



Mayor – Sandy Sanders

City Administrator – Carl Geffken

City Clerk – Sherri Gard

Board of Directors

Ward 1 – Keith D. Lau

Ward 2 – Andre' Good

Ward 3 – Mike Lorenz

Ward 4 – George Catsavis

At Large Position 5 – Tracy Pennartz

At Large Position 6 – Kevin Settle

At Large Position 7 – Don Hutchings

AGENDA~Summary

Fort Smith Board of Directors SPECIAL STUDY SESSION October 10, 2016 ~ 12:00 Noon Elm Grove Community Center 1901 North Greenwood Avenue

CALL TO ORDER

- All present, except Director Keith Lau and Director George Catsavis
- Mayor Sandy Sanders presiding

1. Review third party administrator services proposals for employee insurance coverage
Presentation only from Arthur J. Gallagher & Co. (handout attached)

Hutchings/Lorenz placed resolution authorizing the City Administrator and Director of Human Resources to negotiate third party administrator services for employee insurance coverage on the October 18, 2016 regular meeting agenda.

ADJOURN



The City of Fort Smith

Partially Self-insured Medical/Rx and Dental Plans – Request for Proposal Summary

1. The prior plan design structure and wellness initiative features were complex to the point that insurance companies, and many third party administrators, could not administer the plan effectively.
2. Wellness initiative features were “result based” and incentives were in the form of a combination of employee contribution penalties AND plan design adjustments.
3. This complex wellness initiative incentive structure was difficult to communicate effectively to employees and did not provide adequate financial incentive to encourage ALL adult participants to have an annual physical examination and come under the regular care of a primary care physician.
4. The City was, on average, contributing a higher percentage of plan cost when compared to benchmark data.

Background

Four aspects of the medical/rx plans where the Directors wanted to see improvement beginning in Plan Year 2016.

- The Directors, in approving certain plan design and funding changes for Plan Year 2016, gave the management team the following directives:
 1. To implement a 70%-30% plan contribution split between the City and participating employees beginning in 2016 which would more closely approximate benchmarking data.
 2. To offer employees a choice of medical plans based on tiered calendar year deductibles beginning in 2016 thus allowing them to determine coverage and personal cost.
 3. To simplify and streamline the wellness initiative structure, including employee contribution and plan design features.

Background

Directives - 2016

- Each directive was implemented for the 2016 plan year with the following results year-to-date (through August, 2016)
 1. Medical/Rx and dental paid claims are 10% lower.
 2. Reduction was achieved by plan design revisions, implementation of the 70%-30% contribution split, and dis-enrollment of employees and/or dependents.
 3. Participation in annual physical examination by employees and spouses is significantly improved. This should lead to a reduction in frequency and severity illness resulting from undiagnosed conditions (diabetes, hypertension, coronary disease and cancer).
 4. The Human Resource Department staff did an incredible job of communicating, enrolling and transitioning to the new plan on a VERY short time line.

Background

Results - 2016



- The following four results through eight months of operation indicate a successful transition:
 1. There is a projected operating gain of \$1.1 million for the medical/rx plans.
 2. Current rates are adequate to fund anticipated medical cost trend for the 2017 Plan Year.
 3. No additional appropriation action is required to fund expected cost for the coming plan year.
 4. The only plan design change needed for Plan Year 2017 is to increase the out-of-pocket maximum to the new IRS allowable:
 5. Cadillac Plan Excise Tax projections indicate no liability for the City in 2020.

Background

Results - 2016

Paid Medical & Dental Claims

Rolling 12 Months Comparison – 8/31/2015-16

Claim Development: City of Fort Smith

Medical & Pharmacy

Self Funded

	Claim Development (PEPM)	
	9/1/2014 - 8/31/2015	9/1/2015 - 8/31/2016
Measurement Period		
Net Paid Claims	\$7,180,298	\$6,444,512
Subscriber Months	10,827	10,267
Average Claim Value	\$663.18	\$627.69
Experience Midpoint	3/1/2015	3/1/2016
Projection Midpoint	7/1/2017	7/1/2017
Trend Months	28	16
Claims Adjusted Trend Rate	6.9%	6.9%
Trend Factor	1.168	1.093
Change in Reserve Adjustment	1.006	1.006
Contract Size Adjustment	1.004	1.003
Projected Incurred Claims	\$782.32	\$692.17
Experience Weighting	30%	70%
Total Blended Projected Incurred Claims PEPM	\$719.21	

	9/1/2014 - 8/31/2015	9/1/2015 - 8/31/2016
Gross Paid Claims	\$542,282	\$485,223
Subscriber Months	11,402	11,378
Average Claim Value	\$47.56	\$42.65
Experience Midpoint	3/1/2015	3/1/2016
Projection Midpoint	7/1/2017	7/1/2017
Trend Months	28	16
Claims Adjusted Trend Rate	5.0%	5.0%
Trend Factor	1.121	1.067
Change in Reserve Adjustment	1.004	1.004
Total Projected Incurred Claims PEPM	\$53.51	\$45.70
Experience Weighting	30%	70%
Total Projected Incurred Claims PEPM		\$48.04

Affordable Care Act – Cadillac Plan Projection

Medical & Pharmacy

Self Funded

Status Quo

Plan Years: 2020 - 2024

Carrier(s): Meritain

"The estimate for the 2020 cadillac tax is based on the current plans projected at an annual trend rate of 6.9%. Although the 2020 plan cost may be less than the tax threshold, a tax may be incurred due to employer and employee contributions to a health FSA, non-excepted dental or vision benefits, and/or on-site clinic benefits."

	Coverage Tiers		2020 ¹	2021 ¹	2022 ¹	2023 ¹	2024 ¹
Tax Level	Employee Only		\$10,926	\$11,254	\$11,592	\$11,939	\$12,298
	Employee + Spouse		\$29,458	\$30,342	\$31,252	\$32,190	\$33,155
	Employee + Child(ren)		\$29,458	\$30,342	\$31,252	\$32,190	\$33,155
	Employee + Family		\$29,458	\$30,342	\$31,252	\$32,190	\$33,155
Plan Name	Coverage Tiers	Enrollment Assumption	2020 ¹	2021 ¹	2022 ¹	2023 ¹	2024 ¹
WELL NO NIC 500 DED	Employee Only	362	\$6,674	\$7,134	\$7,626	\$8,153	\$8,715
	Employee + Spouse	86	\$14,006	\$14,972	\$16,005	\$17,110	\$18,290
	Employee + Child(ren)	80	\$11,338	\$12,120	\$12,957	\$13,851	\$14,806
	Employee + Family	130	\$18,674	\$19,963	\$21,340	\$22,812	\$24,386
MED WELL + NIC 2000 DED	Employee Only	61	\$5,803	\$6,204	\$6,632	\$7,089	\$7,579
	Employee + Spouse	16	\$12,179	\$13,019	\$13,918	\$14,878	\$15,904
	Employee + Child(ren)	14	\$9,859	\$10,539	\$11,267	\$12,044	\$12,875
	Employee + Family	30	\$16,238	\$17,359	\$18,556	\$19,837	\$21,205
MED NO WELL 1250 DED	Employee Only	45	\$6,674	\$7,134	\$7,626	\$8,153	\$8,715
	Employee + Spouse	0	\$11,338	\$12,120	\$12,957	\$13,851	\$14,806
	Employee + Child(ren)	14	\$11,338	\$12,120	\$12,957	\$13,851	\$14,806
	Employee + Family	0	\$11,338	\$12,120	\$12,957	\$13,851	\$14,806 ⁷
Total Tax (\$)		838	\$0	\$0	\$0	\$0	\$0

- We received only one fully-insured proposal from the four remaining national health underwriting insurance companies:
 1. United Health Care – DNQ
 2. Aetna – DNQ (stated their best offering was through Meritain, their own TPA)
 3. CIGNA – DNQ (stated their best offering was through Allegiance, their own TPA)
 4. Blue Cross – Proposed

BCBSARK	Plan 1	Plan 2	Plan 3
Employee Only	\$540.14	\$556.75	\$587.96
Employee & Children	\$840.83	\$866.68	\$915.27
Employee & Spouse	\$1,181.71	\$1,218.05	\$1,286.33
Employee & Family	\$1,560.93	\$1,608.93	\$1,699.12

CURRENT	Plan 1	Plan 2	Plan 3
Employee Only	\$393.68	\$423.20	\$452.73
Employee & Children	\$668.82	\$718.98	\$769.15
Employee & Spouse	\$826.19	\$888.16	\$950.12
Employee & Family	\$1,101.56	\$1,184.18	\$1,266.80

Request for Proposal

Plan Year 2017

- We received proposals from four third party administrators who offered various PPO networks in conjunction with their administrative services:

1. Meritain - Aetna
2. Allegiance - CIGNA
3. Web TPA – Aetna (lesser PPO network)
4. Health Scope – Various lesser PPO networks (CIGNA, Aetna, First Health, The Coalition)
5. Blue Cross and Blue Shield did not get their proposal submitted prior to the deadline.

