THE UNIVERSITY OF TEXAS SYSTEM

REQUEST FOR PROPOSALS

FOR

ADMINISTRATIVE SERVICES

FOR THE

SELF-FUNDED UT SELECT PPO PLAN

TO BE EFFECTIVE

SEPTEMBER 1, 2013

[This Page Intentionally Left Blank]

TABLE OF CONTENTS

APPENDICES

1.0 INTRODUCTION AND OVERVIEW

1.1 DESCRIPTION OF THE UNIVERSITY OF TEXAS SYSTEM

The Texas Constitution of 1876 provided that "the Legislature shall, as soon as practical, establish, organize and provide for maintenance, support and direction of a university of the first class, to be located by vote of the people of this State, and styled 'The University of Texas.'" In 1881, the 17th Texas Legislature passed an act to establish The University of Texas. Later that year, voters determined that the Main System was to be located in Austin and the Medical School was to be located in Galveston.

Today, The University of Texas System (System) includes nine (9) academic institutions in Arlington, Austin, Brownsville, Dallas, Edinburg (Pan American), El Paso, Odessa (Permian Basin), San Antonio and Tyler, plus six (6) health institutions in Dallas, Galveston, Houston (2), San Antonio and Tyler. In addition, the main System Administration office is located in Austin; however, many of the operations of System Administration are decentralized and therefore located in numerous areas of Texas, as well as in Washington, D.C. Most institutions have their own payroll systems.

The System has approximately 88,000 benefits-eligible employees and close to 20,300 benefits-eligible retired employees. The following table shows the location and the approximate number of benefits-eligible employees and retired employees associated with each institution in the System as of July, 2012.

THE UNIVERSITY OF TEXAS SYSTEM			
Location	**The University of Texas System Institutions**	**Benefits-Eligible Employees July 2012**	**Benefits-Eligible Retired Employees July 2012**
Austin	The University of Texas at Austin	17,005	4,551
	The University of Texas System Administration	565	263
Brownsville	The University of Texas at Brownsville	1,126	233
Dallas	The University of Texas at Arlington	3,899	1,009
	The University of Texas at Dallas	3,231	523
	The University of Texas Southwestern Medical Center at Dallas	11,410	1,390
Edinburg	The University of Texas – Pan American	1,743	441

El Paso	The University of Texas at El Paso	3,088	728
Galveston	The University of Texas Medical Branch at Galveston	10,702	4,028
Houston	The University of Texas Health Science Center at Houston	5,357	1,381
	The University of Texas M.D. Anderson Cancer Center	18,791	2,784
Odessa	The University of Texas of the Permian Basin	333	99
San Antonio	The University of Texas at San Antonio	3,729	663
	The University of Texas Health Science Center at San Antonio	5,453	1,441
Tyler	The University of Texas at Tyler	738	204
	The University of Texas Health Science Center at Tyler	854	593
	TOTAL	**88,024**	**20,331**

Although the majority of employees of The University of Texas Medical Branch (UTMB) are in the Galveston area, UTMB also has employees in the central and eastern parts of Texas who are involved with providing medical care to prisoners at state prisons located in those areas. The University of Texas at Austin also has staff members at a marine biology center in Port Aransas and at an astronomical observatory in Fort Davis. A small number of employees from various institutions also either reside or work outside of Texas. Additionally, although most retired System employees reside in Texas, there are a number of retired employees who live in other states or countries.

1.2 Summary of Current Benefit Plans

At the start of the current plan year, there were approximately 108,350 employees and retired employees plus approximately 105,400 dependents participating in benefit plans through the System's Uniform Group Insurance Program, a key component of the UT Benefits package which includes insurance, retirement, and wellness programs. In addition, there are approximately 1,600 COBRA participants continuing coverage in various health plans within the program. The System offers a self-funded, preferred provider (PPO) health plan (UT SELECT) for eligible participants. Approximately 103,000 employees, retired employees, and COBRA subscribers along with more than 77,000 dependents were covered by UT SELECT during July 2012. UT SELECT medical benefits are currently administered by Blue Cross and Blue Shield of Texas, and prescription benefits are currently administered by Express Scripts, Inc. (Express Scripts), formerly Medco Health Solutions.

The System's "Living Well" program, a comprehensive health and wellness initiative available to all UT SELECT participants, is integrated with both the medical and prescription plans. As part of the UT

Benefits program, the System also currently offers the following optional benefit plans: a self-funded dental PPO plan (UT SELECT Dental) currently administered by Delta Dental, a fully insured PPO supplemental plan (UT SELECT Dental Plus) issued by Delta Dental, a fully insured dental health maintenance organization currently operated by Delta Dental, voluntary group term life and accidental death and dismemberment insurance currently issued by Dearborn National, dependent group term life and accidental death and dismemberment insurance currently issued by Dearborn National, short- and long-term disability coverage currently issued by Dearborn National, vision care coverage consisting of both a standard and an enhanced benefits plan currently issued by Superior Vision, flexible spending accounts for both health and dependent day care expenses currently administered by PayFlex Inc., and long term care insurance currently issued by CNA. Participation in these optional benefit plans is voluntary, and the premiums are generally paid solely by the participating employees and retired employees.

The System's Office of Employee Benefits (OEB) is located at the System's headquarters in Austin, Texas, and has responsibility for the oversight of all fully-insured and self-funded benefit plans provided as part of the UT Benefits program. Maximizing the benefits and services that eligible System employees, retired employees, and their covered dependents receive for each dollar spent on benefits is a primary objective for OEB.

1.3 OBJECTIVES OF THIS REQUEST FOR PROPOSAL (RFP)

Section 1601.054 of the Texas Insurance Code requires the System to submit for competitive bidding at least once every six years each of its group insurance plan agreements, including agreements for the administration of self-funded plans. Accordingly, as described in this Request for Proposal (RFP), System is soliciting proposals from qualified and appropriately licensed vendors to provide administrative, claims processing, network management and utilization review services for the self-funded UT SELECT PPO, for the three-year period beginning September 1, 2013, through August 31, 2016, with the opportunity at System's sole option to renew for an additional three-year period, subject to terms and conditions acceptable to the System.

It is the System's intention to have a signed contract in place and to begin implementation planning by January 9, 2013.

2.0 GENERAL INFORMATION AND REQUIREMENTS

2.1 CONFLICT OF INTEREST

No member of the System Board of Regents or System employees (including the Chancellor, Executive Vice Chancellor for Business Affairs, Assistant Vice Chancellor for Employee Benefits and Services, and Office of Employee Benefits management) may have any direct interest in the awarding of the Contract or any indirect conflict of interest involving the vendor, including but not limited to any financial interest.

2.2 NONRESPONSIVE PROPOSALS

The System will not accept for consideration any proposal that does not comply with the criteria set forth herein. Failure to address any of the RFP requirements may result in rejection of a proposal.

2.3 REPRESENTATIONS BINDING

Representations made within the proposal will be binding on the vendor. The System will not be bound to act by any previous communication or by any nonconforming proposal submitted by a vendor.

2.4 NONDISCRIMINATORY PRACTICE

A vendor shall not discriminate by excluding, seeking to exclude, or otherwise restricting services or benefits on the basis of gender, race, national origin, religion, age, sexual orientation, veteran status, disability, or pregnancy.

2.5 BINDING ARBITRATION CLAUSE EXCLUSION

Each proposal must specify that the vendor will not impose a binding arbitration requirement upon a plan participant. Any proposal containing a requirement that plan participants must agree to engage in binding arbitration will not be accepted by the System.

2.6 MODIFICATION PROHIBITED

No proposal may be changed, amended, or modified after submission to the System except to correct an inadvertent error.

2.7 EXEMPTION FROM STATE TAXES

Coverages provided by the System are exempt from state premium and maintenance taxes.

2.8 VENDOR INITIATED CHANGES

The vendor shall notify the System prior to implementing material changes in policies, business practices, and key personnel on the System account management team.

2.9 PARTICIPANT IDENTIFICATION AND CONFIDENTIALITY OF SOCIAL SECURITY NUMBERS

System issues a unique eight-character alphanumeric Benefits ID (BID) as the primary reference ID used to identify plan subscribers and their dependents (collectively referred to herein as "participants") that is used across all benefit plans offered by the System, including the UT SELECT PPO. The vendor must be able to identify a participant and the participant's coverage using the BID. The BID shall be the preferred identifier for use in telephone communication, unencrypted electronic communication, and printed reports referencing specific participants.

Vendors must be able to comply with all federal and Texas state legislation, as well as System policy, applicable to the protection and use of confidential data, which includes Social Security numbers. The vendor must be able to coordinate with System to fully comply with all applicable laws and System policies relating to the security, protection and use of plan participants' personally identifiable information. All System data must be encrypted whenever transmitted over the Internet.

2.10 COMPLIANCE WITH LEGAL REQUIREMENTS AND FUTURE CHANGES

All proposals must comply with all currently applicable state and federal laws and regulations including, but not limited to, rules promulgated by the Texas Department of Insurance.

The requirements of applicable laws and regulations, as well as future program appropriations made by the Texas Legislature, are subject to change and such changes may affect overall plan design and/or administrative responsibilities. The System requires a good faith effort on the part of the vendor to comply with any additional responsibilities imposed by changes in state or federal laws or regulations, or by future court or administrative rulings, without requiring midyear administrative fee increases.

Vendors must agree to collaborate with the System to effect necessary changes and to execute any agreement that may be required as a result. Should a mandated change materially affect the vendor's obligations under the Contract, the System reserves the right to negotiate with the vendor regarding any administrative fee adjustment that may be appropriate under the circumstances, as provided in the Contract.

2.11 SYSTEM'S HISTORICALLY UNDERUTILIZED BUSINESS (HUB) PROGRAM

The System is committed to providing full and equal opportunity for all businesses to provide goods and services needed in support of the System's missions. The System's Historically Underutilized Business (HUB) Program formalizes the System's commitment to carry out this effort. The HUB program ensures compliance with state HUB laws and serves to educate both the university and business communities about the benefits of using HUB vendors. In all contracts entered into for professional services, contracting services, or commodities with an expected value of $100,000 or more, the purchase solicitation must indicate whether the System has determined that subcontracting opportunities are probable in connection with the contract. If so, a HUB Subcontracting Plan is a required element of the vendor response to this RFP.

2.11.1 SUBCONTRACTING OPPORTUNITIES DETERMINATION

System has reviewed this RFP in accordance with Title 34, Texas Administrative Code, Section 20.13 (a), and has determined that subcontracting opportunities are probable under this RFP. As identified by the System Office of HUB Development, the HUB Goal for this RFP is 24.6% percent.

For specific questions regarding the HSP, please submit questions through the RFP website and questions will be directed to the UT System Office of HUB Development.

2.11.2 HUB SUBCONTRACTING PLAN (HSP) REQUIRED FOR CONSIDERATION

A HUB Subcontracting Plan ("HSP") is required as part of vendor's proposal. The HSP will be developed and administered in accordance with System's Policy on Utilization of Historically Underutilized Businesses, attached as Appendix I to this RFP, and incorporated for all purposes.

Each vendor must complete and return the HSP in accordance with the terms and conditions of this RFP, including System's Policy on Utilization of Historically Underutilized Businesses. Vendors that fail to do so will have their proposals considered nonresponsive to this RFP in accordance with Section 2161.252, Texas Government Code.

The Contractor will not be permitted to change its HSP unless: (1) the Contractor completes a newly modified version of the HSP in accordance with the terms of System's Policy on Utilization of Historically Underutilized Businesses that sets forth all changes requested by the Contractor, (2) the Contractor provides System with such a modified version of the HSP, (3) System approves the modified HSP in writing, and (4) all agreements or contractual arrangements resulting from this RFP are amended in writing by System and the Contractor to conform to the modified HSP.

2.11.3 GOOD FAITH EFFORT REQUIRED

All agencies of the State of Texas are required to make a good faith effort to assist historically underutilized businesses (each a "HUB") in receiving contract awards. The goal of the HUB program is to promote full and equal business opportunity for all businesses in contracting with state agencies. Pursuant to the HUB program, if under the terms of any agreement or contractual arrangement resulting from this RFP the Contractor subcontracts any of the services to be provided, then the Contractor must make a good faith effort to utilize HUBs certified by the Procurement and Support Services Division of the Texas Comptroller of Public Accounts. Proposals that fail to comply with the requirements contained in this section will constitute a material failure to comply with advertised specifications and will be rejected by System as nonresponsive.

Additionally, compliance with good faith effort guidelines is a condition precedent to awarding any agreement or contractual arrangement resulting from this RFP. Proposing vendor acknowledges that, if selected by System, its obligation to make a good faith effort to utilize HUBs when subcontracting any part of the services to be provided in connection with this RFP will continue throughout the term of all agreements and contractual arrangements resulting from this RFP. Furthermore, any subcontracting of such services by the vendor is subject to review by System to ensure compliance with the HUB program.

2.11.4 MANDATORY REQUIREMENTS FOR HSP SUBMISSION

Each vendor must submit to the System three (3) original copies of the HSP along with, but packaged separately from, its complete proposal. The three (3) originals of the HSP must be submitted under separate cover in a clearly marked envelope (the "HSP Envelope") that is attached to the outside of the box containing the other proposal materials submitted by the vendor or must otherwise be provided contemporaneously with the other proposal materials. The top outside surface of the HSP Envelope when attached to the exterior of the packaging for the vendor's other proposal materials must clearly show:

- the RFP title (as noted on the cover page) and the Submittal Deadline, both marked in the lower left hand corner of the front of the envelope,
- the name and return address of the proposing vendor, and,
- the phrase "HUB Subcontracting Plan."

It is the vendor's sole responsibility to ensure that the HSP arrives concurrently with the other proposal materials as specified above. System will open a vendor's HSP Envelope prior to opening the proposal submitted by the vendor, to ensure that the vendor has submitted the number of completed and signed originals of the vendor's HSP that are required.

A vendor's failure to submit the required number of completed and signed originals of the HSP will result in rejection of the proposal as nonresponsive due to material failure to comply with

advertised specifications; without exception, any such proposal will be returned to the vendor unopened.

Note: The requirements regarding submission of the HSP outlined above are separate from and do not affect a vendor's obligation to provide the specified number of copies of the complete proposal as specified elsewhere within this RFP.

