current Forms**

NOTE: Not applicable to this procurement

## **Appendix 7**

### **State Employee Membership and Billing System**

#### **A. Benefits Eligibility System**

The Department maintains a central membership system that contains the records of all employees, retirees, other eligibles, and their dependents that have coverage under the state employee health benefits program. The system is a live time system known as the Benefits Eligibility System (BES). BES is used to receive enrollment changes, provide enrollment

updates to all carriers, and is the official eligibility source for all programs, in addition to providing the self billing information used to transfer premiums to fully insured carriers on a monthly basis. All eligibles, including both the enrollee and their dependents, are required to carry an identification number that currently is their social security number. Eligibility updates, including the identification number, are made available to carriers electronically as frequently as daily. It is requested that carriers also carry the dependent identification on their claims files.

Enrollment to the state program is largely done through the Office of Health Benefits (OHB)'s web based enrollment system that is called Employee Direct (E-Direct). Eligible persons may go to the E-Direct site to enroll, change membership types, change dependent information, or receive general information on the state's programs, along with other functions. E-Direct has a live time interface with BES and a change is updated while the caller is on line and a confirmation is provided. The state enrollee has the option of completing a manual enrollment/waiver form and giving it to their agency benefits administrator for keying directly to BES, but E-Direct is well accepted at this time and most employees use the web based system.

As stated above, eligibility updates will be made available to all contractors through a FTP process on a daily basis. It is expected that contractors maintain their eligibility files on a current basis to provide for accurate claims processing.

## **B. Billing for Self Funded Plans**

The services billed under the self-funded plans fall into two categories. These are billing for claims payments and billing for administrative fees (Section 4.0 as records accumulated, and invoiced in total to the Department on a weekly basis. The OHB staff reviews the invoice and the Contractor is reimbursed through an electronic transfer of funds within 48 hours of the receipt of the billing documentation. The billing documentation will at a minimum consist of: a cover invoice which provides the net claim dollars to be paid broken between the state employee and the TLC program, and support documentation for each program that provides the claims dollars paid for each benefit category during the period covered by the invoice and year to date. This procedure will be finalized with each contractor as part of the negotiation process and the cycle may be varied based upon compelling reasons, such as claim volume and dollars.

The administrative expenses are invoiced monthly to OHB by each contractor by the 15<sup>th</sup> of the following month. In this process, the OHB will review the invoice and authorize reimbursement through the EDI process. Again the billing documentation will consist of a cover invoice providing the administrative dollars in total for each program with a summary for all programs, and documentation which supports the summary invoice. This support will at minimum consist of a breakdown by each program of billing units by price per unit, shown for the current period and year to date. The number of billing units for each employer under the TLC program will also be required. The monthly administrative invoice may also be used as the financial transfer document for miscellaneous non-claim items that are either due from or to the Department when supported by clear documentation. This procedure will also be finalized during final negotiations.

## **C. Billing for Fully Insured Plans**

The Department makes monthly premium payments to all fully insured carriers by a self-billing procedure based on the BES records as of the first day of each month of coverage. The self-billing process is ran on the 5<sup>th</sup> working day of each month of coverage based on all first day eligibles and takes into consideration any retroactive changes. The self-billing file includes

all eligibles for a contractor shown by agency and premiums due. The file is transferred electronically to the carrier and at the same time generates the request for payment. An EDI transfer around the 10th working day of each month makes payments. (See Appendix for a description of the Commonwealth's EDI payment system and forms required to be completed)

## **Appendix 8**

### **THE LOCAL CHOICE (TLC) PROGRAM ADMINISTRATION**

#### **A. Adoption by Local Governmental Employer Groups**

The TLC was established by the General Assembly of Virginia to provide an optional source of health insurance benefits to local government entities within Virginia. The program operates under regulations established by the Commonwealth of Virginia and enrolled its first member groups on July 1, 1990. The regulations require that a prospective group complete a formal application (see Appendix 7.B), and the Department's underwriters provide the applicant with monthly premiums for each of the plans which are available to the group based on area of the state. A group may join the

program at the beginning of any month, but all groups renew with a July 1 effective date (except for a few school groups who may choose an October 1 renewal date. A prospective group joins the program by completing a legal adoption agreement and submitting a document containing the plan choices that they will offer to their employees. The choice of the plans is an employer decision and their employees may only choose from the plans selected. At this time all selected contractors are notified and the contractor's representatives meet with the group and provide them with the material needed to conduct an open enrollment.

## **B. Enrollment by employees of TLC Member Groups**

Each member group conducts an open enrollment process prior to the start of each plan year. For the renewing groups, this open enrollment is normally held during the months of April and May and will vary in length and formality depending upon the group's size and other influencing factors. Standard enrollment/waiver forms are provided to the groups by the program, along with summary information on plans offered. Each Contractor is required to provide a toll free customer service line to provide information about their plan and to receive orders for plan specific materials from either individuals or to ship in bulk supply to the group's benefit administrator.

Each member group defines their eligible employees within the policies of the TLC program's eligibility rules. A group is required to complete the enrollment process and provide each selected plan with completed enrollment/waiver forms by June 1. This allows each plan at least 30 days in which to set up the enrollees on their membership system, issue identification cards, and provide the current July billing to the groups.

## **C. Membership Files and Group Billing**

Each Contractor is responsible for maintaining membership files for enrollees of any TLC group that selects their plan as one of the group offerings. It is the intent of the program to develop a consolidated membership and claims history data base as is used with the state employee program, but this will not be in place at the effective date of this contract. Therefore, each Contractor with a plan offered to a TLC group would handle the membership functions as if the group was one of their direct contracted groups.

The monthly premium billing to TLC groups plans is due to the group by the 20<sup>th</sup> of the month proceeding the month of coverage. Payments are due back to the plan by the first day of the coverage month with normally a 10-day grace period for late payments to be received. This monthly billing and reconciliation should be handled by the plans like it is done with groups, which are contracted with directly. The billing of the self-funded plans to the Department for claims payments was described previously in Appendix 7.

For self-funded plans, the premiums collected during any month are transferred to the Department by the 5<sup>th</sup> working day of the following month. The premiums submitted should be shown by group and coverage period with total dollars by plan. For fully insured plans, the carrier retains the premiums.

## **D. Renewal Process**

Each year the local group member groups go through a formal renewal process in which they are provided the full menu of plans available in their area with the premiums for the

upcoming plan year. The renewal process starts on September 15th prior to the upcoming July 1 effective date when each carrier is required to provide firm premiums for the next year. The communications development for the upcoming year begins immediately with the involvement of all Contractors. The paid claims data for the self-funded plans is pulled through December 31<sup>st</sup> for each member group and is entered into the tabular rating system along with current demographics and the costs of the pooled products (dental, MISA, and prescription drugs). The program underwriters proceed to develop rates by group for each self-funded plan, print a complete proposal including any fully insured plans available in the TLC groups area. Proposals are assembled and delivered to member groups by February 28<sup>th</sup>. The groups then have until April 1<sup>st</sup> to either renew or withdraw from the program. Renewing groups conduct open enrollment during April and May and are responsible for getting changes to the appropriate carrier by June 1<sup>st</sup>.

## **Appendix 9**

### **Electronic Data Exchange (EDI)**

All payments to Contractors will be made by EDI. The Financial Handbook and forms to be completed are found at the Web location below:

[http://www.doa.virginia.gov/General\\_Accounting/EDI/tradingpartnerguide.pdf](http://www.doa.virginia.gov/General_Accounting/EDI/tradingpartnerguide.pdf)