Request for Proposal

Plan Year 2017

- The two finalists based on pricing and RFP responses were Meritain/Aetna and Allegiance/CIGNA.

Meritain/Aetna							
5 Year Offer		2016	2017	2018	2019	2020	2021
MERITAIN HEALTH Current Services	Lives	Current	Renewal	Renewal	Renewal		
Medical Administration Fee (Med/UR/ CM/ COBRA/PPO/ ID CARDS)	809	\$ 21.95	\$ 23.50	\$ 25.25	\$ 27.10	\$ 28.95	\$ 30.85
Maternity Mgmt.	809	\$ 0.65	\$ 0.65	\$ 0.65	\$ 0.65	\$ 0.65	\$ 0.65
PBM Coordination Fee	809	\$ 1.00	\$ 1.00	\$ 1.00	\$ 1.00	\$ 1.00	\$ 1.00
Retiree Billing	25	\$ 0.65	\$ 0.75	\$ 0.75	\$ 0.75	\$ 0.75	\$ 0.75
Healthy Merit Jog Program	809	\$ 1.95	\$ 2.00	\$ 2.00	\$ 2.00	\$ 2.00	\$ 2.00
Disease Management (total Pop)	784	\$ 5.00	\$ 5.00	\$ 5.00	\$ 5.00	\$ 5.00	\$ 5.00
Total Cost of MERITAIN HEALTH Services		\$ 31.20	\$ 32.90	\$ 34.65	\$ 36.50	\$ 38.35	\$ 40.25
Dental Administration (with Dentemax Network)	809	\$ 2.50	\$ 2.60	\$ 2.60	\$ 2.60	\$ 2.60	\$ 2.60
Flexible Spending Acct.	79	\$ 4.50	\$ 4.50	\$ 4.50	\$ 4.50	\$ 4.50	\$ 4.50

Allegiance/CIGNA							
5 Year Offer		2016	2017	2018	2019	2020	2021
MERITAIN HEALTH Current Services	Lives	Current	Renewal	Renewal	Renewal		
Medical Administration Fee (Med/UR/ CM/ COBRA/PPO/ ID CARDS)	809	\$ 21.95	\$ 29.30	\$ 29.30	\$ 29.30	\$ 30.65	\$ 30.65
Maternity Mgmt.	809	\$ 0.65					
PBM Coordination Fee	809	\$ 1.00			Included		
Retiree Billing	25	\$ 0.65					
Healthy Merit Jog Program	809	\$ 1.95					
Disease Management (total Pop)	784	\$ 5.00	\$ 2.75	\$ 2.75	\$ 2.75	\$ 2.95	\$ 2.95
Total Cost of MERITAIN HEALTH Services		\$ 31.20	\$ 32.05	\$ 32.05	\$ 32.05	\$ 33.60	\$ 33.60
Dental Administration (with Dentemax Network)	809	\$ 2.50	\$ 2.50	\$ 2.50	\$ 2.50	\$ 2.50	\$ 2.50
Flexible Spending Acct.	79	\$ 4.50	\$ 5.25	\$ 5.25	\$ 5.25	\$ 5.25	\$ 5.25

Request for Proposal

Plan Year 2017

AML Proposal

- The AML provides a valuable service to smaller municipalities:
 1. Of the 352 entities participating in the AML plan, there is only 1 with more than 400 employees.
 2. The AML, through its employee benefit trust, is providing a vital service and employee benefit solution to the smaller municipalities of Arkansas. Through this RFP process we have validated that the fully-insured market place has been seriously impacted by its current regulatory environment, and is struggling to offer affordable insured medical plan solutions to smaller employers. Without the AML program, these smaller cities might well find it impossible to offer medical benefits at all.
 3. We would be very interested in considering AML once it determines to develop a solution for larger municipalities with more flexibility and self-direction.

AML Proposal

- The following are some aspects of the AML plan that are inconsistent with the City's approach to employee benefit management:
 1. The PPO network, as currently configured, would produce significant geo-access problems for some employees; would result in significant disruption of historical provider choices by participants; and would cause an increase in the cost of healthcare through a reduction in PPO provider discounts, particularly outside Arkansas.
 2. The AML plan achieves its cost control, in large measure, by transferring liability to participants through significant benefit limitations. It does not presently have the ability to allow the City to deviate from the AML plan structure.
 3. The pooling mechanism of the Trust has more benefit to smaller municipalities, and is less attractive to larger cities.

AML Cost Comparison

- The City utilizes a 4-tiered medical rate structure to achieve greater equity in determining employee contribution. The structure causes a single parent with one child to pay less than an employee who covers and spouse and multiple children. The AML program is offered with a 2-tiered medical rate structure. For comparison purposes, we have converted the City's 4-tiered rate structure to a 2-tiered one for comparison purposes.

CURRENT	Plan 1	Plan 2	Plan 3	Plan 1	Plan 2	Plan 3
Employee Only	\$393.68	\$423.20	\$452.73	\$393.68	\$423.20	\$452.73
Employee & Children	\$668.82	\$718.98	\$769.15	\$870.87	\$937.68	\$1,003.39
Employee & Spouse	\$826.19	\$888.16	\$950.12	\$870.87	\$937.68	\$1,003.39
Employee & Family	\$1,101.56	\$1,184.18	\$1,266.80	\$870.87	\$937.68	\$1,003.39

AML	Plan 1	Plan 2	Plan 3
Employee Only	\$346.50	\$382.50	\$423.00
Employee & Children	\$766.50	\$847.50	\$937.50
Employee & Spouse	\$766.50	\$847.50	\$937.50
Employee & Family	\$766.50	\$847.50	\$937.50

- Authorize the City Manager and Director of Human Resources to conduct interviews and receive best and final offers from:
 - Meritain/Aetna
 - Allegiance/CIGNA
- Authorize the City Manager and Director of Human Resources to facilitate contracting with the proposer of choice for an effective date of 1-1-2017.
- Approve a continuation of current rates and City appropriation level.
- Approve a continuation of current medical/rx and dental plan design except for increasing the out-of-pocket maximum to 2017 IRS allowable.

Conclusion

Recommended action

VII. GENERAL QUESTIONNAIRE

W/ AML

A. FINANCIAL AND RISK MANAGEMENT QUESTIONS.

Provide financial statements for the most current two years.

See Attached 2014 and 2015 Audit Reports.

B. IMPLEMENTATION, ENROLLMENT, ELIGIBILITY AND MAINTENANCE QUESTIONS

What is the normal lead-time required to implement a group?

While a 90-day lead time is preferred, groups are often implemented with a 30 to 60-day lead time.

Do you require a deposit or imprest balance for claim funding?

No.

Are your banking requirements on a claims paid/processed basis or checks cleared?

AML funds the account prior to checks being processed/paid. AML has a Positive Pay Agreement with Centennial whereby AML sends the bank an electronic file daily and they are matched before the check clears the bank. Please refer to the attached Positive Pay Agreement for further details.

Please provide a copy of your banking agreement.

Attached are the following agreements:

Master Agreement for Cash Management Services

Business Associate Agreement

Positive Pay Service Addendum

Lockbox Service Addendum

What mediums do you accept for plan enrollment?

Checks or electronic payments.

Do you offer online eligibility maintenance for all clients?

Yes.

If so, is there a charge?

No.

Is there a charge for hard copy maintenance?

No.

How often is membership updated?

Monthly.

Can you maintain membership by employee and dependent?

Yes.

Explain your billing procedure.