2.12 USE OF SUBCONTRACTORS

Any planned or proposed use of subcontractors by the vendor must be clearly disclosed and documented in the submitted proposal and agreed to by the System. The vendor shall be completely responsible for all services performed and for the fulfillment of its obligations under the Contract, even if such services are delegated to a subcontractor. Any proposal to utilize subcontracting must be addressed in the vendor's Subcontracting HUB Plan, as described in a separate section.

2.13 HIPAA AND PRIVACY POLICY COMPLIANCE

The UT SELECT Medical plan is a Covered Entity that is required to comply with all applicable provisions of the Health Insurance Portability and Accountability Act, codified at 42 USC § 1320d through d-8 (HIPAA), and any regulations, rules, and mandates pertaining to the HIPAA privacy and security rules, as well as with any applicable state medical privacy requirements. The vendor will also be required to comply with System's privacy and applicable information technology security policies. The vendor contract includes a Business Associate Agreement that the vendor will be required to sign. In response to the related interrogatories included in Section 12.0 of this RFP, the vendor must describe in detail its HIPAA Privacy and Security programs as well as its information security program.

2.14 CONTINUATION OF COVERAGE (COBRA)

As specified by Title XXII of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), the System institutions will notify employees, spouses and qualified dependent children of their option to continue their group health coverage at the time of initial enrollment. The System institutions also notify any individual who, because of a qualifying event, becomes eligible for continuation of coverage and provide COBRA applications to such individuals. If an individual chooses to continue coverage, it is individual's responsibility to complete the COBRA application and to send it and applicable premium payment directly to the group health plan's COBRA administrator.

The vendor will serve as the COBRA administrator and will be required to work with the System to administer benefits to COBRA participants to ensure System compliance with its COBRA obligations, including providing monthly direct billing services and notification to COBRA subscribers at least 180 days prior to the date that the continuation of coverage will terminate. Premiums for COBRA coverage will be set at 102% of the active employee premium rate, with premiums under the disability extension set at 150% of the active employee premium. The vendor must provide COBRA enrollment data to the

System on at least a weekly basis, in a format specified by System. COBRA premiums are to be remitted to System monthly and accompanied by an electronic remittance dataset that meets the requirements described in this RFP. In the Spring of 2013, System will implement a central retired employee billing process. Through this new initiative, OEB may determine it is appropriate to also centralize COBRA administration at which point this function would be removed from the vendor's administrative function at a date to be determined in the future.

The vendor may subcontract the administration of the COBRA program. However, the vendor will continue to be responsible for compliance with the Contract executed on the basis of this RFP and for meeting all requirements under applicable federal law.

2.15 TERM OF ACCEPTANCE

It is the intent of the System, at this time, to enter into a three-year contract for administration of the UT SELECT PPO beginning September 1, 2013. At the System's option, this Contract may be renewed for an additional three-year period beginning September 1, 2016, subject to terms and conditions acceptable to the System.

2.16 RESERVATION OF RIGHTS

2.16.1 ADDITIONAL INFORMATION

System reserves the right to request additional documentation and vendor agrees to provide the information requested.

2.16.2 VALIDATION OF PROPOSAL MATERIALS

The System reserves the right to audit and validate all materials and responses submitted with the vendor's proposal.

2.16.3 REJECTION OF PROPOSALS

The System retains the right to reject any or all proposals submitted and to call for new proposals.

2.16.4 VENDOR NEGOTIATIONS

The System reserves the right to enter into discussions and negotiations with one or more vendors selected at its discretion to determine the best and final terms. The System is not under obligation to hold these discussions or negotiations with each vendor that submits a proposal.

2.16.5 REVISION OF PROVISIONS

The System specifically reserves the right to revise any or all RFP or Contract provisions set forth at any time prior to the System's execution of a Contract.

2.16.6 EXECUTION OF CONTRACT

The System is under no legal obligation to execute a Contract on the basis of this RFP or upon receipt of a proposal.

2.17 REFERENCES

Each vendor must provide a list of current major customers, as requested in this RFP. These customers may be contacted by the System to provide information regarding the vendor's overall record of service in providing the program for their employees.

The provision of references by the vendor shall constitute verification that the System has the vendor's permission to contact these organizations and obtain any required information without obtaining further permission from the vendor.

2.18 MATERIALS

A copy of materials to be used by the vendor in administering the UT SELECT benefits must be provided as requested in the section of this RFP dealing with communications requirements. The System retains the right to review and approve all such materials prior to distribution. The vendor is required to submit proposed marketing and other informational materials in the specified format and according to deadlines set by the System. The cost for preparation of such materials for the term of the Contract should be accounted for in the proposed administrative fees quoted by the vendor.

2.19 COMPENSATION FOR EXPENSES NOT AVAILABLE

Vendors shall submit proposals at their own expense. No compensation will be provided to vendors for expenses incurred for proposal preparation or demonstrations, unless otherwise expressly stated in writing by the System.

2.20 RETENTION OF PROPOSALS

Proposals and all materials submitted in response to this RFP become the sole property of the System and will not be returned to the vendors. During the evaluation process, the System shall make reasonable efforts as allowed by law to maintain proposals in confidence, and shall release proposals only to personnel involved with the evaluation of the proposals and implementation of the Contract unless otherwise required by law. Further information dealing with the confidential status and potential disclosure of proposal contents is included in a separate section.

2.21 CONFIDENTIAL STATUS AND DISCLOSURE OF PROPOSAL CONTENTS

As a state institution of higher education, the System is subject to the Texas Public Information Act ("the Act"), Chapter 552 of the Texas Government Code, and has no authority to enter into a

confidentiality agreement in contravention of the Act. In response to any public information requests under the Act that are submitted during the RFP process, the System shall deem and argue to the State Attorney General that during the bidding process all proposals submitted in response to the RFP are confidential under the Act. However, once the RFP process has concluded, this exception will no longer apply.

Vendors should be aware that the Texas Attorney General may determine that full or partial disclosure is required for information deemed to be confidential or proprietary by a vendor. It is the sole obligation of a vendor to advocate for the confidential or proprietary nature of any information provided in or along with its proposal. The System shall not advocate for the confidentiality of the vendor's material to the Texas Attorney General or to any other person or entity. Upon receipt of any public information request involving a submitted proposal after the conclusion of the RFP process, the System shall, pursuant to the Act, make a good faith effort to notify the vendor of the request.

For any such request, the vendor will be responsible for submitting written justification to the State Attorney General detailing why particular information should be withheld, such as the exception applicable to certain commercial information. To ensure its ability to claim exemption from the release of information contained in a submitted proposal, a vendor should clearly designate within its proposal and accompanying materials any information that it believes to be exempt from disclosure and provide legal justification for each instance.

Additionally, vendors should be aware that, pursuant to the Act, upon request from a member of the Legislature and where needed for legislative purposes, the System may be required to release a vendor's entire proposal, including information designated by the vendor to be confidential or proprietary. By submitting a proposal, a vendor acknowledges its understanding and agreement that System shall have no liability to the vendor or to any other person or entity for any disclosure of information made in accordance with the Act.

This section applies regardless of whether a contract is awarded as the result of this RFP.

2.22 News Releases and Public Communication

Written approval by the System will be required prior to the issuance of any news release or other public communication regarding any Contract awarded to a vendor. The contracting vendor must agree not to publicize the Contract or disclose, confirm or deny any details thereof to third parties or use any photographs or video recordings of the System's employees or use the System's name in connection with any sales promotion or publicity event without the prior express written approval of the System.

2.23 USE OF SYSTEM INFORMATION FOR SOLICITATION IS PROHIBITED

The vendor must explicitly agree never to use any information received from any source about System employees or retired employees for any marketing purpose or to solicit business of any other type. This agreement extends to all forms of discussions, advertisement, distribution, or other marketing by the vendor (or a parent or subsidiary) for coverage, products, or materials other than those explicitly relating to the vendor's services under the UT SELECT PPO, including the provision of such items to lists of System employees or retired employees obtained from other vendors contracting with System. This prohibition is also applicable to any use of the vendor's System-specific website. This prohibition continues subsequent to termination of the Contract.

2.24 AGENT OF RECORD

The System will not designate an Agent of Record or any other such company employee or commissioned representative to act on behalf of either the System or the vendor. Requests for the System to provide such designation shall be rejected. Vendors are specifically instructed to submit proposals directly to the System as specified herein in separate sections detailing HUB Subcontracting Plan submission requirements and overall proposal submission requirements. Proposals submitted through a third-party agent will not be accepted.

2.25 DEFINITIONS

For purposes of this RFP and any responses provided, the terms "employee," "dependent," "optional coverage," "retired employee," and "The University of Texas System" (System), shall have the same meaning as set forth in Chapter 1601 of the Texas Insurance Code. A copy of Chapter 1601 is included as Appendix G to this RFP. System reserves the right to define any other terms used in this RFP.

2.26 RESPONSES, ORDERING OF CONTENTS, DEVIATIONS

Proposals must concisely describe the vendor's ability to meet the requirements of the RFP. Emphasis should be on providing complete, clear responses that demonstrate an understanding of the requirements and of the System's needs. The content of all responses submitted must be ordered to correspond with the specifications as they appear in this RFP.

Unless a deviation is specifically noted in a response, it will be assumed that the vendor agrees to meet all specifications exactly as set forth in this RFP. Proposals containing deviations, items not called for herein, or irregularities of any kind are subject to disqualification at the System's option.

2.27 ENROLLMENT AND CLAIMS DATA

A variety of exhibits containing historical enrollment, financial, utilization and cost data for UT SELECT are included in the appendices to this RFP. Detailed information regarding how to interpret the data provided are also included.

In addition to the data exhibits provided, the appendices also include: (i) a recent enrollment file, (ii) a file containing recent UT SELECT claims to be re-priced by the vendor as described in Section 13 of this RFP, and (iii) a file containing five provider network-related exhibits which are to be completed by the vendor as described in Section 13 of this RFP.

2.28 CERTIFICATION

An authorized officer of a vendor submitting a proposal must certify that the proposal complies with the RFP specifications by completing the Signature Page included in this RFP and submitting the signed document with the original copy of vendor's complete proposal as specified.

2.29 SUBMISSION OF PROPOSALS

Only proposals submitted in compliance with the requirements listed in this subsection will be accepted by System.

- This RFP is available on the System's RFP website in both PDF and Word format. Vendors *must* use the Word version of the RFP to complete and include the following items with your submission:
    1) Detailed responses to each interrogatory;
    2) Indicate "Reviewed and Agreed" after each section of the RFP to confirm you have read and understand each portion of the RFP. If you are unable to indicate "Reviewed and Agreed" after each section, please explain under Interrogatory 1 Section 12.1 the reason you are unable to agree.
    3) Proposed administrative fees, reimbursement guarantees, and rebate guarantees; and
    4) The signature page, verifying the vendor's ability to meet all requirements.

- One (1) original proposal signed with blue ink and clearly marked "Original," and thirteen (13) identical copies of the proposal must be received by the System **on or before 3:00 p.m. (Central) on Friday, October 19, 2012**. The original and copies of the proposal should be delivered to:

    Laura C. Chambers, Director
    Office of Employee Benefits
    The University of Texas System
    702 Colorado Street, Suite 2.100
    Austin, Texas 78701-3043

- Vendors must submit three (3) complete electronic versions of the proposal on separate discs or USB drives, using either Microsoft Office or PDF format for all included documents. The discs/drives must be clearly labeled with the vendor name and the title of this RFP. All materials included in the printed binders must be included with the electronic versions, including exhibits and the separate HUB Subcontracting Plan submission.
- Proposals must be valid for one hundred twenty (120) days following the proposal receipt date.
- The proposed administrative fee must be firm and guaranteed for at least three (3) years beginning September 1, 2013, through August 31, 2016.
- A Table of Contents with sufficient detail (including page numbers) to facilitate easy reference to all sections of the proposal, as well as to separate attachments, must be included. Any supplemental items not requested in the RFP should be clearly identified as such in the Table of Contents and must be provided in a separate section(s) of the proposal from required items.
- All materials, other than the HUB Subcontracting Plan (HSP), must be submitted in sealed envelope(s), box(es), or container(s). The HSP must be affixed to the outside of the main proposal packaging so that it arrives along with the other proposal materials, but is separately accessible. Proposal packaging must clearly indicate the submittal deadline, the vendor's name, and the vendor's return address on the exterior.
- Under no circumstances will proposals received after the submission deadline be considered. Properly marked late proposals will be returned unopened at the vendor's expense. Unmarked late proposals will be held at the System Office of Employee Benefits for 30 days and then discarded.
- Proposals transmitted electronically, or by any means other than as specified in this section, will not be considered.

2.30 ADDENDA TO RFP, INQUIRIES REGARDING SPECIFICATIONS

Questions and comments regarding the RFP should be submitted as soon as possible and must be sent via email using the link on System's RFP website (**http://utdirect.utexas.edu/rfp/**) that has been established for this purpose.

Any response to an inquiry that alters an interpretation of, or requires a change to, this RFP will be posted as addenda on the RFP website. All vendors will be responsible for regularly checking this website for RFP addenda and other announcements. All addenda issued by the System prior to receipt of a proposal shall be considered part of the RFP. All vendors are required to acknowledge all of the addenda issued on the space provided on the Signature Page of this proposal.

To ensure that all replies can be provided to all prospective vendors prior to the deadline for submission of proposals, no questions received after 5:00 p.m. (Central) on **Tuesday, October 2, 2012,** will be considered or responded to by the System.

2.31 PRE-BID CONFERENCE VIA MICROSOFT LIVE MEETING FOR INTERESTED VENDORS

To provide representatives of interested vendors an opportunity to pose questions regarding the specifications and selection process, a pre-bid conference via Live Meeting for prospective respondents is scheduled to be held on **Friday, September 28, 2012, from 10:00 a.m. until noon, (Central)**. If you are interested in participating in this event, please register online at http://utdirect.utexas.edu/rfp.

Questions and comments should be submitted via the RFP website as described above and should be sent as much in advance of the teleconference as possible to allow time for the System to gather information as needed and to prepare complete responses prior to the teleconference. Following the teleconference, any remaining questions and comments must also be submitted via the RFP website.

System plans to conduct the pre-bid conference via Microsoft Live Meeting. Additional details regarding the conference will be provided in advance to those vendors that register to participate.

2.32 FINALIST INTERVIEW

Following the System's initial review of the RFP Proposals, if a vendor is selected as a finalist in the vendor selection process, the System may, at its sole option, request that personnel from the vendor, at the vendor's expense, attend a meeting at a System-designated location to clarify responses and to answer questions regarding the vendor's Proposal. If the System deems necessary, a site visit to the vendor may be conducted during the RFP review period at the System's expense.

3.0 IMPLEMENTATION TIMELINE

The dates below apply to key milestones during the implementation phase for the UT SELECT plan. Vendors will be required to meet the deadline listed below for submission of proposals. The vendor will be required to meet all deadlines as shown throughout the implementation process.

Request for Proposal (RFP) Issued	09/17/2012
Prospective vendor pre-bid conference	09/28/2012
Last date to submit written questions to the System	10/02/2012
Vendor proposals due to the System	10/19/2012
Target date for vendor selection	12/10/2012
Vendor implementation team designated and tasks assigned	12/15/2012
First planning meeting between the System and vendor	12/15/2012
Contracts finalized and signed	01/09/2013
Drafts of Annual Enrollment materials due to the System	04/01/2013
Drafts of new employee communication materials to the System	05/01/2013
Distribution deadline of Annual Enrollment materials to institutions	06/01/2013
Testing of automated transmission of claims data processing system and electronic Fee Billing Invoice	06/01/2013
System-specific vendor website available for testing	06/01/2013
Setup of SFTP procedures and authorizations for eligibility data exchange	06/19/2013
System-specific UT SELECT website ready for use	06/23/2012
Benefits & Human Resource Conference in Austin, Texas	06/26-28/2013
Annual Enrollment Period (employee meetings)	07/15-31/2013
Begin testing transmission of eligibility data	07/10/2013
New employee materials due to the Institution Benefit Offices	08/01/2013
Begin testing of Electronic Fee Billing Invoice	08/01/2013
Begin testing of eligibility error dataset transmission from vendor	08/09/2013
First transfer of new plan year enrollment data to the vendor	08/11/2013
Banking arrangements completed	09/01/2013
Plan Year 2013-2014 begins	09/01/2013
Production of automated transmission of claims data processing system and electronic Fee Billing Invoice	10/11/2013

4.0 THE CONTRACT AND OTHER LEGAL REQUIREMENTS

The Contract shall be in the format specified by the System. The Contract will incorporate this RFP, the vendor's proposal thereto, and any other information the vendor may be required to provide. Until a Contract has been executed and signed, the RFP and the vendor proposal will be binding. A Sample Contract is included as Appendix H to this RFP. Vendor responses containing proposed substantive changes to the Sample Contract will not be considered. If the vendor cannot confirm that it can agree to the substantive content of the Sample Contract should not submit a Proposal. Accordingly, review by the vendor's legal counsel should occur prior to the vendor's submission of a Proposal.

Important: The vendor should not attempt to modify or sign the Sample Contract. The actual Contract will be prepared by the System Office of General Counsel and signed by the vendor prior to January 9, 2013.

4.1 INTRODUCTION

No Contract will be executed until the System has accepted a vendor's proposal and has notified the vendor of its approval. The Contract will be for a three-year term beginning on September 1, 2013 and will extend through August 31, 2016, to be renewed at the System's option for an additional three-year period unless terminated as provided herein or in the Contract. If the current vendor submits a proposal and is not selected, the current vendor shall continue to perform in good faith all obligations under its existing contract with the System.

The System and the contracting vendor shall agree and acknowledge, as applicable, that the benefits and coverage to be provided under the Contract will be provided from September 1, 2013, through August 31, 2016. However, the System and the contracting vendor shall also agree and acknowledge that there are duties and obligations specified by the RFP to be performed prior to September 1, 2013, and following August 31, 2016, and the Contract will specify that the parties agree to perform all such duties and obligations, and that all applicable damage provisions shall be in effect as to these duties and obligations.

The Contract shall comprise the complete and exclusive statement of each agreement between the System and the contracting vendor and supersede all prior or contemporaneous agreements, negotiations, course of prior dealings, and oral representations relating to the subject matter hereof.

The System has specific contracting requirements that cannot be waived or altered. All vendors should carefully review the Sample Contract included as Appendix H to this RFP, including but not limited to the provisions on Indemnification, Auditing, and the EIR Warranty. The vendor should include in their written submission all alternate requirements, terms, or conditions they wish to have considered. **However, the vendor should not assume that an opportunity exists to add such matters through the contract negotiation as a part of the RFP process.** Unacceptable terms and conditions added by the

vendor may result in the rejection of the vendor's proposal, despite other factors to be evaluated. In addition, the vendor should not strike-through or otherwise alter anything in the Sample Contract. Submission of an altered Sample Contract as part of a response may result in rejection of the vendor's proposal, despite other factors to be evaluated.

In the event that a contracting vendor fails or refuses to perform any of its duties or obligations as provided by the Contract, the System, without limiting any other rights or remedies it may have by law, equity or under contract, will have the right to terminate the Contract immediately. Notwithstanding such termination, certain obligations of the vendor shall survive the termination of the Contract.

This Contract is for the personal services of the vendor and the vendor's interest in such agreement. Duties assigned to the vendor under the contract may not be assigned or delegated to a third party.

4.2 NOT AN ERISA PLAN

As a governmental entity, the System is not subject to the provisions of the Employee Retirement and Income Security Act (ERISA).

4.3 COMPLIANCE WITH TEXAS DEPARTMENT OF INSURANCE RULES

Pursuant to Chapter 1601 of the Texas Insurance Code (Code), System is exempt from many of the provisions of the Code and regulations promulgated by the Texas Department of Insurance (TDI). However, nothing in any agreement between the System and a contracting vendor shall be construed to require or permit any action that is prohibited by, or in conflict with, an applicable provision of the Code or an applicable TDI rule or regulation.

4.4 VENDOR ID NUMBERS

A vendor must obtain a Vendor Identification Number issued by the Comptroller of Public Accounts of the State of Texas. The vendor will be required to complete and submit a Payee Identification Form to receive payment.

4.5 AUTHORIZED SIGNATURES

The Chief Executive Officer, General Counsel, or an authorized officer of the vendor must sign the Contract. The proposal must state the name and office of the individual who will sign the Contract on behalf of the vendor and include documentation verifying that the individual has the authority to do so.

4.6 RELATIONSHIP OF PROPOSAL TO CONTRACT

Any contract resulting from the selection of a vendor by the System shall incorporate by reference the RFP including Appendices, the vendor's response thereto, and any other information the vendor may be required to provide.

5.0 FINANCIAL REQUIREMENTS

5.1 INSURANCE RISK

The UT SELECT PPO is financed on a fully self-funded basis. The contract to be executed in accordance with this document shall involve no insurance or reinsurance. The contract shall be for administrative services, claims processing, network management and credentialing, utilization review, and disease management services as described within this RFP. The cost to meet the requirements described in this RFP shall be recovered by the vendor only by making provision for such expense in the vendor's Administrative Fee Proposal included with the response to this RFP.

5.2 VENDOR FINANCIAL STRENGTH

To be eligible for consideration, the vendor must have a net worth of at least $100 million, as demonstrated by an audited financial statement as of the close of the vendor's most recent fiscal year. To affirm financial capability, the vendor must submit all documentation as requested in the related interrogatories included with this RFP.

5.3 NETWORK PROVIDER RISK POOLS

In keeping with the self-funded nature of the UT SELECT PPO, System wishes to participate in the settlement of any network provider risk pools utilized in the administration and management of the plan. System recognizes that each vendor's risk pools have unique operational characteristics and, accordingly, shall not specify requirements for its participation in such pools. Instead, the vendor should describe the arrangement that shall be applicable to UT SELECT in response to the applicable interrogatory items.

5.4 ADMINISTRATIVE FEE

The vendor shall propose an administrative fee which will be guaranteed for three (3) years. To the extent that the vendor intends to recover start-up costs through the administrative fee, such recovery should be amortized over the three-year period.

The administrative fee proposed by the vendor should be adequate to cover costs incurred for the performance of all services described within this RFP, both prior to and during the period of the Contract as well as during any runoff period following termination of the Contract.

5.5 PAYMENT METHODOLOGY FOR ADMINISTRATIVE FEES AND CLAIMS

For each monthly coverage period, the System shall pay the vendor per member per month (PMPM) administrative fees which may become due under the Contract within 60 days from the beginning of the coverage month based on System's self-bill. Specific details on the requirements for the payment of the administrative fee, including the self-bill, are included in the technical and data exchange

requirements section of this RFP. Billable fees associated with utilization of specific administrative services will be paid on the same schedule provided the vendor presents invoices for such fees in a timely manner on a monthly basis.

The vendor shall process and pay all claims submitted under UT SELECT as described herein and in the Contract. The vendor shall pay claims through the issuance of drafts or through Electronic Funds Transfer (EFT) from the vendor's account prior to seeking reimbursement from the System. On at least a weekly basis, the vendor shall present an invoice to the System for claim payments made during the previous invoice period. The vendor shall be responsible for maintaining its own funds which are sufficient to provide for the costs incurred under the UT SELECT PPO. All payments from the vendor to System must be by ACH or other electronic fund transfer methods. The vendor will be responsible for the escheatment process in accordance with Texas law for any payments disbursed on behalf of UT SELECT.

Due to the timing of the reimbursements, the vendor could potentially be required to advance up to two weeks of claim payments before being reimbursed by the System. Recently, two (2) weeks of claims payments under the UT SELECT plan have averaged around $25 million.

The vendor shall be reimbursed only for actual claim payments (i.e., it is not acceptable for the vendor to seek reimbursement from the System in an amount that is different than the amount vendor paid to the provider, facility, or participant). The vendor shall be reimbursed only for paid claims, and shall not be reimbursed for claims that have been processed but not yet paid.

If the vendor's contracts with providers include payment on a capitation basis, such capitation shall be submitted and reimbursed as any other claim as described above. Reimbursement of capitated amounts shall be subject to adequate documentation presented by the vendor. Such documentation shall include the provider's name, the number of UT SELECT participants included in each capitation arrangement, and the amount of the capitation.

Section 51.012 of the Texas Education Code authorizes System to make any payment through electronic funds transfer (or by electronic pay card). The vendor must confirm the ability to receive reimbursement payments from System through ACH or other electronic fund transfer methods. Banking information will be verified during implementation. Any changes to the vendor's banking information must be communicated in writing to the System at least thirty (30) days in advance of the effective date of the change.

5.6 ANNUAL EXPERIENCE ACCOUNTING

Within 90 days after the end of each Contract Year, the vendor shall provide the System with a complete accounting of the UT SELECT financial experience under the Contract. The accounting shall include detail regarding monthly enrollment, paid claims, and administrative fees.

In addition, the vendor shall provide the System with any other experience data and accounting information that the System may reasonably require. Such information will include, but not be limited to, utilization rates for the following services:

- C-Section;
- Mammography;
- Pap smear;
- Childhood immunization;
- Prenatal care; and
- Diabetic retinal exam.

5.7 ACTUARIAL REPORTING

The vendor shall submit to System and the consulting actuary, at a minimum, on a monthly basis a detailed file including all claims processed during the previous calendar month. This data will be used to analyze claims experience and reconcile weekly invoices. The files and all information contained in the files will be the property of System. System and the consulting actuary will agree not to disclose confidential provider discount information to any other party. The vendor shall not require an indemnification provision. The detailed claim file will include but will not be limited to paid date, date of service, provider of service, service provided, line charge, allowable amount, plan payment and patient share. This file will be due no later than the 15th of the month for the previous month's claim payments.

5.8 AUDIT OF VENDOR

System contracts with an independent auditor to conduct an annual audit of its medical claims and the vendor's administration of UT SELECT to determine both the adequacy of the vendor's procedures for the payment of claims and the accuracy of claim payments. The System will provide the vendor with a minimum of thirty days' notice prior to commencement of the audit.

In addition to audits that may be conducted by the State Auditor, System may, at its sole discretion, conduct other audits of the vendor as deemed necessary. System shall determine the scope of each audit. The vendor is required to fully support all audit-related activities and to cooperate in good faith with the auditor. The vendor must maintain readily available data that is accessible electronically as well as through hard copy, such that it can meet a reasonable timeline and provide timely responses for audit purposes. Neither the System nor the auditor shall reimburse or indemnify the vendor for any expense incurred or any claim that may arise in connection with or relating to either annual or other audits.

The vendor is responsible for addressing the independent auditor's findings to the satisfaction of System. Audit findings that conclude certain claims were not adjudicated correctly shall result in the recalculation and financial settlement with the System within a reasonable timeframe, not to exceed

the end of the following Plan Year. Recommendations made by independent auditors shall be discussed with System and incorporated by the vendor where appropriate.

5.9 CLAIMS RUN-OFF

Following termination of the Contract for any reason, the vendor must continue to be responsible for processing and paying claims which were incurred during the term of the Contract. The cost of such run-off administration should be accounted for in the proposed administrative fee. The System will not incur additional administrative fees during the run-off period. The current contracting vendor is responsible for processing and payment of all claims incurred prior to September 1, 2013.

5.10 FIDUCIARY LIABILITY

Although UT SELECT is self-funded, it is the intent of the System that the vendor assume, pursuant to the Contract, fiduciary duties and liability for all of its actions associated with the performance of its duties under the Contract.

5.11 CLAIMS ADMINISTRATION PERFORMANCE GUARANTEE

The vendor must ensure timely and accurate payment of UT SELECT claims subject to performance guarantee assessments described in this section. Assessments related to timeliness and financial accuracy of claims administration will not apply if failure to achieve the required standards is through no error on the part of the vendor or is due to System's failure to perform its required functions. The determination of error shall be made by the System in accordance with the Contract and plan requirements.

5.11.1 TIMELINESS

The vendor must process all UT SELECT claims in accordance with the following standards:

a) 85% of all claims must be processed within fifteen (15) calendar days, and

b) 98% of all claims must be processed within thirty (30) calendar days.

Under this provision, a UT SELECT claim is considered to have been processed if either paid or an information request has been sent. The number of days between the date received and the date processed plus one day will constitute the total number of days required to process a given claim. The additional day recognizes that a check or correspondence likely will not be mailed until the day following final processing.

Compliance with these standards shall be reported monthly and verified by an independent Auditor on an annual basis. For any month in which the vendor fails to meet the UT SELECT claims timeliness standards, a performance guarantee assessment of 1% of the administrative fee for that month will be applied, up to a maximum of four 1% assessments per plan year.