Once a group has been set up in the MHBF system upon enrollment, the MHBF system automatically generates monthly premium invoices. A group can choose to have invoices sent electronically or by regular mail. Invoices are mailed on the 15th of each month prior to the month of coverage and are due on the 1st day of the month (i.e., the bill for March premiums is mailed on February 15th and is due on March 1.) If a payment is made after the 10th day of the month, a late fee of \$10 per group and \$1.00 per member is assessed.

Monthly premium bills are used by the group to provide any census change information to the enrollment department. If a group wishes to add or remove an employee from coverage, or make a change to an employee's coverage, the group administrator includes the information on the current month's bill, adjusts the premium accordingly and remits the required forms and documentation to add, change, or cancel coverage. The MHBF Enrollment Clerk then updates the information provided in the system and posts the premium.

Remittances can be mailed to Municipal Health Benefit Fund Premium, P.O. Box 880, Conway, Arkansas 72033 or remitted electronically.

How frequently are clients billed?

Monthly.

What charges do the billings encompass?

Premiums for members with individual coverage, premiums for members with family coverage, and late fees, if applicable. Premiums reflect the benefits chosen by the group i.e., Medical, Dental, Vision, Life & AD&D, etc.

Can a plan sponsor be issued separate billings for employee subdivisions (e.g., locations, divisions, union/non-union groups, etc.)?

Yes.

C. GENERAL ADMINISTRATION QUESTIONS.

If you are awarded this business, how soon after the notification of the award would you be able to have a draft of the following:

Administrative Agreement(s)

Five business days.

ID Cards

Once enrollment documentation has been received, ID Cards will be produced and mailed to the new member within ten (10) business days. ID Cards are mailed directly to a member's home address.

With respect to ID cards:

Do you charge a fee for card preparation?

No.

Is there a charge for replacement cards?

No.

Can you put the sponsor name and logo on the ID cards?

No.

Is there an additional charge for this?

Not applicable.

Can you do a combination medical/Rx card (Express Scripts is their PBM vendor)?

Yes, we currently provide a combination card. OptumRx is the MHBf's PBM.

When are fees due under your policy?

In order to participate in the MHBf, a City must be a member of the Arkansas Municipal League(AML). Membership fees are due annually.

What is the grace period?

10 days for premium payments; 30 days for annual AML membership dues.

If fees are paid after the grace period, is a penalty and/or interest charge assessed?

There is a penalty for late payment of premiums addressed in Section B. There is no penalty for membership dues.

If yes, explain in detail.

The fees charged for late payment of monthly premiums is addressed in Section B.

Are there any options available with respect to the grace period?

No.

If so, explain the option(s) and any charge that is made for them.

Not applicable.

D. HIPAA

Have you addressed HIPAA in your contract with clients?

Yes.

Indicate if your claims system presently can auto-adjudicate claims electronically, including the origination of electronic payments and credits.

Yes. Clean claims that do not require clinical review are auto-adjudicated. If a provider has an account with ChangeHealthcare (formerly Emdeon), electronic payments are remitted weekly. Otherwise, paper checks are remitted weekly.

Include the name and owner of any leased systems or clearinghouses.

ChangeHealthcare (formerly Emdeon).

Does your system support on-line, real-time eligibility inquiries?

Yes.

Does your system support on-line, real-time claim status inquiries?

Yes.

E. CUSTOMER SERVICE /SATISFACTION QUESTIONS

Do you utilize a call distribution and tracking system to monitor and measure customer service performance and statistics?

Yes, Cisco Systems, Inc.

Can you track the items outlined below?

Number of calls received?

Yes.

Average speed of answer?

Yes.

Call abandonment rates?

Yes.

Length of call?

Yes.

Others?

If requested.

F. TECHNOLOGY QUESTIONS

1. Which of the following tasks can members and plan sponsor representative perform ONLINE?

Enrollment (New Hires and Open Enrollment)

If a group uses MHBF's partner, American Fidelity, for supplemental benefits an electronic enrollment platform is available that is administered by American Fidelity representatives during the open enrollment process and as needed for new hires.

Changes in Status.

Billing

Provider search

Access provider directories

Is there an additional cost for online services?

No.

Are provider directories available online?

Yes.

G. REPORTING QUESTIONS.

Complete the following chart; identify the standard reports available to the client and its professional advisor.

Report	Frequency	Additional Cost	Comments
<i>Loss Ratio Report</i>	<i>Quarterly</i>	<i>No</i>	<i>Available upon request.</i>
<i>ACA Coverage Reports</i>	<i>Annually</i>	<i>No</i>	

Are special or ad hoc reports available to the client?

Special or ad hoc reports will be considered on a case-by-case basis.

Are there any additional costs associated with any of these reports?

No.

If there are additional fees, are the fees generated on a fixed cost per report or billed on an hourly basis?

Not applicable.

Can the reports be provided by division, location, department or union subdivision within a single employer group?

Yes.

If so, can this be done at no additional cost?

Yes.

Does the client have the ability to access your data base in real time for purposes of:

Add/deletes?	<i>No.</i>
Tracking plan experience?	<i>No.</i>
Utilization patterns?	<i>No.</i>
Other available plan information?	<i>No.</i>

How is this ability provided?

Not applicable.

Is there any charge to the client?

Not applicable.

VIII. ASO/TPA CLAIMS ADMINISTRATION QUESTIONNAIRE

A. SPECIFICATIONS

1. **You must permit the employer to have access to all files on request (e.g., a claims audit).**
Disagree. The MHBF is audited on an annual basis by an independent accounting firm. Results of the audit are published and available to the public.
2. **Run-out claims will be paid by the existing carrier. Your pricing should assume no run-in claims payment.**
Agree.

B. FIRM / ORGANIZATION

1. **How many trained examiners do you employ at this site?**
25.

What is their average length of experience (in years)?
10 years.

2. **Show the number of employer groups you service in each of the size categories below.**
 - **1-100 Employees - 300**
 - **101-400 Employees - 51**
 - **401-1,000 Employees - 1**

C. CLAIMS ADMINISTRATION SERVICES

1. **Describe the options available to the group for submitting eligibility data.**
Paper and electronic formats will be accepted.
2. **Do you maintain separate bank accounts for each client?**
No.
3. **Do you maintain a record for all checks issued but not cashed?**
Yes.
 - **How often will you provide this record to the client (monthly, quarterly, annually)?**
Not applicable.
 - **Who is responsible for follow-up of uncashed checks?**
AML's Finance Department.
 - **Who is responsible for reconciling the bank account?**
AML's Finance Department.
4. **What claims adjudication system do you use? (If proprietary, describe the staffing and client capabilities of your IT staff).**
IBM Mainframe

- **Is your system leased or owned?**
Owned.
 - **When was the system last updated?**
The system is constantly maintained and updated.
- 5. Confirm in writing your ability to adjudicate the existing and alternative benefit plan(s).**
The MHBF has the ability to adjudicate its existing benefit plans.
- 6. The client reserves the right to carve out PBM services. Do you agree to this requirement?**
The proposal provided includes PBM services.
- 7. Do you have a claims quality assurance or review process?**
Yes.
- 8. Describe your system edits for identification of fraudulent claims.**
The iSeries system is designed to reject duplicate billing; non-specified codes; CPT codes that are age restricted; and revenue codes that do not match the type of claim being billed.
- 9. Describe the types of physician and hospital fee discount arrangements your claims system can accommodate.**
Percentage off billed charges; case rates; DRGs; per diem; per visit rates; and fee schedules.
- **What limitations does your system have?**
None.
- 10. Identify and comment on any major claim / eligibility / reporting system changes or upgrades planned in the next 12 to 24 months.**
MHBF is developing a second option for coverage but it is still under construction and is not available at this time.
- 11. Describe the claims appeal process and associated timeframes.**
Please refer to Section 8: Appeals, pages 53 – 63 of the attached MHBF Fund Booklet.
- 12. What method does your firm utilize to determine Usual and Customary (HIA, company profile, network contracted rates, RVS, etc.) for Arkansas and out-of-state?**
To determine UCR charges billed by a medical provider for services and supplies, the Fund reserves the right to use national tables (including but not limited to, RBRVS, ADP and MDR, Medispan, First Databank) and methods in accordance with health care industry standards. The client may not select a different level.
- 13. How often are allowances revised?**
Annually.
- 14. Can your system accept electronic claims submission?**
Yes.
- What percentage of claims is submitted electronically?**
95%.

15. What percentage of claims is currently auto-adjudicated through your system?

Approximately 85%.