5.11.2 FINANCIAL ACCURACY

The following standard shall apply separately to (1) network and (2) non-network and out-of-area claims:

a) Financial processing errors for UT SELECT claims shall not exceed 1% of the total claim amount processed during any Fiscal Year.

Financial accuracy shall be determined during the annual audit on the basis of a statistically valid stratified random sample selected by System to ensure a 95% confidence level with a 1.5% precision rate. For each percentage point of error (or portion thereof) in financial processing that exceeds the allowable 1%, a performance guarantee assessment equal to 1% of the total administrative charge for the applicable Fiscal Year will be applied.

The UT SELECT financial accuracy standard shall apply to the absolute values of any overpayments and underpayments in aggregate (i.e. underpayments and overpayments will not offset each other in the calculation of financial accuracy).

5.12 HEALTH CARE MANAGEMENT PERFORMANCE INCENTIVE

Under the contract, the vendor will have an incentive for the efficient and cost-effective management of health care provided to in-area participants. Generally, the incentive will be a bonus or a penalty to the vendor based on actual in-area claims (Actual Claims) as compared to Target Claims agreed upon in advance by the TPA and System. The vendor will earn a bonus if Actual Claims are less than 95% of Target Claims. The vendor will be charged a penalty if Actual Claims are more than 105% of Target Claims. This incentive is not an insurance or reinsurance arrangement. The Contract will not include either specific or aggregate stop loss coverage.

A vendor's ability to provide a cost-effective network is best evaluated on the basis of the in-area Target Claims level to which the vendor is willing to commit. Accordingly, the vendor's proposed Target Claims Cost will be an important factor in the evaluation process.

5.12.1 INCENTIVE STRUCTURE

1) The vendor's Proposal must include a Target Claim Cost (TCC) for participants residing in-area. The TCC will include both network and non-network claims expected to be incurred during the fiscal year. Out-of-area participants and Medicare-eligible retirees over age 65 will not be included in the determination of the health care management incentive. Costs associated with the UT SELECT Prescription Drug Plan (PDP) are not a part of the TCC determination.

2) The TCC will be expressed as an amount per Employee/Retiree per month as specified in the Target Claims Cost Response section of this RFP.

3) The TCC for FY2014 will be calculated and finalized on or before February 1, 2014, based on a specified, guaranteed formula submitted in the Proposal and accepted by the System along with the actual claims experience for FY2013 as determined using data available through November 30, 2013. A provision accounting for incurred, but unpaid FY2013 claims as of November 30, 2013, will be established through good faith negotiations.

4) The formula referenced in (3) must be specified in the Proposal, although it may take into account the actual FY2013 claims experience, FY2014 enrollment data available through November 30, 2013, and the anticipated impact of benefit design or eligibility changes implemented for FY2014, if any. Enrollment variables may recognize the following changes in composition of the in-area participation: (a) relative proportion of the enrollment in the various employee/dependent categories, (b) age distribution, (c) gender distribution, and (d) geographic distribution. The manner in which the variability in these factors will be recognized must be clearly specified. The anticipated impact of any benefit design or eligibility changes will be determined through good faith negotiations.

5) All in-area locations will be combined for the purpose of determination of the TCC and the ultimate calculation of the gain or loss.

6) The Target Claims for FY2014 will be equal to the sum of the products obtained by multiplying each month's actual in-area enrollment by the TCC determined above.

7) System recognizes that a certain degree of variability in claims experience is inevitable and beyond the influence of the vendor. Accordingly, System provides that should Actual Claims fall within +/- 5% of Target Claims (Actual Claims = 95% to 105% of Target Claims), neither a bonus nor a penalty will be assessed under the Health Care Management Incentive.

8) The Actual Claims for FY2014 will be determined based on claims incurred through August 31, 2014, using actual claims paid through February 28, 2015. A provision accounting for incurred, but unpaid FY2014 claims as of February 28, 2015, will be determined through good-faith negotiation.

9) The gain or loss for the year will be determined through comparison of Target Claims and Actual Claims calculated as described herein.

10) Should Actual Claims exceed 105% of Target Claims, the vendor will be assessed a penalty determined as follows, with a maximum penalty of 1.5% of Target Claims:

    - When Actual Claims are more than 5% but less than 10% above Target Claims, the vendor will pay a penalty equal to 10% of the difference between Actual Claims and 105% of Target Claims.
    - When Actual Claims are more than 10% but less than 15% above Target Claims, the vendor will pay a penalty equal to 0.5% of Target Claims plus 20% of the difference between Actual Claims and 110% of Target Claims.

- When Actual Claims are more than 15% above Target Claims, the vendor will pay a penalty equal to 1.5% of Target Claims.

11) Should Actual Claims be less than 95% of Target Claims, the vendor will receive a bonus determined as follows, with a maximum bonus of 1.5% of Target Claims:

- When Actual Claims are more than 5% but less than 10% below Target Claims, the vendor will receive a bonus equal to 10% of the difference between 95% of Target Claims and Actual Claims;
- When Actual Claims are more than 10% but less than 15% below Target Claims, the vendor will receive a bonus equal to 0.5% of Target Claims plus 20% of the difference between 90% of Target Claims and Actual Claims; and
- When Actual Claims are more than 15% below Target Claims, the vendor will receive a bonus equal to 1.5% of Target Claims.

Independent determinations will be made for each year of the Contract following similar procedures as described herein.

Table 1, included after the following section detailing Renewal Year Target Claims Cost, presents both tabular and graphic displays of the requested health care management incentive structure.

5.12.2 RENEWAL YEAR TARGET CLAIMS COST

In addition to submission of a formula with guaranteed factors for FY2014, a vendor responding to this RFP must also submit a formula for determination of the TCC for the second and third years of the Contract. While such a formula may take into consideration Actual Claims, actual enrollment, and the anticipated impact of any benefit design or eligibility changes that may be implemented in the second and/or third years, it must guarantee the maximum trend factors that will be utilized in developing second and third year TCC.

The actual trend factors used for renewal year TCC will be determined through good faith negotiation subject to the guaranteed maximum. The anticipated impact of any benefit design or eligibility changes effective for the second and third years of the contract will be determined through good faith negotiation. Any benefit design or eligibility changes occurring after the TCC has been established for a given year will result in a revision to the TCC as determined through good faith negotiation.

5.12.3 TABLE AND EXAMPLES

The table and graphic display on the following page represent the in-area health care management incentive arrangement. Several example calculations of the incentive amount are included on the page following the table and graphic representation of the incentive.

TABLE 1

UT SELECT

Health Care Management Incentive Arrangement

Actual Claims Range	Relative Share of Gain (Loss)[1] In the Actual Claims Range		Maximum Bonus/Penalty to Vendor
	System	Vendor	
95%–105% of Target Claims	100%	0%	0
90%–95% of Target Claims, or 105%–110% of Target Claims	90	10	0.5% of Target Claims
85%–90% of Target Claims, or 110%–115% of Target Claims	80	20	1.5% of Target Claims
Less than 85% of Target Claims or more than 115% of Target Claims	100	0	1.5% of Target Claims

[1]Gain (Loss) = Target Claims – Actual Claims

This arrangement can be displayed graphically as follows:

		−15%	−10%	−5%	Target Claims	+5%	+10%	+15%
Relative Share of Gain (Loss)	System	100%	80%	90%	100%	90%	80%	100%
	Vendor	0%	20%	10%	0%	10%	20%	0%

EXAMPLE CALCULATIONS OF HEALTH CARE MANAGEMENT INCENTIVE

Each of the following examples is based on these assumptions:

- Target Claims = $400 million
- Maximum bonus/penalty = $6 million

EXAMPLE 1:

Actual Claims = $392 million
Bonus to Vendor = $0

Actual Claims are more than 95% of Target Claims

EXAMPLE 2:

Actual Claims = $428 million
Penalty to Vendor = $800,000

Actual Claims exceed Target Claims by 7%; i.e., they fall in the range of more than 5% but less than 10% of the target claims. Therefore, the vendor incurs a penalty of 10% of $8 million.

Example 3:

Actual Claims = $352 million
Bonus to Vendor = $3.6 million

Actual Claims are 12% less than Target Claims; i.e., they fall in the range of more than 10% but less than 15% of the Target Claims. Therefore, the vendor earns a bonus of (a) 10% of $20 million, plus (b) 20% of $8 million.

6.0 BENEFITS, PROVIDER NETWORK, AND PROGRAM REQUIREMENTS

6.1 INTRODUCTION

The System designs the UT SELECT plan. The System is conducting this RFP process to obtain the desired high-quality services at the best possible economic value and is not seeking to redesign the network or operational aspects of UT SELECT. Therefore, the System requires that the vendor be able to effectively administer a provider network, benefit design, and overall program which meets or exceeds the requirements presented in this RFP. The vendor may recover the costs of the services described in this section only by making provision for such costs in the calculation of the proposed administrative fee.

6.2 THE BENEFIT (OR PLAN) YEAR

The UT SELECT Plan Year begins on September 1st and ends the following August 31st. This time period corresponds with the fiscal year of the System and the State of Texas.

6.3 PLAN PARTICIPATION

Chapter 1601 of the Texas Insurance Code (TIC), a copy of which is attached as Appendix G to this RFP, establishes eligibility criteria and enrollment requirements for the UT SELECT plan.

6.3.1 ELIGIBILITY

Section 1601.101 of the Texas Insurance Code provides that an employee who is expected to work at least 20 hours per week and to continue in the employment (is expected to work) for a term of at least four and one-half months, or is appointed for at least 50% of a standard full-time appointment, is eligible for employee group insurance benefits.

In accordance with TIC Section 1601.102, certain retired employees of the System are eligible for benefits.

6.3.2 BASIC COVERAGE

Basic group insurance coverage provided by the System must be comparable, as determined by System, to the coverage commonly provided in private industry and at other institutions of higher education.

The basic package for benefits-eligible employees includes employee-only coverage under UT SELECT, $20,000 basic group term life (GTL), and $20,000 basic accidental death and dismemberment (AD&D) coverage.

The basic coverage for benefits-eligible retired employees includes retiree-only coverage under UT SELECT and $6,000 basic GTL.

6.3.3 PREMIUM SHARING

On a biennial basis, the Texas Legislature determines the amount of premium sharing available for employees, retired employees and any eligible dependents. For the current biennium, premium sharing is funded to cover the total cost of the basic package for full-time employees, half the cost for part-time employees and the total cost of the basic package for retired employees. A percentage of the medical plan cost for covered dependents of participating active and retired employees is also paid through premium sharing.

Currently, for newly benefits-eligible employees, state premium sharing is not available for payment of the basic package until the first of the calendar month that begins after the 90th day after the employee begins employment. Effective September 1, 2014 the maximum waiting period will be 90 days. Each institution has the option to supplement premium sharing for all employees during this waiting period. However, if an institution does not supplement premium sharing, that institution's employees will not be eligible for the UT SELECT Medical Plan, including prescription benefits, until the end of the waiting period.

For newly retired benefits-eligible employees, state premium sharing is available to pay the retired employee's premium for the basic package if there is no break in coverage between the period of active employment and the effective date of retirement. If there is a break in coverage between active employment and retirement, premium sharing is not available for payment of the retired employee's basic package until the first day of the calendar month that begins after the 90th day after the effective date of retirement or effective September 1, 2014, after 90 days. System institutions do not have the option to supplement premium sharing for retired employees during this waiting period.

At this time, full-time employees and retirees with comparable coverage from another source may waive the basic coverage package and receive up to 50% of the state premium sharing amount to pay premiums for certain optional coverages. Additionally at this time, part-time employees with comparable coverage from another source may waive the basic coverage package and receive up to 25% of the state premium sharing amount to pay premiums for certain optional coverages.

6.3.4 ENROLLMENT

System policies, in accordance with TIC Chapter 1601, define the enrollment process for the System's employee group insurance program. Annual Enrollment for all insurance plans is held during the month of July. During the Annual Enrollment period for the initial plan year in which benefits for the self-funded UT SELECT PPO will be administered by the vendor, any eligible System employee or retired employee may elect UT SELECT Medical coverage.

If an employee or retired employee elects to make enrollment changes during any Annual Enrollment period, those changes will be effective the following September 1. Unless an employee or retired employee elects to change or cancel their coverage during the Annual Enrollment period to be held during July, 2013, those employees or retired employees who are enrolled in UT SELECT coverage as of August 31, 2013 will continue enrollment at the same level of coverage, along with their eligible, enrolled dependents, under the new Contract that takes effect on September 1, 2013.

The first date that enrollment data for the 2013-2014 Plan Year is expected to be transferred to the vendor will be August 11, 2013. Technical and data exchange requirements related to eligibility and enrollment are detailed in a separate section of this RFP.

6.4 UT SELECT BENEFITS STRUCTURE

UT SELECT is the sole health plan offered to System employees and retired employees and is structured with two levels of benefits for participants residing in the service area: network and out-of-network. In addition, the current plan provides an out-of-area level of benefits for those residing outside of the service area. System seeks to continue the current structure of the UT SELECT PPO with regard to the levels of network, out-of-network, and out-of-area benefits. It is important to note as a state program, the legislature may, at times, mandate various plan design options be available to employees and retired employees, at which point UT SELECT would not be the sole health plan offered. Additionally, if System determines programs such as Medicare Advantage are in the best interest of System for its Medicare-eligible retired employees, System may choose to offer such alternative plans.

The highest level of benefits is paid when services are received from a network provider. If a plan participant resides in an area where a satisfactory level of network services are available, but elects services outside of the PPO network, then the lower level out-of-network benefits are provided. Plan participants who reside in an area where an adequate PPO network is not available receive out-of-area benefits which fall below the UT SELECT network level of benefits, but are higher than out-of-network benefits. Preference will be given to vendors that can administer increased benefits for out-of-area participants who obtain services from an in-network provider.

For retired employees and their dependents who have primary coverage under Medicare and receive services from a provider who accepts Medicare assignment, the plan will pay all charges allowed but not paid by Medicare without regard to whether the participant has satisfied the annual deductible under Medicare or under UT SELECT if the retired employee is seen by a provider who accepts both Medicare assignment and is a network provider.