16. What was the average turnaround time for paid claims for the last two years?

15 days.

17. Indicate the claims accuracy / error rate for the last two years?

92% accuracy rate. Errors detected are immediately corrected.

18. Can your system detect unbundling of services?

Yes.

19. Can your system detect "code creeping"?

Uncertain of definition of term "code creeping." All codes are validated. Unspecified codes are denied.

20. Explain in detail your procedures for identification and recovery of third-party liability claims.

Treatment, services and supplies for injury or illness for which, as determined by the Fund, another party or payer for a party is liable, including, but not limited to employment related injuries or illnesses; automobile medical payment coverage; liability insurance, whether provided on the basis of fault or non-fault; and any hospital or medical benefits paid or payable under or provided pursuant to any state or federal law or program are benefit exclusions. Nor will the Fund pay for treatment, services and supplies required by school-based programs, federally mandated programs, Medicare, employment physicals, tests, exams and exams requested or directed by a court of law.

If MHBF receives a claim for an injury or illness that may have been related to a motor vehicle accident, on the job injury or any third-party liability, it prompts the Claims Analyst to send the covered member an Accident Claim Form that must be completed and returned to MHBF. Medical records regarding the claim are also requested from the provider so that a determination can be made. Claims are pended until documentation has been received and the information has undergone the clinical review process.

21. Who performs your Medical Reviews?

Medical Reviews are performed in-house by LPNs under the direction of a Medical Review Officer. Medical reviews are included in the fees.

22. Audits:

- **What is the frequency of audits done by your internal staff?**
Weekly audits are performed on all claims being processed for payment.
- **What is the frequency of audits done by external vendors?**
Annually.
- **Who performs the external audits?**
Thomas & Thomas, LLC.

23. Would you be willing to allocate an allowance for outside audits?

Not applicable.

24. In the event of contract termination, how will you process “run-out” claims?

If an entire group or individual member is terminating coverage, any incurred claim for benefits, along with supporting information/documentation must be filed within 60 days of the last day of membership in the Fund, or within the 180 days of the date of service, whichever is less.

Additionally, providers seeking to appeal any denial or reduction of benefit payments must make their appeal within 60 days from the date of the denial or reduction in payment.

25. In the event of contract termination, how will you process the following:

- **Claims in house, but not processed?**
- **Claims submitted prior to termination but not received by your firm until the termination?**
- **Claims submitted after the termination?**

If an entire group or individual member is terminating coverage, any incurred claim for benefits, along with supporting information/documentation must be filed within 60 days of the last day of membership in the Fund, or within the 180 days of the date of service, whichever is less.

Additionally, providers seeking to appeal any denial or reduction of benefit payments must make their appeal within 60 days from the date of the denial or reduction in payment.

26. Would you agree to process run-out claims to match the timely filing provision(s) of the plan?

No, the plan has a separate provision for groups that are terminating coverage.

IX. MEDICAL NETWORK QUESTIONNAIRE

NETWORK QUESTIONS

Physicians

- 1. List the hospital selection/evaluation criteria you use. Specify the certifications / credentials you contractually require hospitals to maintain (e.g., licensure, JCAHO accreditation, evidence of liability insurance, etc.)**

Contractually, a provider agrees to secure and maintain, or cause to be secured and maintained during the term of the Agreement, comprehensive general and professional liability insurance at minimum limits required by state law and industry standards. In addition, a provider agrees to maintain all state and federal required licensure.

- 2. Please describe any discount arrangements with hospitals or other providers outside your normal network that you define as a “center of excellence.”**

MHBF has an agreement in place with a wrap-around network through Multiplan, however, MHBF does not acknowledge any provider as a “center of excellence.”

- 3. Which of the following healthcare services are not available within the network?**

What arrangements have been made to provide these services.

- a. Alcoholism/chemical dependency (inpatient and outpatient)**

Coverage available, precertification required.

- b. Ambulatory surgery.**

Coverage available, precertification required.

- c. **Cardiac catheterization laboratory.**
Coverage available, precertification required.
- d. **CT Scanner.**
Coverage available.
- e. **Emergency department.**
Coverage available.
- f. **Intensive care unit.**
Coverage available, precertification required.
- g. **Neonatal intensive care unit.**
Coverage available, precertification required.
- h. **Obstetrics.**
Coverage available.
- i. **Open heart surgery.**
Coverage available, precertification required.
- j. **Pediatric inpatient unit.**
Coverage available, precertification required.
- k. **Psychiatric (inpatient and outpatient).**
Coverage available, precertification required for inpatient treatment.
- l. **X-ray radiation therapy.**
Coverage available.

4. Provide the number of physicians in your network by the following specialties (count each physician once based on their primary practice).

Family Practice	7,000 +
General Practice	7,000+
Internal medicine	900+
Obstetrics	400+
Pediatrics	1,000+
Gynecology	100 +
General Surgery	400+
Cardiovascular Surgery	50+
Orthopedic Surgery	700+
Urology	250+
Psychiatry	500+
Nephrology	200+
Dermatology	100+
Gastroenterology	250+
Neurosurgery	150+
Otolaryngology	150+
Ophthalmology	400+
Endocrinology	50+
Radiology	950+
Anesthesiology	1,500+
Oncologist	150+
Cardiologist	600+
Hospitals	150+
TOTAL	15,950+

5. Please indicate if your organization's physician application and credentialing process requires the following:

- | | |
|---|----|
| a. Written verification of education and experience | No |
| b. Verification of current license and DEA certification | No |
| c. Investigation for adverse action on license and/or hospital privileges | No |
| d. Verification of letters of recommendation | No |
| e. On-site inspection of physician offices | No |
| f. Personal interviews | No |
| g. Check malpractice history with appropriate State/federal agencies | No |
| h. Malpractice insurance includes limits of at least \$1 million per occurrence and \$3 million aggregate | No |
| i. Regular recertification of participating physicians | No |

6. Is the credential function delegated? If yes, to whom?

Hospital

IPA

Other: *Each provider is responsible for maintaining required credentials.*

7. Does your organization selectively drop physicians within a medical group/physician association while continuing to contract with the medical group/physician association?

No.

8. Do you know of any providers or hospitals that will not be in the network at any time in the future?

No.

9. What was your physician turnover in the past year?

<1% for Family practice physicians, internists, pediatricians, Ob/GYNs, and other specialists.

Mental Health/Substance Abuse Providers

10. Provide the number of participating mental health/substance providers by the following types:

Psychiatrists, Licensed consulting psychologists (Ph.D.s)	>550
Licensed psychologists, MSWs, Psychiatric RNs, Other	1,000 (including LCSW)

11. How are these providers selected?

Either a member asks that a provider be included in the network, or the provider makes a request to be included.

12. How are these providers credentialed?

Credentialing is the responsibility of the provider pursuant to the terms of their contract with MHBF.

13. How are each of these providers reimbursed?

Pursuant to their contractual agreement with MHBF.

14. Do you have a reimbursement incentive that encourage outpatient rather than inpatient treatment?

No.

15. Does your mental health/substance abuse network interface with employer EAPs?

No.

16. Will you carve out mental health/substance abuse services?

No.

Single Specialty Organizations (SSOs)

17. Is your network currently contracting with any SSO or disease management provider groups?

No.

Non-Physician Providers

18. Provide the number of providers in your network.

Physical therapists	500+
Chiropractors	400+
Speech therapists	30+
Home health aides	N/A
Podiatrists	100+
Optometrists	500+

19. Are there any alternative medicine providers in your network?

No.

Other Outpatient Health Services

20. Provide the number of other health services in your network.

Surgical centers	100+
Laboratory	100+
Radiology units	Unknown, included in other counts due to facility where service offered.

Required Documentation

21. Describe the specific measures used by your organization to monitor physician access in the area in which your network operates. Provide the most recent corresponding statistics available. (Examples: physician-to-member ratios, average wait time required for an appointment, etc.)

MHBF relies on member and provider feedback to strengthen and enlarge network. Specific statistical data unavailable.

22. Please provide a flash drive containing a list of all your contracted providers.

This data is available on the Arkansas Municipal League Website www.arml.org under MHBF. The list is not available in the format requested.

23. Geo-Access: Please provide a network accessibility analysis using the employee data included on the census file provided.

The MHBF provider network includes over 1,400 providers in the region based on the census provided.

24. The City wants to ensure satisfactory network access is maintained after a network vendor is selected. Therefore, at any time the vendor's network fails to meet any access standard shown in Question 3-23 above, in any area where significant concentrations of the City employees reside, the network will suspend monthly access fees with respect to those employees until the standards are again met. Please state your willingness to accept this contract provision.

MHBF strives to maintain and enlarge its provider network in all areas of the state of Arkansas; however, since the Arkansas Municipal League promotes the use of services provided in the State of Arkansas, MHBF would not be willing to accept this provision.

Provider Reimbursement

25. Indicate the reimbursement/payment methods for the following types of services. If more than one reimbursement method is used for a service, indicate the breakdown by percentages. If percentages cannot be determined, indicate with an asterisk which is the primary method.

Hospital: Inpatient	<i>Per Case/DRG</i>	<i>Per Diem</i>	<i>Discounted Charges</i>	<i>Fee Schedule</i>
Hospital: Outpatient	<i>Per Case/DRG</i>	<i>Per Diem</i>	<i>Discounted Charges</i>	<i>Fee Schedule</i>
Physicians: PCP			<i>Discounted Charges</i>	<i>Fee Schedule*</i>
Specialist			<i>Discounted Charges</i>	<i>Fee Schedule*</i>
Laboratory			<i>Discounted Charges</i>	<i>Fee Schedule*</i>
Mental Health/ Substance Abuse:				
Inpatient	<i>Per Case/DRG</i>	<i>Per Diem</i>	<i>Discounted Charges</i>	<i>Fee Schedule</i>
Outpatient:	<i>Per Case/DRG</i>		<i>Discounted Charges</i>	<i>Fee Schedule</i>

MHBF contracts with each provider individually and reimbursement/payment methods are set forth in the contract.

26. What provisions are contained in provider contracts regarding increases in payment levels in future years?

None. Increases in payment levels must be set forth in the contract renewal process.

27. If a non-network physician admits to a network hospital, will the admission receive the network discount?

Yes.

28. Do you have more than one type of payment arrangement with the same provider? If so, what arrangement will apply to the City?

Yes. The arrangement depends on the service provided and MHBF's contractual agreement with the provider.

29. HOSPITAL PAYMENT

Using the most current data available and indicating the period your response represents, please provide your discount % for network facilities both for inpatient and outpatient services.

Per a hospital's contractual agreement with MHBF, multiple rates may apply. MHBF receives an average discount of 20% outpatient and 20% for inpatient facilities.

30. PHYSICIAN PAYMENT

Using the most current data available and indicating the period your response represents, please provide your discount % for physician services.

Per a physician's contractual agreement with MHBF, multiple rates may apply. Therefore, data regarding a discount % is unavailable.

31. Is there a formal committee that sets participating provider quality assurance policy and review treatment outcomes on a regular basis?

No.

32. Describe the goals of your quality assurance program and how you measure them.

Not applicable.

33. Describe how quality assurance activities are used to re-credential, re-contract, and/or evaluate individual provider performance.

Not applicable.

34. Describe how quality assurance activities are used to monitor complaints and used to improve patient care and service.

Not applicable.

35. Describe any education programs for staff.

MHBF staff receives continual HIPAA training. Clinical staff are required to maintain licensure by participating in continuing education courses. Specialized training related to job duties and responsibilities is ongoing within the department.

36. What is the average time in the waiting room for scheduled appointments?

MHBF does not monitor this data.

37. Do you issue separate reports to providers to help them measure their practices in terms of practice patterns/variations and costs of alternative treatments/procedures?

No.

38. Describe the responsibilities, credentials, and reporting relationships of the people who work in the quality assurance program.

Not applicable.

39. How are disputes or questions handled about reimbursement amounts:

- a. **Between a patient and the provider?**
- b. **Between the claim payer and the provider?**

A MHBF member can contact our customer service department to receive information regarding the way a claim was processed. If the dispute is with the provider directly, the member should contact the provider's office.

A provider can appeal a payment made by MHBF by following the Appeal Process found in Section 8, page 54 of the MHBF Fund Booklet. A copy of the Fund Booklet is attached.

40. Do you perform patient satisfaction surveys? If so, describe and provide sample results.

No.

41. Describe your criteria for dismissing a participating physician or hospital.

Provider termination from the MHBF network may be voluntarily implemented by the provider upon receipt of written notification and pursuant to the terms set forth in the provider contract. If a provider or hospital fails to maintain the licensure required by State and Federal guidelines, said provider or hospital will receive written notice from MHBF of their termination from the provider network.

42. Have there ever been any malpractice suits filed against a participating physician or hospital?

MHBF does not monitor this data.

43. Please describe your procedure for evaluating a provider's performance.

Not applicable.

44. How many providers have been disciplined or dropped over the past three years?

Less than one percent of providers have been dropped over the past three years.

45. Has your organization acquired American Accreditation Program (AAPI) certification?

No.

46. Please complete the following chart for the aggregate non-Medicare and non-Medicaid annualized utilization data for the current and prior calendar years for your PPO network.

The requested data is not readily accessible in an aggregate format.

X. UTILIZATION MANAGEMENT QUESTIONNAIRE

A. UTILIZATION MANAGEMENT

General Questions

1. Indicate your UM Program accreditation:

NCQA

2. How long has your organization been performing UM services?

Since 1982 – 34 years.

3. Are your services local, national or international?

Local only.

4. Do you have educational material which informs enrollees regarding your UM services and procedures?

Yes, available at no additional cost.

5. Do you have a standard precertification requirement for any of the following?

Yes, precertification is applicable to: *Hospitalizations*
 Outpatient Surgery
 Specified Diagnostic Procedures
 Durable Medical Equipment
 Corrective Appliances / Prosthetics
 Skilled Nursing Facility
 Home Health Care
 Inpatient Mental Health / Substance Abuse

Specific precertification requirements can be found in the MHB Fund Booklet.

6. Precertification includes the analysis and determination of which of the following:

Appropriate level of Care
Reasonable length of Stay of IP confinement
Actual medical necessity and appropriateness of surgery or service being requested.
Necessity for the services of an assistant surgeon with each operative procedure analysis.
Necessity for a proposed preoperative hospital day.

7. Indicate type of review information which is communicated to the claims payor by your firm:

- **Appropriate level of care (e.g., OP)**
 - **Do you notify claims payor?** *Yes*
 - **Approximate Frequency** *Weekly*
 - **Method of Notification** *EOB and Medical Review Form*

- **Certified Length of Stay**
 - **Do you notify claims payor?** *Yes*
 - **Approximate Frequency** *Weekly*
 - **Method of Notification** *Phone Call and Written Follow Up*

- **Procedure / Service determined NOT to be medically necessary**
 - **Do you notify claims payor?** *Yes*
 - **Approximate Frequency** *Weekly*
 - **Method of Notification** *Letter or computer report*

8. Indicate the primary method for determining the appropriate length of a stay for a hospital admission.

Other purchased written LOS table, specifically MCG.

9. **Within the past twelve months, in what % of all precertification cases was a letter of noncertification (denial) for Medical Necessity / Appropriateness for the procedure issued?**
Less than 1%.
10. **Indicate the category of staff who can make a final disapproval for a preservice request.**
LPN/LVN or Physician.
11. **What % of all preservice reviews require your physician advisor review for decision making?**
1 to 10%

Appeal/Grievance Reconsideration Process

12. **Is there any information regarding the option for an appeal, the timeframe and the mailing address in the body of any denial notification letter?**
Yes.

Concurrent/Continued Stay Review

13. **Does your firm perform concurrent review services?**
Yes.
14. **Concurrent review staff are:**
100% MHBF Full-time Employees

Case Management

15. **Describe in detail your large case/catastrophic case management.**
Clinical staff monitors all services that require a precertification through provider's progress reports and medical record review.
16. **Does your firm have an ACTIVE case management program?**
Yes.
17. **During case management, does your staff negotiate fee reductions with providers and vendors?**
Yes.
18. **What is the average percent fee discount this client fee this client could expect your firm to negotiate for service / equipment, etc.?**
While the percent may vary based on the specific service or equipment, 20%.
19. **Describe your catastrophic case management program.**
Clinical staff monitors all services that require a precertification through provider's progress reports and medical record review. Due to the confidential nature of the patient's records, no reports are provided to the client.