System requires that UT SELECT participants have in-network access to System medical providers and to all System medical facilities: UT Health – Houston, UT Health Science Center – San Antonio, UT Health Science Center – Tyler, UT Medical Branch – Galveston, UT M.D. Anderson Cancer Center, and

UT Southwestern Medical Center – Dallas. In addition, vendors must submit an electronic data file of contracting providers in the format described in this RFP.

When describing the proposed service area, vendors should list all zip codes included. Vendors are required to confirm that their provider networks will cover the entire State of Texas, effective September 1, 2013.

6.4.1 IN-AREA

Employees and retirees, regardless of Medicare eligibility, whose residential zip code falls within the UT SELECT network service area are considered to be in-area, as are their dependents unless an exception has been requested as described in the following section. System may consider a change to this structure in the future to treat all Medicare-eligible retirees as in-area participants, regardless of residential zip code. In-area participants have the option to seek health care through the UT SELECT provider network or from any provider of the particpant's choice and will receive the corresponding network or out-of-network level of benefits. In-Area benefits apply to eligible employees, retirees and their covered dependents whose address on record is Texas, New Mexico and Washington, D.C. Participants who are active employees and live out-of-area may request an exception to receive in-area benefits.

6.4.2 ADDITIONAL IN-AREA OPTION(S)

A pilot program between The University of Texas Southwestern (UTSW) Medical Center and System OEB is being offered effective September 1, 2012. UT SELECT participants who receive medical care from a UTSW physician or at a UTSW facility will receive a reduced or eliminated out-of-pocket cost. Additional details about this pilot program have been included in Appendices A and B to this RFP. The responding vendor must be able to comply with a reduced or eliminated co-payment, deductible and co-insurance structure for claims, billing and Estimate of Benefit statements. If the pilot with UTSW is successful, OEB may adjust plan design to allow for a different level of benefit for all UT physicians and facilities. The term of the UTSW pilot is two years and success will be determined within the second year. Additionally, due to UT System being comprised of both research and academic institutions, OEB strives to develop collaborative pilot programs with many of our campuses. Pilot programs range from the study of plan data to consulting for wellness programs.

6.4.3 OUT-OF-AREA

Employees and retirees, regardless of Medicare eligibility, who reside outside of the UT SELECT network service areas, including outside of Texas and outside the U.S., are considered out-of-area along with their dependents. Subscribers who reside in-area, may request an exception to establish out-of-area benefits for their dependents who live outside of the service area.

Out-of-area participants may select any provider and receive the same level of benefits in accordance with a managed indemnity plan. However, it is the System's preference that participants who reside outside the service area have access to the vendor's network, if available in their area, and receive the network level of benefits when utilizing network providers.

Out-of-Area participants must satisfy applicable pre-certification, concurrent review, and other cost containment provisions. Providers may assist participants in complying with requirements and submission of claims forms, however, participants are ultimately responsible for meeting all requirements.

6.5 PLAN DESIGN

A summary description of the current UT SELECT plan design, included as Appendix A to this RFP, is part of the complete UT SELECT 2012-2013 Benefits Guide (the Benefits Guide), included as Appendix B to this RFP. No deviations from these required benefits shall be allowed as part of a response to this RFP.

The System may add new wellness initiatives on an ongoing basis or may elect to make changes to the benefit design based on plan experience or other factors during the contract period. The vendor should be prepared to make adjustments as needed.

6.5.1 PRESCRIPTION DRUG BENEFITS

Prescription drug benefits are provided to UT SELECT participants through a separate pharmacy benefit. Currently, that plan is administered by Express Scripts. However, the UT SELECT medical services administrator shall administer benefits for drug therapies other than retail and mail service prescriptions. These therapies include home infusion therapy, chemotherapy administered at a physician's office or a facility, and drugs dispensed at a facility or physician's office, including fertility drugs. Currently, UT SELECT permits J-code medications to be covered by either the medical plan or the prescription plan. While this arrangement allows the most convenient access for participants, it may not always be the best financial option. System will periodically consult with the pharmacy benefit manager and the medical services administrator to determine if reimbursement costs for J-code prescriptions are comparable.

6.5.2 MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

System is exempt from the requirements of the Mental Health Parity and Addiction Equity Act. Benefits are provided for mental illness and/or substance abuse issues (MH/SA) based on an individual plan participant's clinical need. System's intention is that the features listed below continue to be available as part of the MH/SA benefits structure.

- A triage mechanism, performed by appropriately licensed professionals and available for participants accessing care to any point along the continuum of the delivery system, directs

patients to the proper level of care. Access methods include direct access for participants to mental health or substance abuse treatment professionals, as well as referral by a participant's family care physician. The triage function includes a formal clinical assessment scale to measure functional status and well-being and coordinates with the family care physician.

- A dedicated, toll-free MH/SA phone number allows UT SELECT participants or emergency care providers to obtain assistance in accessing care and benefits information 24 hours a day, 7 days a week. Emergency calls receive a telephone response within 15 minutes. The plan provides benefits for an inpatient facility within a 45-minute drive for the participant and an outpatient facility within a 30-minute drive. Requests for urgent care have the first appointment within 24 hours. Requests for routine evaluation and assessment are accommodated within 5 days.
- Locations of facilities and practitioners providing MH/SA services to UT SELECT participants are guaranteed to be sufficient in terms of geographic convenience, accessibility for individuals with disabilities, and proximity to public transportation routes.
- Benefits for a variety of psychotherapeutic services are available, as appropriate to the presenting problems of an individual participant. Care is delivered based upon an assessment of individual needs. Coverage decisions are based on determinations of medical necessity and are assisted by measurement of functional status and well-being.
- An MH/SA case manager is assigned at the point of the intervention for all participants being admitted to inpatient or alternative treatment facilities or receiving detoxification. Case management continues proactively until the patient is determined to be capable of sustaining long-term stability. As appropriate, the case manager ensures that a post-discharge treatment plan is in place, monitors the patient's progress, and coordinates with the applicable institution Employee Assistance Program.
- Providers and facilities offering varying levels of care are available to the extent that such resources exist in the community, including: residential treatment, partial hospitalization programs, day treatment, halfway houses, intensive outpatient care, and home therapy.
- As participants near plan benefit limits, evaluation is required to determine the appropriateness of providing additional benefits based upon the clinical needs of the patient.

6.5.3 Coverages, Limitations, and Exclusions

UT SELECT coverages, limitations, and exclusions must continue to be administered in substantially the same manner as they are currently administered. Unless otherwise specified herein, the coverages, benefits, limitations, and exclusions shall remain as described in the Benefits Guide included as Appendix B to this RFP.

6.6 Coordination of Benefits

The vendor must be capable of processing coordination of benefit claims for participants who have other coverage to which UT SELECT is secondary. The cost of processing these claims should be

included in the proposed administrative fee. All savings attributable to such programs shall accrue solely to the UT SELECT plan.

Coordination of Benefits with Medicare/Medicaid and other insurance coverage shall be administered as described on pages 45-50 of the Benefits Guide. UT SELECT currently functions as secondary coverage for a Medicare primary participant, rather than as a Medicare carve-out or Medicare supplement. However, the vendor shall work with the System to modify COB processes if requested by System.

The vendor must be capable of coordinating Medicare Secondary Payer (MSP) claims with Medicare and its third party administrators. MSP coordination includes, but is not limited to, working with CMS and its third party administrators to review and resolve any outstanding claims to determine that the order of benefits is properly administered, review and determine if claims or federal offsets were handled correctly and to determine and ensure claims are finalized accurately.

Accuracy in processing MSP claims is particularly important due to a number of UT retirees being employed in benefits-eligible positions which affects the Medicare primary/UT SELECT secondary benefits arrangement. System institutions receive and participate in numerous federal grants and federally-funded programs. Therefore, inaccurate coordination of MSP claims, even at small amounts, may result in the offset of substantial federal funding earmarked for UT System institutions.

6.7 Evidence of Insurability (EOI)

Consistent with federal regulations, evidence of insurability (EOI) is not currently required in order for eligible participants to enroll in UT SELECT coverage, regardless of circumstances. Should the regulatory environment change, EOI requirements could be put in place for eligible individuals who declined UT SELECT coverage upon initial eligibility. In that event, the vendor shall provide the underwriting support and appropriate staff, including qualified and duly licensed medical doctors in good standing with the state of Texas, to service the EOI function.

6.8 Provider Network

The vendor will ensure that the UT SELECT network complies with the following requirements regarding provider accessibility, credentialing and contracting, local medical management, utilization management, and quality assurance.

6.8.1 Network Management

The vendor must provide all network management services specified in this RFP, including but not limited to the following:

- Initial and ongoing recruitment, credentialing, and contracting with a sufficient number of qualified and duly licensed Health Care Providers, as defined herein, in good standing with

the state of Texas, to provide the full range of covered benefits and services in the network service areas;

- Ongoing management of network providers in accordance with applicable laws, regulations, credentialing criteria, and provider contracting provisions;
- Initial and ongoing provider education to ensure that network providers are familiar with and knowledgeable about UT SELECT benefits (including any benefit design changes) and other plan provisions;
- Ongoing review of fees paid to network providers, recommending adjustments as appropriate;
- Ongoing review, with reports as requested, regarding network provider accessibility with respect to driving time and appointment waiting time;
- Ongoing provider quality assurance review, to include periodic participant surveys and other reporting mechanisms;
- Ongoing utilization management, including preauthorization of services, monitoring and enforcement of compliance with medical protocol, and reporting of utilization management information to System as requested;
- Monitoring of denials made under the utilization management program to ensure the ongoing appropriateness of the medical protocol;
- Recruiting of additional network providers on a general, regional, or specific basis when requested by System;
- Notifying System and making reasonable efforts to notify affected current participants in writing at least forty-five (45) days prior to the effective date of the vendor's termination of any provider's contract without cause unless prohibited or limited by applicable law;
- Notifying System as soon as possible upon determining the need to terminate the provider's contract with cause, but no later than the next business day following termination, and using reasonable effort to notify affected participants in writing of such termination;
- Immediately notifying System and making reasonable efforts to notify affected current participants in writing if a provider initiates termination of its contract with the vendor; and
- Including the name of the terminated provider, the names of other providers available to participants, and the effective dates of the changes in all written notices of provider termination being sent to affected participants.

6.8.2 CREDENTIALING AND RE-CREDENTIALING

The vendor is solely responsible for credentialing, re-credentialing, and contracting with all network providers and will contract only with licensed healthcare providers in good standing in their profession and with the appropriate state and/or federal licensing and regulatory agencies. All healthcare providers participating in the network throughout the entire term of the Contract must be screened and investigated through a rigorous credentialing process prior to being

contracted. A detailed description of the vendor's credentialing process must be included with the response as requested in the interrogatory section.

6.8.3 CONTRACTS

The vendor must have a valid contract with each provider that is submitted with the response as part of its network. The contract must include, but not be limited to, agreements regarding accessibility, adherence to medical protocols, utilization management and quality assurance standards, reporting requirements, claims processing procedures, and fee arrangements.

6.8.4 ACCESSIBILITY AND AVAILABILITY

The vendor must provide complete details about its existing provider network in the required format as described in Appendices C, D and E to this RFP. Separate documentation must be provided for primary care physicians (PCPs), specialty care physicians, behavioral health providers and hospitals. Please note that the required documentation is more detailed than what is generally listed in the vendor's provider directory. Failure to properly meet the data requirements as specified in Appendix E may result in a delay in the review of the vendor's response.

System also requires the vendor to provide a GeoAccess report for the proposed provider network. GeoAccess can be analyzed in relation to: 1) driving distance, 2) shortest distance but not necessarily driving distance, or 3) in minutes. System believes that driving distance is the most accurate method for GeoAccess reporting. The applicable access standard to be used for general practitioners (PCPs) is two (2) medical providers within fifteen (15) miles of an employee's residence (or ZIP code). The analysis for PCPs should include providers designated as family practice, general practice, internal medicine, pediatrician and OB/GYN, if used as a PCP. Hospital information should be provided on the basis of one (1) facility within fifteen (15) miles of an employee's residence. In addition, a listing of ZIP codes where the desired access is not met must be submitted for each of the outlined provider types.

Based on the provider network information submitted, System will also conduct a disruption analysis to determine the number of participants that would potentially have to change physicians due to differences between the current network and the vendor's proposed network.

6.8.5 LOCAL MEDICAL MANAGEMENT

The vendor shall have a Medical Director on staff who is a licensed physician in good standing with the State of Texas and who has final authority on medical necessity decisions. The response must include a description of routine interactions between the medical director and network providers via such arrangements as medical protocol committees and utilization review groups.

6.8.6 UTILIZATION MANAGEMENT

The vendor is responsible for providing ongoing utilization management, including, but not limited to preauthorization of services, monitoring and enforcement of compliance with medical policies, and other programs described herein. Network providers will be responsible for meeting all preauthorization requirements, including for:

- Inpatient hospital admission;
- Skilled nursing care in a skilled nursing facility;
- Private-duty nursing;
- Home health care;
- Hospice care;
- Home infusion therapy;
- Motorized and customized wheelchairs and certain other durable medical equipment totaling over $5,000;
- Transplants;
- All inpatient treatment of mental health care, chemical dependency and serious mental illness; and
- The following outpatient treatment of mental health care, chemical dependency and serious mental illness:
    (i) Psychological testing,
    (ii) Neuropsychological testing,
    (iii) Electroconvulsive therapy, and
    (iv) Intensive outpatient programs.

6.8.7 QUALITY ASSURANCE

The vendor shall have in place processes to monitor the provider network, the quality of patient care and participant satisfaction.

6.9 DISEASE MANAGEMENT

The vendor must make available, implement, and administer a comprehensive program to deliver support and educational information intended to assist participants with disease management. The vendor may recommend modifications to materials used in this educational program when the vendor determines such adjustments to be in the best interests of participants who would potentially benefit from the proposed changes. The vendor must notify the System and obtain consent as to any modification of the educational program prior to implementing a change or making revised information available to UT SELECT participants.

The vendor may use program information to profile patients only for the purposes of offering, implementing, and administering its support and educational program providing information for disease management purposes; for assessing patterns of care and measuring outcomes; and for providing opportunity analysis related to potential interventions as well as adherence analysis. Only non-personally identifiable participant information may be used by the vendor to administer, evaluate, and improve its support and educational program for disease management and other care management programs. The vendor must be willing to coordinate with the System's pharmacy benefit manager, currently Express Scripts, and the System's Health Risk Assessment (HRA) vendor to offer comprehensive and seamless education and support to the UT SELECT participant.

The vendor must have the capability to provide quarterly and *ad hoc* reports for disease management and other care management programs.

6.10 WELLNESS BENEFITS

System provides the "Living Well" program, a comprehensive health and wellness initiative available to all UT SELECT participants aged 18 and over. System is also committed to the creation and ongoing enhancement of individual campus wellness programs. The vendor must demonstrate the ability to provide wellness-related services and targeted wellness initiatives as part of the overall administration of UT SELECT. Experience with the effective application of Value-Based Benefit Design (VBBD) concepts and programs will be considered a differentiating factor in the area of wellness benefits.

The vendor's proposal must describe the specific wellness services and initiatives it intends to provide as part of its administration of UT SELECT and how those services and initiatives will be integrated into the existing "Living Well" program. In particular, information provided in the proposal should allow for the assessment of the vendor's willingness to collaborate directly with the System and other contracted vendors regarding wellness-related initiatives and services.

Of high importance will be the vendor's ability to collaborate with the Pharmacy Benefit Manager (PBM) for the UT SELECT prescription plan, currently Express Scripts, regarding conditions and medical issues that may be identified through participant access to PDP benefits. Collaboration with the Health Risk Assessment Program (HRA) will also be essential. Currently, System has an RFP out for bid for HRA services. The ability to accept calls transferred by customer service representatives with the PBM or HRA Program directly to UT SELECT Medical customer service representatives or representatives with the UT SELECT Disease Management Program, when appropriate, is anticipated to be a basic feature of this collaboration.

Additionally, each System institution offers an Employee Assistance Program (EAP) that provides counseling services to employees, retirees and their dependents on numerous topics. In the event that the vendor provides information to participants about services available within the overall UT Benefits program and the Living Well program, whether through direct customer service interactions, UT

SELECT communications materials, or the System-specific UT SELECT website, the vendor should include reference to the institution-based EAP programs.

6.11 Medicare/Medicaid/Veterans Affairs/Department of Defense

The vendor must be capable of processing claims from various state and federal government programs on behalf of UT SELECT participants who also participate in other state and federal government institutional programs. The System will authorize the vendor to process these claims subject to the plan's edits and only in accordance with the approved plan design applicable to claims submitted by a plan participant. The vendor shall pay all claims that meet plan design parameters, in accordance with the plan's terms and reject those that do not meet those parameters, including those that are submitted in the wrong format or are missing one or more data elements that are required by the plan design.

Because of the potential for variations in timely filing requirements among the various state and federal government agencies, claims should not be rejected solely because they do not meet the plan's timely filing edits. In processing such claims under these parameters, the vendor must reimburse the applicable state or federal government agency at the lesser of (1) the amount the agency actually paid, or (2) the negotiated network price, minus any applicable deductible, copayment or coinsurance that the UT SELECT participant is responsible for under the plan design. The cost for this process shall be included in the proposed administrative fee.

6.12 Process for Grievance and Appeals

The vendor must have in place a claims review and appeals process that complies with applicable requirements specified in the Affordable Care Act (ACA; Public Law 111-148). Details of the current, ACA-compliant claims review and appeal process for the UT SELECT plan are included on pages 37-45 of the Benefits Guide. The current vendor is responsible for all appeals submitted for claims incurred in connection with services rendered on or before August 31, 2013.

7.0 OPERATIONAL REQUIREMENTS

The vendor shall administer UT SELECT in a manner consistent with all applicable laws and regulations, as well as with the requirements set forth in this RFP. The vendor shall provide all services associated with the administration of the plan, including, but not limited to the items specified in the following sections. The vendor may recover the cost of compliance with the requirements described in this section only by making provision for such cost in the proposed administrative fee.

7.1 GENERAL REQUIREMENTS

a) The vendor shall provide general administrative support as required in the operation of the UT SELECT plan.

b) The vendor shall provide legal and technical assistance as it relates to the operation and administration of UT SELECT.

c) The vendor shall provide certain reports that are required to administer a self-funded plan including, but not limited to, IRS Form 1099.

7.2 IMPLEMENTATION AND ACCOUNT TEAMS

If selected, the vendor must notify the System in writing of the names and roles of all members of its complete Implementation Team no later than December 15, 2012. In addition, the vendor will be required to establish an Account Management Team that is acceptable to System and agree to make staffing adjustments to this team as required by System throughout the contract period. The vendor must ensure that the Account Management Team is established no later than March 1, 2013, and that this team will be available to assist System as required every Monday through Friday from 8:00 a.m. until 5:00 p.m. (excluding national holidays).

The vendor's Implementation and Account Management Teams must each include a designated information technology contact with the technical knowledge and expertise to efficiently and effectively collaborate with System's information technology team regarding data transmission, data integrity, and timely processing of data. The designated information technology contact should be appropriately positioned within the vendor's organization to allow for direct management of all technical issues related to the contract.

7.3 CUSTOMER AND ACCOUNT SERVICE

a) The vendor's Account Management Team must provide a minimum of four in-person reviews to the System per year regarding the utilization and performance of UT SELECT, including cost saving recommendations and updates regarding ongoing operational activities. The System may also require monthly operational meetings (in person or via telephone conference), as needed.

b) The system strongly believes that the account service relationship is the critical link in developing and maintaining a strong partnership dedicated towards the achievement of plan objectives. As

such, the vendor must be committed to provide the System with service attention that is at the highest levels in the industry, and fully consistent with expectations. The vendor and the System shall define the criteria for measurement and evaluation of service performance.

c) The vendor shall notify the System prior to implementing material changes in policies, business and key personnel on the System account management team.

d) The establishment and staffing of a customer service unit dedicated exclusively to the administration of UT SELECT is required. The unit should be staffed adequately to handle questions specific to UT SELECT benefits, resolution of complaints, provide interpretation of Explanation of Benefits statements, requests for program clarification, and to assist participants with provider identification and selection. The vendor's customer service hours should include, at a minimum, Monday through Friday from 7:00 a.m. to 7:00 p.m. (CT), Saturday from 7:00 a.m. to 3:00 p.m. (CT), and emergency service coverage outside of the required business hours;

e) Customer Service call centers serving UT SELECT must be located within the United States, preferably within the state of Texas. The establishment of toll-free lines (telephone and facsimile) is required and customer service staffing levels must be adequate at a minimum to maintain the following performance standards:

- Average abandonment rate of 5% or less; and,
- Average time to answer of 30 seconds or less.

f) The vendor must provide System staff the ability to listen to and monitor UT SELECT-related calls to and from the vendor's customer service call center(s) on an as-needed basis;

g) By May 1, 2013, the vendor shall designate a Client Service Team with at least two employees whose first and primary responsibilities will be to respond to and resolve, within a reasonable timeframe, UT SELECT-related customer service needs. The Client Service Team may handle a variety of specific tasks related to the contract, possibly including answering questions from the System and institution Human Resource and Benefit Offices, scheduling vendor attendance at institution Annual Enrollment meetings, and distributing vendor materials.

To facilitate benefits administration between OEB and the designated Client Service Team, a secure email connection must be made available between OEB and Client Services. The system must integrate with System's Outlook email rather than a standalone secure email system.

Based on standards established during monthly operational meetings and as work and service requirements demand, the System and vendor will jointly monitor and establish appropriate staffing levels for the Client Service Team, to System's sole satisfaction. The vendor warrants and represents that it will adequately train additional team members as needed to support the System's requirements.

h) The vendor's Client Service Team must be authorized to accept verbal verification of a participant's coverage when provided by a representative of the System who has been designated to provide this information or must be prepared to verify the specific participant's coverage through an online system. Upon receipt of either verbal or online verification of the establishment of or a change to a specific participant's coverage, the Client Service Team must be authorized and able to update coverage in the vendor's data system prior to receipt of System's next weekly or monthly enrollment dataset;

i) During and following System's Annual Enrollment period each year, the vendor shall dedicate additional staff members, as needed, to update UT SELECT-related records and accounts and to provide additional help for the vendor Client Service Team.

7.4 CLAIMS PROCESSING AND ADMINISTRATION

a) The vendor shall process and administer all required UT SELECT claims incurred in connection with services rendered on or after September 1, 2013, and throughout the term of the Contract. General requirements for claims processing include the following:

- Using System enrollment records, the vendor shall create and maintain enrollment records for all participants to be relied on for the processing of claims and other administrative functions for UT SELECT. In the event of a conflict between enrollment data stored at System and information on file with the vendor, the System's information shall be considered authoritative;
- The vendor shall review claims for eligibility based on covered dates of services. Any ineligible claims that are inadvertently paid by the vendor, including those identified through System eligibility audits, shall be recaptured and returned to the System;
- The vendor shall process claims submitted directly by UT SELECT participants, including Coordination of Benefits claims for which UT SELECT pays secondary benefits. An Explanation of Benefits (EOB) must be included with each direct claim payment. The vendor must submit all claim forms and sample EOBs as an attachment to the Proposal for the System's review and approval;
- UT SELECT claims filed by participants must be processed within fifteen (15) calendar days of submission to the vendor unless additional information or investigation is required;
- The vendor shall investigate unusual or extraordinary charges to determine all relevant circumstances and report its findings to System. The vendor shall determine eligible claims, subject to System's final authority on all claims matters.
- The vendor must process and pay UT SELECT claims using its own funds before seeking reimbursement from the System. The required methodology for requesting reimbursement is described within the Financial Requirements section of this RFP.

b) In the event the vendor issues excess payments or payments for ineligible claims or participants, it will:

- Take all steps necessary to recover the overpayment, including recoupment (offset) from participants' or providers' subsequent claim payments;
- Assume 100% liability for incorrect payments which result from policy or System errors attributable to the vendor in whole or in part;
- Refrain from initiating litigation to recover such overpayment unless authorized by the System;
- Provide the System with detailed reports on a monthly basis that itemize the amounts of each overpayment and the reason for each; a listing of payees with outstanding overpayment recoveries due; an accounting of: (a) prior balances of recoveries due, (b) current month

overpayments, (c) recoveries, (d) new balances and (e) percentage of overpayment dollars recovered; and an aging of receivables report for 30, 60, 90 and 91+ days; and,

- Reimburse the plan for any covered services paid on behalf of a former UT SELECT participant who was reported by the System to the vendor as no longer being eligible for plan benefits at least two (2) full business days prior to the date of such services.

c) The plan deems all plan participants receiving benefits to have assigned all rights of recovery to the plan. The vendor is responsible for providing all subrogation services, as appropriate, including but not limited to: 1) investigating claims to determine potential third-party liability, 2) contacting participants to obtain information related to third-party liability, 3) initiating demands, and filing liens to protect UT SELECT's interests, 4) initiating or intervening in litigation when necessary, and 5) employing or retaining legal counsel for such purposes.

The vendor shall be responsible for costs associated with subrogation activities and any associated litigation. Provision for such costs should be made by vendors when determining their proposed administrative fees. Payment of claims must not be withheld while a claim against a third party is pending.

d) The vendor shall maintain a complete and accurate claims reporting system and provide for the retention, maintenance, and storage of all payment records with provision for appropriate reporting to the System. The vendor shall maintain all such records throughout the term of the Contract and for at least three (3) years following the end of the Contract, and shall make such records accessible and available to the System for inspection and audit upon the System's request. In the event the vendor is scheduled to destroy payment records, the vendor must contact the System for approval prior to the destruction of the payment records. If the System approves destruction, verification of the destroyed records shall be required at the System's direction.

e) The vendor shall provide System with access to statistical information associated with UT SELECT. The information to be made available must include current fiscal year information as well as the full twelve (12) months of the preceding fiscal year. The vendor shall furnish all necessary software and hardware at no additional cost to the System.

7.5 Cost Containment Initiatives

7.5.1 Fraud Detection

The vendor must maintain effective automated systems to detect fraud and misuse of the program, overpayments, wrongful or incorrect payments, unusual or extraordinary charges, verification of enrollment and unnecessary medical treatment. The vendor shall also conduct thorough, diligent, and timely investigations with regard to fraudulent or suspicious claims and report monthly all such claims to the System. The vendor must include a written description of its comprehensive fraud detection plan with its response.

The vendor understands that System may develop further policies in connection with the detection and prevention of fraud or abuse of the UT SELECT plan. The vendor shall comply with all

applicable laws and regulations and shall also comply with all System policies and is encouraged to develop additional safeguards as allowed by law.

7.6 Reporting and Information Sharing

Routine vendor reporting, including utilization and cost data, is required to support the System's ability to proactively monitor trends and to identify and address variances on targeted vendor performance guarantees and customer service standards. Access to online tools for OEB staff to obtain plan data is also a requirement for the responding vendor. The timelines and formats for required reports shall be specified by the System. Additionally, the System may request customized reports on an ad hoc basis. Such reports must be provided in a timely manner at no additional cost to the System.

7.6.1 Flexible Spending Account Administration

The vendor will be required to exchange eligibility and claims information electronically with the contracted administrator of the UT FLEX Plan to facilitate the administration and adjudication of claims submitted for reimbursement under a UT SELECT participant's Healthcare Expense Reimbursement Account.

7.6.2 Performance Monitoring

Some report formats shall include a column indicating a performance standard for the item being reported, which shall be utilized by the System as a benchmark to monitor compliance and to analyze the reported statistics. See the Administrative Performance Report template, included as Appendix F to this RFP, for examples of this type of reporting.

7.6.3 UT SELECT Statistics

The vendor shall accumulate claims payment statistics and develop reports for UT SELECT as is typically done in the normal course of business, but no less frequently than on a monthly basis. The vendor shall provide copies of such reports upon request by the System along with results of any audits conducted in connection with the reports.

7.6.4 Consulting Actuary

The System retains an independent consulting actuary, Rudd and Wisdom, on insurance matters. The consulting actuary, who is a HIPAA Business Associate of the UT SELECT Medical plan, assists and advises System staff on benefit plan design, proposal review, and administrative fee analysis. System staff or the consulting actuary may, from time to time, request that the vendor provide additional information specific to UT SELECT. The vendor must cooperate with and act in good faith in working with the consulting actuary and must be prepared to respond to these requests promptly.

8.0 TECHNICAL AND DATA EXCHANGE REQUIREMENTS

Each institution of the System self-administers its eligibility. The System's sixteen (16) institutions do not use the same payroll system; currently approximately nine (9) different systems are used. System institutions transmit eligibility data to the System, and the System in turn transmits the appropriate data to the plan vendor.