Reporting

20. Indicate your standard method of reporting savings from the review of IP hospitalization.

IP hospital savings reports not available. Savings are calculated on a monthly basis comparing actual billed charges to amount due after clinical review and represent aggregate totals.

21. Indicate your standard method of reporting savings from the review of OP surgery.

OP surgical reporting not available. Savings are calculated on a monthly basis comparing actual billed charges to amount due after clinical review and represent aggregate totals.

Auditing

22. Does your organization perform hospital bill audits? If yes, describe the basis of your compensation.

Yes. MHBF's clinical review team reviews requests and reviews the itemization of billed charges for any claim over \$10,000.00 and makes the appropriate adjustments. There is no additional charge for this service.

XI. DISEASE MANAGEMENT QUESTIONNAIRE (OPTIONAL)

1. Does your organization offer disease management programs?

No.

Questions 2 through 16 are not applicable since MHBF does not offer disease management programs at this time.

XII. COST EXHIBITS

A. ASO/TPA SERVICES

WITH THE EXCEPTION OF THE SET-UP FEE (If any), QUOTE ALL ON A PEPM BASIS.

All services described in the responses to this Questionnaire, as well as those outlined in the Fund Booklet attached to this proposal are included in the member premium which is based on the programs chosen. There are no additional fees assessed, with the exception of late payment fees, if applicable.

B. DISEASE MANAGEMENT (STAND-ALONE)

Not applicable.

MEDICAL/RX PLAN PROPOSED RATES

PLEASE REFER TO THE ATTACHED PROPOSALS INCLUDED WITH THE RESPONSES TO THIS QUESTIONNAIRE.

**XIII. PROVIDER DISRUPTION RESPONSE FORMS
TOP 100 PROVIDER ANALYSIS REPORT
FOR MEDICAL CLAIMS PAID BETWEEN 01/01/2015 AND 07/29/2016**

Please note that for those providers that are not currently in MHBF's network, every effort will be made to add them prior to the group's effective date provided that they are within the geographic region of the City. MHBF also utilizes Multiplan, a wrap-around network.

<u>DIVISION</u>	<u>PROVIDER NAME, STATE, ZIP CODE</u>	<u>PPO (Y/N)</u>
ALL	FORT SMITH HMA LLC, GA 30384	Y
ALL	RESTAT LLC, WI 53224	Y
ALL	ST EDWARD MERCY MEDICAL CENTER, MO 63150	Y
ALL	IMWELL HEALTH LLC	N
ALL	COORPER CLINIC PA, AR 72917	Y
ALL	LITTLE ROCK DIALYSIS INC, AR 72221	Y
ALL	WASHINGTON REGIONAL MEDICAL CENTER, AR 72703	Y
ALL	NMHC RX	N
ALL	ST EDWARD MERCY CLINIC INC, MO 63150	Y
ALL	PLATTE DIALYSIS LLC, PA 19178	N
ALL	AIR EVAC LIFETEAM, MO 65775	Y
ALL	UAMS, AR 72225	Y
ALL	BOSTON HEART LAB, MA 01702	N
ALL	VAN BUREN HMA, GA 30384	Y
ALL	ARKANSAS CHILDREN'S HOSPITAL, AR 72203	Y
ALL	FORT SMITH HMA PBC MGMT LLC, GA 30384	Y
ALL	FORT SMITH PHYSICIAN MGMT LLC, AR 72908	Y
ALL	HEALTH DIAGNOSTIC LABORATORY INC., VA 23219	N
ALL	FORT SMITH MEDICAL CENTER PLLC, ME 04915	Y
ALL	CISTERNA EMERGENCY PHYSICIANS, PA 19101	Y
ALL	MAYO CLINIC ROCHESTER, MN 55480	N
ALL	KEYSTONE MEMPHIS LLC, TN 38125	Y
ALL	NORTHWEST ARKANSAS HOSPITALS LLC, AR 72764	Y
ALL	FORT SMITH RHEUMATOLOGY PC, AR 72917	Y
ALL	SURE HAVEN INC, CA 92626	N
ALL	MAYO CLINIC – ST. MARYS HOSPITAL, MN 55480	N
ALL	RADIOLOGISTS PA, AR 72913	Y
ALL	LABORATORY MEDICINE ASSOC, AR 72902	N
ALL	JOHNSON DERMATOLOGY CLINIC, AR 72916	Y
ALL	TREASURE COAST RECOVERY, CA 91189	N
ALL	EASTSIDE OBGYN PLLC, AR 72903	Y
ALL	HCA HEALTH SERVICES OF TN, GA 30387	N
ALL	SEQUOYAH MEMORIAL HOSPITAL, OK 74955	Y
ALL	BAPTIST HEALTH, TX 75284	N
ALL	WESTERN AR ANESTHESIOLOGY ASSOC, AR 72913	Y
ALL	ARKANSAS PAIN AND WELLNESS, AR 72901	Y
ALL	FAYETTEVILLE VAMC, TN 37167	N
ALL	ADVANCED MONITORING SERVICES INC, AR 72703	N
ALL	VALLEY BEHAVIORIAL HEALTH, AR 72703	Y

<u>DIVISION</u>	<u>PROVIDER NAME, STATE, ZIP CODE</u>	<u>PPO (Y/N)</u>
ALL	SOUTHWEST LABORATORY LLC, TX 75204	N
ALL	STRATEGIC ANESTHESIA SERVICES LLC, TN 37229	Y
ALL	RGH ENTERPRISES INC, OH 44087	Y
ALL	TULSA SPINE SPECIALTY HOSPITAL, OK 74132	N
ALL	ARKANSAS HEART CENTER PLC, AR 72917	Y
ALL	PHILLIPS LANDING EMERGENCY PHYSICIANS, NV 89193	Y
ALL	MARSH MICHAEL A, AR 72902	Y
ALL	CHOCTAW NATION HEALTH CARE CTR, OK 74571	N
ALL	PHYSICIANS SPECIALTY HOSPITAL LLC, AR 72703	Y
ALL	HEALTHSOUTH OF FORT SMITH LLC, TX 75395	Y
ALL	THE DERMATOLOGY CENTER, AR 72745	N
ALL	WASHINGTON REGIONAL MEDICAL SYSTEM, AR 72745	Y
ALL	NORTHWEST AR ANESTHESIA SERVICES, PA 19178	Y
ALL	FORT SMITH EMERGENCY MEDICAL SERVICES, AR 72918	N
ALL	LASER SPINE SURGERY CTR OF OK LLC, OH 45263	N
ALL	LABORATORY CORPORATION OF AMERICA, NC 27216	Y
ALL	MD ANDERSON HOSPITAL, TX 77210	N
ALL	CHEROKEE NATION, OK 74182	N
ALL	PEDIATRIC PARTNERS, PA, AR 72901	Y
ALL	EYE GROUP LLC, AR 72901	Y
ALL	RADIOLOGY SERVICES, AR 72902	N
ALL	ADVANCED INTERVENTIONAL PAIN & DIAG., AR 72903	Y
ALL	KRISTIN R ROLLER, AR 72703	Y
ALL	POUDRE VALLEY HEALTH CARE INC, TX 75373	N
ALL	MEDEXPRESS URGENT CARE ARKANSAS PA, ME 04915	Y
ALL	STEPHEN K MAGIE MD, AR 72205	Y
ALL	SCAUP INPATIENT SERVICES LLC, NV 89193	Y
ALL	CLEVELAND CLINIC FOUNDATION, OH 44195	N
ALL	BARNES JEWISH HOSPITAL, MO 63195	N
ALL	SEUBOLD FAMILY CHIROPRACTIC, OK 74954	N
ALL	FORT SMITH SLEEP LAB LLC, AR 72901	Y
ALL	POINTER TRAIL FAMILY CLINIC, AR 72956	Y
ALL	PHOENIX ANESTHESIA PA, AR 72917	Y
ALL	CLINICAL PARTNERS PA, TX 75606	Y
ALL	TAHLEQUAH CITY HOSPITAL, OK 74465	Y
ALL	JOHN C WHITAKER, AR 72903	Y
ALL	PREMIER ANESTHESIA OF AR, TX 75267	Y
ALL	ST JOHN MEDICAL CTR, OK 74104	Y
ALL	FORT WALTON BEACH MED. CTR INC., GA 30384	N
ALL	LABONE INC, KS 66219	Y
ALL	EASTERN OK MED CTR, OK 74953	Y
ALL	MINIMED DISTRIBUTION CORP, IL 60693	N
ALL	SKY TOXICOLOGY, TX 77210	N
ALL	W AR PLASTIC & RECONSTRUC. SURG. CTR, AR 72917	Y
ALL	JAMES BLAIR BLANKENSHIP MD PA, AR 72703	Y
ALL	JAMES ELLIS DDS, AR 72903	N
ALL	FORT SMITH ORAL & MAXILLOFACIAL SURG., AR 72903	Y