Datasets are transmitted by institutions directly to the System as often as desired. Institutions can also make real-time updates to the System eligibility database and can transmit either a full replacement file or a partial replacement file as needed. Some institutions update their payroll files only shortly before payroll is processed; therefore, they transmit eligibility data to System only twice per month. However, other institutions update their data more often.

Due to the nature of the processes involved, there can often be a delay between the effective date of coverage and notification of eligibility to the vendor. To accommodate the variation in institutional eligibility administration and payroll systems and minimize delays and errors, the System has developed standardized methods for receiving and transmitting information between System, institutions, and vendors.

8.1 SECURE FILE TRANSFER PROTOCOL (SFTP) OVER THE INTERNET

A vendor's ability to use SFTP over the Internet and to work with HIPAA-compliant ASC X12N 834 transaction sets will be important requirement in the System's evaluation of the proposals.

8.2 SYSTEM DATA SECURITY REQUIREMENTS

For the purpose of this RFP, System data is defined as any and all information maintained, created, or received by or on behalf of System including all data maintained, created, or received by or on behalf of the UT SELECT Medical plan.

Responding vendors must maintain a robust security program capable of protecting the integrity, confidentiality, appropriate accessibility, and security of System data. Questions included in Section 12.23 of this RFP are designed to elicit specific information about the vendor's security program and must be thoroughly and accurately completed.

8.3 WEB AUTHENTICATION VIA SECURITY ASSERTION MARKUP LANGUAGE (SAML)

Security Assertion Markup Language (SAML) is an XML-based framework that forms the basis for the method of single sign-on user authentication that System strongly prefers be used for a vendor's System-specific website. An alternative method of user authentication must also be provided for those participants who cannot or who choose not to authenticate via single sign-on, including many retired

employees. Responses that indicate a vendor's willingness and ability to implement SAML-based authentication (v2.0) will be strongly preferred over those that do not.

When implementing SAML-based authentication for a vendor's System-specific website, each of the 16 System institutions will act as an Identity Provider (IdP) and determine whether the user has authenticated properly using local credentials. If the user authenticates correctly, System will redirect the user's browser and pass a SAML assertion to the vendor site in question. The vendor site will accept the SAML assertion in order to grant access.

The vendor must either agree to use System's SAML Discovery Service or to host an alternative solution for IdP discovery on the vendor's System-specific website. The vendor must agree to accept the IdP's assertion that identifies the individual using the Benefits Identification (BID) number, which may7 be the sole attribute in the SAML assertion. Each participant has a unique BID, and BIDs will be regularly communicated to the vendor via eligibility dataset.

Only user authentication will be handled via SAML. Authorization to access specific information, such as limiting the ability to view participant-specific data to only the authenticated participant, will still need to be handled by the vendor website.

It is System's strong preference that the vendor be capable of immediate implementation of SAML-based authentication (v2.0) at the start of the Contract period or that the vendor anticipates being able to implement within three to six months of the start of the Contract period. A vendor who is currently unable to implement SAML-based authentication (v2.0) should provide a statement of its ability to support authentication via proxy and should note in its response whether it anticipates being able to implement SAML-based authentication (v2.0) and, if so, when it anticipates being ready to do so.

8.4 ELIGIBILITY DATA

8.4.1 SECURITY PROTOCOLS

The vendor will be required to accept encrypted eligibility data via Secure File Transfer Protocol (SFTP) over the Internet. The data is encrypted using Pretty Good Privacy (PGP) public key encryption. The System requires that these methods be used and responses must affirmatively state that the vendor agrees to use both PGP encryption and SFTP.

8.4.2 SYSTEM'S ELIGIBILITY DATABASE

Each institution's eligibility data is transmitted to the System and used to update an eligibility database maintained by System. This database provides the information for System to generate eligibility (enrollment) datasets specific to the UT SELECT plan. The database maintained by System is directly updated by enrollees during the Annual Enrollment period using the System's *My UT Benefits* online enrollment application. During the July 2012 Annual Enrollment, approximately 61% of all employees and retired employees made their Annual Enrollment elections using the *My UT*

Benefits online system. This enrollment process provides the advantage of having most new enrollment data available several weeks prior to September 1, the beginning of each new plan year.

8.4.3 ELIGIBILITY DATASET EXCHANGE

Currently, both full replacement and partial replacement eligibility files are being transmitted by the System to plan administrators on a regular schedule. Eligibility data will be sent to the vendor at least three times per week and will be available to the vendor by 6:00 a.m. (CT) on designated days of the week.

The vendor will be required to receive and process at least three partial replacement eligibility (enrollment) datasets for UT SELECT per week. A partial replacement dataset includes only records for individuals who are new or who have had a change in coverage since the last dataset was generated. Once per month a full replacement dataset that includes all current participants will be sent to the vendor. Each year during the second half of August and the majority of September, larger than normal datasets can be expected due to updates related to annual enrollment and the start of the new plan year.

It is System's expectation that the vendor will immediately process eligibility datasets and that updated information will be loaded into the vendor's information system within 24 hours of receipt under normal circumstances. Within twenty-four hours, the vendor must positively confirm via email the receipt, processing, and successful load (or failure to load) of each eligibility dataset. Further, in the event that an eligibility dataset fails to load, the vendor should provide an explanation for the failure to load either within or as immediate follow-up to the initial notification. The vendor must work directly with System as needed to ensure that dataset load issues are resolved as quickly as possible and updates are loaded to the vendor's information system.

The required format for eligibility data being transferred to and from the System is the HIPAA-compliant "Benefit Enrollment and Maintenance Transaction Set (ASC X12N 834)" format. Responses must confirm that the vendor agrees to use the ASC X12N 834 format or, if unable to comply with the requirement, should include a rationale to use another applicable ANSI X12 transaction set.

8.5 RETROACTIVE ELIGIBILITY ADJUSTMENTS

The System requires contracting vendors to allow a retroactive window for eligibility changes to be made up to 90 days after the end of the coverage period affected. The adjustments that must be allowed include activation of eligibility, termination of eligibility, and other variations that may occur as a result of participant status changes. The System retroactively adjusts the payment of administrative fee assessments to ensure agreement with updated eligibility information. For claims rendered ineligible as a result of a retroactive eligibility change, System requires the vendor to purse recapture in a manner consistent with standard practices applicable to any other ineligible claim.

8.6 REQUIREMENTS TO FACILITATE EMERGENCY UPDATES

On occasion, System institutions may need to make emergency updates to the coverage of their plan participants. Emergency updates are updates to eligibility coverages on the vendor's eligibility system made through a means other than the eligibility dataset. The System has implemented a "controlled emergency update email process" through which an institution Benefits or Human Resources representative can submit an emergency update request when needed.

The institutions are required to update the System eligibility database prior to sending an emergency update request to the plan vendor. The eligibility system verifies the coverage prior to sending an emergency update email which is always sent from a single, controlled, email account.

Social Security numbers will never be transmitted on emergency update email messages. The vendor will either need to be able to add a new participant to their eligibility system prior to receiving the Social Security number or be able to connect to a secured System website to retrieve complete update information. The link to the secure website will be included in all emergency update email messages.

The emergency update system can be configured to send the email update request to designated vendor staff members for handling. The email can be formatted to include the vendor's preferences for coding, and its structure does include some free-form text. The vendor may choose up to five (5) email addresses to receive emergency update emails. Confirmation of a completed update to the vendor's database is required within four (4) business hours of receipt of an emergency update email.

Preference will be given to responses indicating the willingness and ability to accept and process emergency updates via email as specified above. However, if a vendor is unable to receive and process emergency update emails, the vendor may, as a less preferred option, provide an access-controlled software interface through which the System can directly update the vendor's eligibility database. The preferred method for this option is an Internet interface accessible via a Web browser such as Firefox, Microsoft Internet Explorer, Google Chrome, or Apple Safari.

8.7 DETAILED CLAIMS DATASET REQUIREMENTS

System requires that the vendor provide detailed claims datasets as support for the claims invoices and for the purpose of claim eligibility audits and for analysis by the System's consulting actuary. The System also requires direct online access to claims information at all times at no additional charge.

System prefers that detailed claims information be provided in conjunction with each claims invoice. System requires that a detailed claims dataset must be transmitted weekly by the vendor to System. For weeks that include the end of a month, two claims datasets will be required to facilitate a clear division of claims processed in each month. A supporting claims dataset must be received by System before reimbursement can be issued for claims included on the associated claims invoice.

The claims dataset must be provided in the HIPAA "Health Care Claim: Medical" Transaction Set (ASC X12N 837) format and should include all UT SELECT claims that were processed, adjusted, or rejected during the previous period and included on the associated claims invoice. The detailed claims dataset must be PGP encrypted and sent by SFTP via the Internet to System and the consulting actuary.

8.8 COBRA Premium Remittance Dataset

For the purpose of this contract, the COBRA Premium Remittance Datasets can be in either Systems Premium Billing / Remittance format or in the HIPAA-approved "Payroll Deducted and Other Group Premium Payment for Insurance Products Transaction Set (ASC X12N 820)" format. The dataset must be transmitted via SFTP over the Internet to the System's secure FTP server. An automated email will be sent to the appropriate contacts notifying them the dataset has been received and processed. Each remittance must reflect remittance detail for the current billing month plus may make any necessary adjustments for the prior three months.

8.9 Data Format for Administrative Fee Payments

The System will produce a self-bill by the fourteenth (14th) day of the month for the PMPM administrative fee due to the vendor for the prior month (billing month). Bills currently are created in a System-specific premium billing dataset format; however, for the purpose of this contract, self-bills may be generated in either an administrative fee billing format or in the HIPAA-compliant "Payroll Deducted and Other Group Premium Payment for Insurance Products Transaction Set (ASC X12N 820)" format.

The dataset will be transmitted via SFTP over the Internet to a secure FTP server. Upon placement of the dataset on the server, an automated email will be sent to the appropriate vendor contacts with notification of the dataset transmission and billing total. Each bill will reflect remittance detail for the current billing month along with any necessary adjustments for the prior three months.

Based on an eligibility snapshot taken from the System eligibility database on the first Sunday of each month, the System will prepare a report detailing the administrative fee remittance as support for the monthly payment of the administrative fee. The report will reference specific plan participants, their BIDs, affected coverage periods, and the fee amounts being remitted for each.

8.10 Electronic and Information Resources (EIR) Warranty

System is required to acquire all EIRs in compliance with the legal requirements governing access to such EIRs by individuals with disabilities ("EIR Accessibility Requirements"). The EIR Accessibility Requirements applicable to the University are set forth in Chapter 2054, Subchapter M of the Texas Government Code, Title 1, Section 206.70 of the Texas Administrative Code, and Title 1, Chapter 213, Subchapter C of the Texas Administrative Code. In order for System to ensure that the EIRs offered by

each Proposer responding to this RFP are in compliance with the EIR Accessibility Requirements, Proposer must include all of the following in its proposal:

COMPLIANCE WITH THIS STATUTE AND THESE RULES IS NOT OPTIONAL AND THEIR APPLICABILITY CANNOT BE WAIVED.

1) The vendor must warrant that the website complies with the requirements set forth in Title 1, Rules §§ 206, 213.30 and 213.36 of the *Texas Administrative Code* (as authorized by Chapter 2054, Subchapter M of the *Texas Government Code*). The proposal must provide that to the extent vendor becomes aware that the website does not satisfy the EIR Category Warranty, vendor will, at no cost to System, perform all necessary remediation to make the website satisfy the EIR Category Warranty.
2) Vendor is required to submit a completed Electronic and Information Technology (EIR) Accessibility Checklist (included as Appendix J to this RFP) along with proposals. Proposals or bids without a completed checklist will be disqualified.
3) Vendor must provide a written explanation for each of its responses to the requirements in the Checklist with respect to the website:
    - If Proposer determines that the website ***complies*** with an applicable accessibility requirement in the Checklist, Proposer's written response to that requirement must identify how Proposer made such a determination (merely responding with "Complies" or similar non-explanatory language is ***not acceptable***).
    - If the vendor determines that the website ***does not or will not comply*** with an applicable accessibility requirement in the Checklist, Proposer's written response to that requirement must identify the cause of such non-compliance and the ***specific*** efforts and costs that Proposer would need to assume in order to remedy such non-compliance (merely stating "Does not comply" or similar non-explanatory language is ***not acceptable***).
    - If Proposer determines that an accessibility requirement in the Checklist ***is not applicable*** to the website, then Proposer's written response to that requirement must identify the reason for such inapplicability (merely stating "N/A" or similar non-explanatory language is ***not acceptable***).
4) All vendor Proposals must:
    - Agree to authorize UT System to engage in product accessibility conformance testing prior to and after completion of purchase.
    - Provide the name and contact information of the individual responsible for addressing accessibility questions and issues about the product.
    - Describe the vendor's capacity to respond to and resolve any complaint regarding accessibility of products or services provided pursuant to this RFP.

8.11 AD HOC REQUESTS AND ISSUE RESOLUTION

The vendor shall provide the System with priority positioning for delivery of ad hoc system service requests and issue resolutions. Through the designation of an appropriate technical contact as

required for the Implementation and Account Management Teams, the vendor shall ensure that all System information systems requests and issues are given priority positioning and thoroughly analyzed to ensure speedy resolution. The vendor shall provide competent, focused attention to each information systems request or issue presented by System.

It is the expectation that the vendor will make every effort to deliver a resolution within 30 days from receipt of the System's written notification of a request or issue related to the vendor's information systems. The System will be responsible for supplying detailed information reasonably necessary for the vendor to complete the requested services. If a 30-day resolution is not reasonable for a particular issue, the vendor must provide System with an implementation plan and timeline for resolution within five (5) days from receipt of notification.

An example of a requirement falling under this provision would include, but would not be limited to:

> Modifications to benefits or eligibility processing requirements must be reviewed, responded to, and approved by the vendor within 15 days of such request by System. If the vendor requires adjustments prior to granting approval, the vendor shall immediately notify the System and set up weekly update meetings to be held until the System agrees that the modifications will meet the System's operating requirements. Once requested modifications have been mutually agreed upon, the vendor shall complete the eligibility or benefits project, including required testing within 45 days of Systems' approval.