<u>DIVISION</u>	<u>PROVIDER NAME, STATE, ZIP CODE</u>	<u>PPO (Y/N)</u>
ALL	MEDICAL ASSOC OF NW AR, AR 72701	Y
ALL	HAMBY & HAMBY FAMILY MED. CLINIC, AR 72956	Y
ALL	DR ROGER R BULLINGTON, AR 72903	Y
ALL	OPNET, AZ 85002	N
ALL	SOUTH CENTRAL, AR 72901	N
ALL	OZARK REGIONAL VEIN CTR LLC, KS 67201	Y
ALL	TRANHAM MEDICAL SVCS, TX 75389	N
ALL	BALKMAN CHIROPRACTIC CLINC, AR 72903	Y
ALL	DRS SCOTT & BETTY JO CLARK, AR 72903	N
ALL	LAVACA WELLNESS CLINIC PA, ME 04915	N
ALL	SHIPLEY & SILLS FAMILY PRACTICE PLLC, AR 72903	N
ALL	TRUE HEALTH DIAGNOSTICS LLC, TX 75033	N
ALL	VISTA HEALTH, AR 72703	Y
ALL	MYRIAD GENETIC LAB, UT 84108	N

XIV. QUESTIONNAIRE – SELF-INSURED MULTIPLE EMPLOYER TRUST

Plan Design

1. **Can the City offer its employees more than one medical plan design option to choose from?**
No.
2. **If the medical plan is selected, must the City also offer the basic term life and AD&D coverage, or can that be placed with another carrier.**
No, optional benefits are priced separately.
3. **If the medical plan is selected, must the City also offer the optional dental, vision or disability income plans, or can those coverages be placed with another carrier.**
No, those coverages can be placed with another carrier.
4. **Can a City such as Fort Smith elect to design its own medical benefits, or must it adopt one of the current plan design options entirely.**
The City must adopt one of the current plan design options.
5. **What has been the practice of the Trust in the past when the limits placed on benefits work to leave an individual participant with an unmanageable medical cost exposure (i.e., a lengthy in-hospital stay)?**
In addition to MHBF making every effort to work with providers to obtain the best rates available, every member has the opportunity to appeal benefit and policy decisions to the Board of Trustees. Information regarding the appeal process can be found in Section 8 of the Fund Booklet.

Fund Operation

1. **Are initially proposed “rates” (accruals) a guarantee of maximum cost, or an estimate that may be adjusted periodically during a plan year as claim experience occurs?**
Claims experience and client rates are reviewed two times per year and adjustments may be effective in July or January of a given plan year.
2. **How often may the Trust adjust accrual rates?**
Two times per year if necessary.
3. **As a City participates in the Trust over time, is there an accumulation of funding to cover the IBNR reserve required to pay terminal administration and claim cost following a subsequent termination of participation within the Trust?**
Yes.
4. **At the end of each accounting period, how are deficits and surpluses handled? Is the City required to fund any accumulated deficit (including additional IBNR reserve funding)? Is the City refunded surplus plan revenue?**
At the end of each accounting period, the Plan may adjust future rates to offset deficits. Surpluses are entered into a reserve designated for the City that is used to offset potential

deficits and stabilize rates. The City is not required to fund any accumulated deficit, nor is the City refunded surplus revenue.

- 5. If a City elects to terminate participation in the Trust while in a deficit position, what residual costs are assessed? Deficits? Claim run-out? If termination occurs while a City is in a surplus position, will the surplus be refunded to the City?**

If the City elects to terminate participation while in a deficit position, no costs are assessed. If termination occurs while a City is in a surplus position, the surplus will be maintained by the Trust and available in the event that the City returns to the Fund.

- 6. To what extent might a City be required to subsidize other Trust participating employers during a period when the City's medical plan cost are better than expected with the Trust in general, or several Cities in particular, operate at a deficit?**

The Trust maintains a large reserve which has expanded due to investment strategies over time which currently prevents a City's surplus funds from being used to offset another City's deficits.

PPO Network

- 1. The City has a significant number of plan participants who live in Oklahoma and seek medical care there. In such cases, how does the PPO network provide in-network access to such employees?**

MHBF will make every effort to extend contracts to providers in a region where a City's employees reside. If a provider chooses not to participate in the MHBF's network, MHBF utilizes a wrap-around network (Multiplan) to price claims with providers outside the scope of the MHBF network.

- 2. Does the PPO network include a Centers of Excellence feature for organ transplants and other major occurrences?**

Yes, MHBF currently has five transplant centers in the Preferred Provider Network.

XV. ATTACHMENTS

CENSUS DATA: The census of plan participants is available upon request.

SPD – Medical and Dental (see Bid Solicitation section on City's website.)

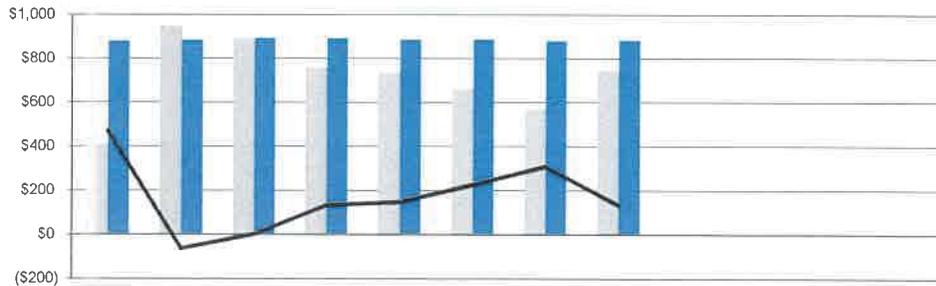
MHBF's proposal included with the Questionnaire includes Medical, Dental, Life and AD&D, and Vision Coverage options.

Carrier: Meritain Health
Specific Deductible: \$200,000
Contract Type: 24/12
Plan Year: 1/1/2016 - 12/31/2016

Paid Month	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Year-to-Date		
													Total	PEPM	
Enrollment															
Subscribers	830	827	819	820	825	824	830	828	0	0	0	0	6,603		
Members ⁽¹⁾	1,560	1,556	1,541	1,548	1,555	1,555	1,564	1,558	0	0	0	0	12,437		
Claim Payments															
Medical Claims	\$258,262	\$513,409	\$423,761	\$440,947	\$416,834	\$348,179	\$272,804	\$456,657	\$0	\$0	\$0	\$0	\$3,130,853	\$474.16	
Pharmacy Claims	\$8,834	\$188,749	\$225,519	\$103,751	\$103,433	\$115,805	\$106,392	\$87,587	\$0	\$0	\$0	\$0	\$940,070	\$142.37	
Claims Administration	\$1,753	\$9,047	\$9,897	\$5,701	\$17,140	\$14,035	\$23,411	\$35,713	\$0	\$0	\$0	\$0	\$116,697	\$17.67	
Claims Over-Specific	\$0	\$0	\$0	\$0	\$0	(\$4,441)	(\$303)	(\$32,411)	\$0	\$0	\$0	\$0	(\$37,156)	(\$5.63)	
Total Net Claim Payments	\$268,850	\$711,205	\$659,177	\$550,399	\$537,407	\$473,578	\$402,304	\$547,545	\$0	\$0	\$0	\$0	\$4,150,464	\$628.57	
Fixed Costs															
Administrative Fees	\$28,884	\$28,780	\$28,501	\$28,536	\$28,710	\$28,675	\$28,884	\$28,814	\$0	\$0	\$0	\$0	\$229,784	\$34.80	
Stop Loss Premiums	\$37,790	\$37,672	\$37,224	\$37,410	\$37,580	\$37,594	\$37,870	\$37,658	\$0	\$0	\$0	\$0	\$300,797	\$45.55	
Estimated TRF ⁽²⁾	\$3,735	\$3,722	\$3,686	\$3,690	\$3,713	\$3,708	\$3,735	\$3,726	\$0	\$0	\$0	\$0	\$29,714	\$4.50	
Total Fixed Costs	\$70,409	\$70,173	\$69,411	\$69,636	\$70,002	\$69,977	\$70,489	\$70,198	\$0	\$0	\$0	\$0	\$560,295	\$84.85	
Total Plan Cost	\$339,258	\$781,378	\$728,588	\$620,035	\$607,409	\$543,555	\$472,792	\$617,743	\$0	\$0	\$0	\$0	\$4,710,760	\$713.43	
Budget Comparison															
Budgeted Cost	\$729,828	\$729,828	\$729,828	\$729,828	\$729,828	\$729,828	\$729,828	\$729,828	\$0	\$0	\$0	\$0	\$5,838,623	\$884.24	
Actual Cost	\$339,258	\$781,378	\$728,588	\$620,035	\$607,409	\$543,555	\$472,792	\$617,743	\$0	\$0	\$0	\$0	\$4,710,760	\$713.43	
Variance from Actual	\$390,570	(\$51,550)	\$1,240	\$109,792	\$122,419	\$186,272	\$257,036	\$112,085	\$0	\$0	\$0	\$0	\$1,127,863	\$170.81	

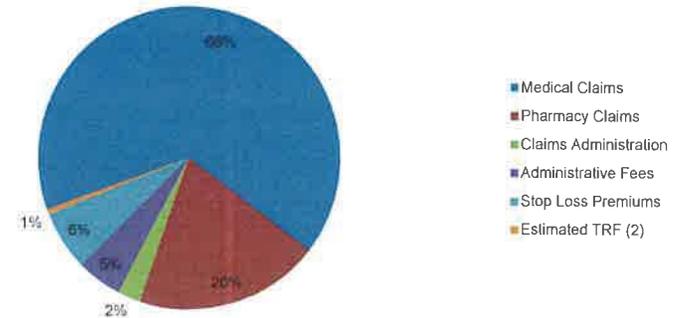
(1) Medical Membership count is estimated based on an average factor of 1.5 dependents per EC coverage tier and 2.5 dependents per EF coverage tier.
(2) Estimated Transitional Reinsurance Fee is based on \$2.25 PMPM towards 2015 PPACA Fees. This does not represent actual amounts owed.

Budget Comparison PEPM



	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16
Actual Cost	\$409	\$945	\$890	\$756	\$736	\$660	\$570	\$746	\$0	\$0	\$0	\$0
Budgeted Cost	\$879	\$883	\$891	\$890	\$885	\$886	\$879	\$881	\$0	\$0	\$0	\$0
Variance	\$471	(\$62)	\$2	\$134	\$148	\$226	\$310	\$135				

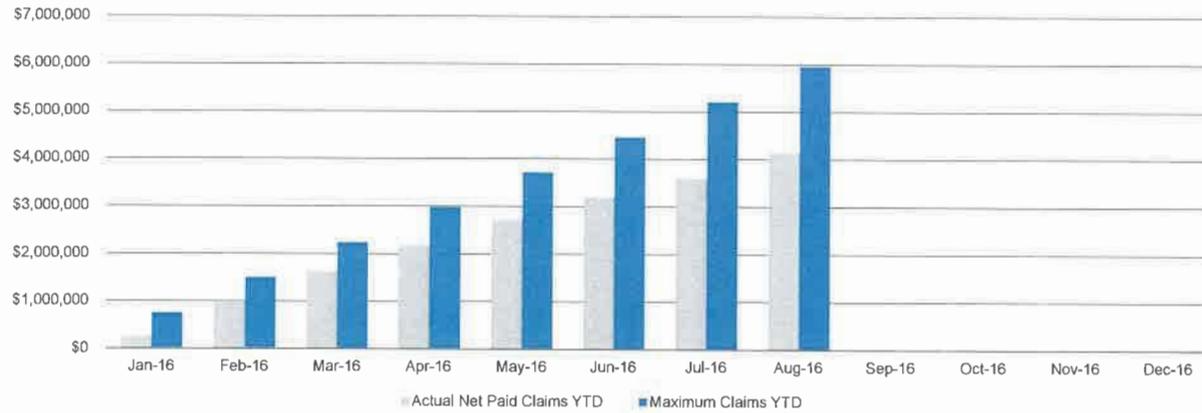
Combined Plan Expenses



Carrier: Meritain Health
Specific Deductible: \$200,000
Contract Type: 24/12
Plan Year: 1/1/2016 - 12/31/2016

Paid Month	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Year-to-Date	
													Total	PEPM
Enrollment														
Subscribers	830	827	819	820	825	824	830	828	0	0	0	0	6,603	
Aggregate Stop Loss														
Actual Net Paid Claims	\$268,850	\$711,205	\$659,177	\$550,399	\$537,407	\$473,578	\$402,304	\$547,545	\$0	\$0	\$0	\$0	\$4,150,464	\$628.57
Maximum Claims	\$747,769	\$745,450	\$736,549	\$740,312	\$743,633	\$743,947	\$749,399	\$745,136	\$0	\$0	\$0	\$0	\$5,952,194	\$901.44
Maximum vs. Actual	36.0%	95.4%	89.5%	74.3%	72.3%	63.7%	53.7%	73.5%	0.0%	0.0%	0.0%	0.0%	69.7%	

Maximum vs. Aggregate Claims YTD





Carrier: Meritain Health
Specific Deductible: \$200,000
Contract Type: 24/12
Plan Year: 1/1/2016 - 12/31/2016

Claimant	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Total	Expected Reimbursement
1	\$0	\$0	\$0	\$115,204	\$59,475	\$29,762	\$303	\$32,411					\$237,156	\$37,156
2 *	\$0	\$0	\$0	\$0	\$0	\$0	\$158,317	\$25,593					\$183,910	\$0
3	\$0	\$0	\$0	\$0	\$0	\$0	\$139,914	\$16,716					\$156,630	\$0
Total	\$0	\$0	\$0	\$115,204	\$59,475	\$29,762	\$298,534	\$74,720					\$577,696	\$37,156
Claimants above \$100,000	0	0	0	1	1	1	3	3					3	

* This Claimant Has A Specific Limit Of \$300,000.00

Carrier: Meritain Health
Plan Year: 1/1/2016 - 12/31/2016

Paid Month	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Year-to-Date		
													Total	PEPM	
Enrollment															
Subscribers	919	921	912	911	915	915	1,125	916	0	0	0	0	7,534		
Claim Payments															
Dental Claims	\$36,546	\$51,482	\$45,438	\$47,685	\$51,323	\$32,382	\$35,709	\$39,689	\$0	\$0	\$0	\$0	\$340,255	\$45.16	
Total Net Claim Payments	\$36,546	\$51,482	\$45,438	\$47,685	\$51,323	\$32,382	\$35,709	\$39,689	\$0	\$0	\$0	\$0	\$340,255	\$45.16	
Fixed Costs															
Administrative Fees	\$965	\$967	\$958	\$957	\$961	\$961	\$1,181	\$962	\$0	\$0	\$0	\$0	\$7,911	\$1.05	
Total Plan Cost	\$37,511	\$52,449	\$46,396	\$48,642	\$52,284	\$33,342	\$36,891	\$40,651	\$0	\$0	\$0	\$0	\$348,166	\$46.21	
Budget Comparison															
Budgeted Cost	\$54,275	\$54,275	\$54,275	\$54,275	\$54,275	\$54,275	\$54,275	\$54,275	\$0	\$0	\$0	\$0	\$434,199	\$57.63	
Actual Cost	\$37,511	\$52,449	\$46,396	\$48,642	\$52,284	\$33,342	\$36,891	\$40,651	\$0	\$0	\$0	\$0	\$348,166	\$46.21	
Variance from Actual	\$16,764	\$1,826	\$7,879	\$5,633	\$1,991	\$20,932	\$17,384	\$13,624	\$0	\$0	\$0	\$0	\$86,034	\$11.42	

Budget Comparison PEPM





Arthur J. Gallagher & Co.

This analysis is for illustrative purposes only, and is not a guarantee of future expenses, claims costs, managed care savings, etc. There are many variables that can affect future health care costs including utilization patterns, catastrophic claims, changes in plan design, health care trend increases, etc. This analysis does not amend, extend, or alter the coverage provided by the actual insurance policies and contracts.

Please see your policy or contact us for specific information or further details in this regard.