9.0 COMMUNICATION REQUIREMENTS

The vendor will be required to communicate information regarding UT SELECT design approved by System. All plan communications should be designed to educate both potential enrollees and current participants and must be approved by System prior to dissemination. Communications regarding UT SELECT must be clear and concise, using terminology familiar to participants as specified by System.

The vendor will be required to develop UT SELECT communications for written, electronic, and verbal dissemination to accommodate the varying needs of potential participants. However, System prefers that electronic communication be used whenever reasonably possible. Printed materials must always be made available electronically. Communication materials must meet ADA requirements for accessibility.

The vendor may recover the costs of the services described in this section only by making provision for such costs in the calculation of the proposed administrative fee.

9.1 GENERAL INFORMATION

Communication materials to be developed by the vendor may include, but are not limited to:

- Participant brochures and information for inclusion in benefits books and newsletters;
- A customized, System-specific UT SELECT website;
- Mobile applications;
- Presentations to institution Benefits Staff and participants;
- Online videos (or participation in System's video development process as needed);
- Scripted responses to be used by customer service representatives;
- Advertising materials in association with UT SELECT enrollment;
- Explanations of Benefits (EOBs), order forms, and claim forms;
- Provider Directory, including a specific disclaimer stating that the list of providers is subject to change;
- News releases, including contract signing announcement;
- Participant welcome packet; and
- Token giveaways for enrollment fairs and events.

Communication materials designed for UT SELECT participants cannot, and the vendor represents and warrants that it shall not, advertise or promote coverage, products, or materials, other than those relating to the vendor's administration of UT SELECT.

9.2 SAMPLE COMMUNICATION MATERIALS REQUIRED

Electronic draft copies of proposed Plan Year 2013-2014 printed materials, Benefits Guide, and advertising (newspaper ads, radio scripts, television ads, etc.) must be submitted as part of the proposal. Respondents to this RFP should also submit samples of other communication materials with their proposal, including consumer targeted educational materials (in both print and electronic format) and the format of the customized System-specific website.

9.3 ANNUAL ENROLLMENT

Annual Enrollment information must be promptly provided to all benefits-eligible employees and retirees. The requirements listed below apply to all Annual Enrollment materials, including information for benefits guides.

9.3.1 CUSTOMER SERVICE INFORMATION

All items must include the customer service phone number, hours of operation, a description of the process for filing claims, the appeal process for claim denials, and the vendor's website address.

9.3.2 DESCRIPTION OF BENEFITS

The vendor must provide a Schedule of Benefits that contains the benefits as set forth on pages 4-11 of the Benefits Guide, included as Appendix B to this RFP. The summary shall include any additions, limitations and exclusions approved by the System.

9.3.3 NETWORK PROVIDER DIRECTORY

A System-approved Provider Directory in print-ready format must be made available (see the Custom Website section of this RFP for details regarding the online Provider Directory). It should include each provider's address, National Provider Identifier (NPI), specialty, clinical and hospital affiliations, and whether or not the provider is accepting new patients, along with additional available details including board certifications and quality ratings. The Provider Directory must include a prominent disclaimer that contracting providers are subject to change.

The Provider Directory must be updated on at least a monthly basis.

9.3.4 DUE DATES FOR ENROLLMENT MATERIALS

All educational and enrollment materials used for both Annual Enrollment and new employees must be distributed to all System institution benefit offices no later than June 1 of each plan year.

9.3.5 ATTENDANCE AT ANNUAL ENROLLMENT MEETINGS

The contracting vendor is required to attend key scheduled Annual Enrollment meetings at each System institution when requested by the institution Benefits Office at the vendor's own expense. Vendor participation at Annual Enrollment meetings will help educate employees about UT SELECT. If the contracting vendor is unable to attend all Annual Enrollment meetings being offered at a particular System institution, the institution will have the discretion to designate a particular meeting or meetings as high-priority and request vendor attendance specifically for the designated priority meeting(s).

9.3.6 CUSTOMER SERVICE DURING ANNUAL ENROLLMENT

The vendor's dedicated Customer Service Team will be required to assist in answering questions regarding UT SELECT each year during System Annual Enrollment period(s), including during the July 2013 Annual Enrollment period. Education by the vendor Customer Service Team must be provided to all current and potential UT SELECT participants. Customer service should be made available via phone, email, in writing, or in person.

9.4 SYSTEM-SPECIFIC WEBSITE

The vendor must establish a customized, System-specific website with the primary goal of allowing participants to easily access plan information regarding customer service toll-free numbers, claims, and plan contacts for UT SELECT. The website must meet all requirements as detailed in this section as well as those included in the EIR Warranty described in Section 8.10 of this RFP.

The vendor's System-specific website must be available to the System for testing no later than June 1, 2013. The final System-approved website for plan year 2013-2014 must be completed by June 23, 2013, and must include the System-approved enrollment materials. The System must approve new website additions or redesigns at least two weeks prior to any scheduled launch date. The vendor must be able to provide detailed web activity reports to System monthly, quarterly or upon request.

9.4.1 CONTENT SPECIFICATIONS

The System-specific website should be kept regularly updated with timely, relevant information for UT SELECT. All content for the System-specific website must be approved by the System before it is released. The site must include:

- A link to the UT SELECT Benefit Guide, which is inclusive of the System's self-funded PPO Medical Plan and the PDP summary as approved by the System;
- An interactive current, System-approved Provider Directory. It is Systems requirement that the online Provider Directory be updated at least weekly during Annual Enrollment and at least monthly throughout the plan year. The directory must be user-friendly and must include the following:

1) Geographic search capability, including by zip code;
2) Each provider's specialty and assigned National Provider Identifier (NPI);
3) Clinical and/or Hospital affiliations for each provider;
4) Additional available details including each provider's board certifications and quality ratings;
5) An indication whether each provider is accepting new patients or not;
6) An indication of language(s) spoken in provider's office; and
7) A disclaimer stating that contracting providers are subject to change.

- Customer service information, including phone numbers, mail and claim addresses, hours of operation, and guidelines for the complaint and appeals process;
- Electronic forms or email addresses for customer complaints and questions. Responses to email complaints should have no more than a 48-hour turnaround time. A tracking system for complaints submitted online, similar to the tracking of telephone complaints, must be in place with the ability to provide data and details to the System upon request;
- All necessary forms (e.g. claims forms) for participants. If forms are made available in PDF format, an easily identifiable link must be provided to download Adobe Acrobat Reader to enable participant viewing and printing;
- System's branding and a System-specific welcome message must be included to clearly indicate the site is specific to UT System and UT SELECT;
- A link to the System's Employee Benefits website; and
- If the vendor provides personal account access through which participants may view specific individual information, the site must utilize secured protocol (https://) and require authentication. The site may not use the participant's Social Security number, in whole or part, as either the user identification or the password.

The Benefits ID may be used as the user identification. Authentication via single sign-on is strongly preferred over requiring a unique user identification and password specific to the site. See the section of this RFP entitled "Technical and Data Requirements" for additional details.

9.4.2 TECHNICAL SPECIFICATIONS

The System-specific website must be accessible to as many participants as possible. Therefore, the following specifications must be met:

- All website content must be clearly visible and functional in current and recent versions of Chrome, Firefox, Internet Explorer, Safari, and Opera browsers;
- Entering a Social Security number should not be required at any time to access information on the website;
- The logon page must not allow the browser to store the information entered in the cache. The auto-complete feature must be turned off for every form;

- The font must be easy to read, no smaller than 10px; and
- All electronic and information resources (EIR) including website navigation, videos, interactive applications, Adobe Portable Document Format (PDF) files, etc. must conform to the Texas Department of Information Resources (DIR) Accessibility Rules.

9.5 UT SELECT BENEFITS GUIDE

A separate plan booklet, the Benefits Guide, must be provided for the UT SELECT plan for each plan year. If corrections or amendments need to be made to the Benefits Guide during a plan year, an updated electronic version will be made available on the System Office of Employee Benefits website as well as the vendor's UT SELECT website.

The Benefits Guide must include the following:

- A Summary of Benefits as approved by the System;
- Any additions, limitations and exclusions;
- A description of the appeals process;
- A description of current eligibility requirements as set forth in Chapter 1601 of the Texas Insurance Code; and
- The vendor and System co-branding.

The contracting vendor is responsible for providing a draft of the Benefits Guide each year and is expected to assist System with the development of the booklet.

Final drafts of the Benefits Guide must be submitted by the vendor to System for review no later than July 1, 2013 for the 2013-2014 plan year. It is System's intent to distribute the plan booklet in both electronic and hard copy no later than the first week of September of each plan year.

UT SELECT participants who do not have an email address on file will be notified that they can request a printed Benefits Guide. Members with an email address on file will receive an email from System with a link to an electronic version of the plan booklet. During the plan year, the Benefits Guide will be available online or through institution Benefits Offices.

9.6 UT SELECT IDENTIFICATION (ID) CARDS

Prior to September 1, 2013, the vendor must send UT SELECT ID cards to all UT SELECT participants, including those who enroll in the plan during the July 2013 Annual Enrollment period. Throughout the contract period, the vendor must issue ID cards to all new enrollees within five (5) business days after the vendor receives the enrollment information from the System. Additionally, due to information security requirements, the vendor must provide System with a monthly dataset that includes all identifying information from each UT SELECT ID card issued and the name and address to which each was sent for all ID cards issued during the prior month. The UT SELECT prescription drug plan has its own unique ID card issued by Express Scripts.

The UT SELECT ID card may not include the participant's Social Security number. The card must use the Benefits ID number as specified by the System, as well as other standard information in a format prescribed by the System. The Benefits ID number should be written in a font that clearly distinguishes each character. Replacement cards must be provided at the request of a UT SELECT participant. Once initially distributed, ID cards do not need to be automatically replaced unless changes to the benefit plan design require updates to the information shown on the card or changes are made to a participant's name as shown on the card (such as a change to a participant's last name due to marriage).

9.7 PROHIBITIONS; NOTICE OF INQUIRIES FROM THIRD PARTIES

As the third party administrator for UT SELECT, the vendor may receive numerous inquiries from interested third parties relating to UT SELECT and their program administration. The vendor is strictly prohibited from disseminating any information about coverage, products, or materials on the vendor's website other than those explicitly relating to the vendor's plan offered or service provided to System participants, including the System-specific UT SELECT website.

The vendor must forward all inquiries from interested third parties relating to UT SELECT and program administration to the System Office of Employee Benefits.

9.8 DISSEMINATION OF COMMUNICATION MATERIALS

Communication materials may be considered "published" when a final electronic copy is delivered to the System or is accessible on the vendor's website. Materials that contain protected health information or other confidential information such as a participant's Benefits ID number must be mailed in an envelope or packaging designed to secure confidential information from casual viewers.

9.9 TRAINING OF SYSTEM AND INSTITUTION STAFF

The vendor must provide training to System staff and institution HR and Benefits staff regarding UT SELECT. Centralized training for institution HR and Benefits staff occurs on an annual basis during the Benefits and Human Resources Conference (BHRC) hosted in Austin by OEB. The BHRC is usually scheduled during the month of June. In addition, specific training for institution HR and Benefits staff may be required at other times during the year based on changes to operations and the needs of the System. The vendor will provide System with updates on current industry best practices and legislative changes as they relate to non-federal governmental health plans.

10.0 PERFORMANCE STANDARDS AND PENALTIES

The vendor must monitor its administrative performance to ensure compliance with the requirements listed below and must report the specified information to the System on a quarterly basis in an Administrative Performance Report. See the template included as Appendix F to this RFP for the required format for the Administrative Performance Report.

Annual audits of the vendor conducted on behalf of the System will also determine compliance with these and other standards. The vendor must agree to the annual audit, generally conducted during the first quarter of each calendar year for the preceding plan year.

The vendor selected to administer UT SELECT must agree to pay the financial penalties as shown in this section if the associated performance standards are not met. Additionally, the vendor should be aware that compliance with these requirements will be a key consideration during any future contract renegotiations.

10.1 ADMINISTRATIVE REPORT TIMELINESS

System Requirement: Each Administrative Performance Report is due no later than the 20th of the month following the end of the System plan year quarter or by the first business day following the 20th, if it falls on a weekend or holiday.

Financial Penalty: A penalty of $2,000 may be assessed for each quarter in which the vendor fails to submit the Administrative Performance Report by the required due date.

10.2 CUSTOMER SERVICE CALL HANDLING

System Requirement: When contacting the toll-free UT SELECT customer service number, the average time a caller waits before speaking to a vendor customer service representative should be 30 seconds or less. The average abandonment rate should not exceed 5%.

The average speed of answer (ASA) and average abandonment rate (ABR) must be reported on a quarterly basis. System-specific data is strongly preferred; however, if System-specific data is not available due to technical limitations, these two customer service statistics for the complete book of business may be reported instead.

Financial Penalty: A separate penalty of $4,000 each may be assessed for each quarter in which the ASA exceeds 30 seconds and for each quarter in which the ABR exceeds 5%.

10.3 CALL CENTER AND WEBSITE OUTAGES

System Requirement: Outages of customer service access points, including telephone and IVR services at the Customer Service call center as well as with the System-specific website, should be kept to a

minimum. If an outage does occur (or is expected to occur), the vendor must report the outage to System as soon as possible and service should generally be restored within one (1) hour of the outage, dependent upon specific circumstances.

Financial Penalty: A penalty of $1,000 may be assessed for each outage longer than one (1) hour but less than eight (8) hours. If an outage is greater than 8 hours but less than 24 hours, a penalty of $2,000 may be assessed. If an outage lasts longer than 24 hours, a penalty of $4,000 may be assessed for each occurrence, up to a maximum penalty of $12,000 for each quarter. OEB may waive this penalty based on extenuating circumstances, including down time due to unusually severe weather, a natural disaster, or an act of terrorism.

10.4 UT SELECT ID CARDS

System Requirement: Prior to September 1, 2013, the vendor should mail 100% of UT SELECT Identification (ID) Cards to enrollees within five (5) business days from the date of receipt of enrollment information from the System. Beginning September 1, 2013, the vendor should mail an average of 95% of ID cards to System participants within five (5) business days from the receipt of a request from the participant or from the receipt of enrollment information from the System.

Reporting: The total number of UT SELECT ID cards mailed to current and newly enrolled System participants and the percentage that were mailed within five (5) business days from the receipt of request or from the receipt of enrollment information must be included in each quarterly report. The initial report for the Contract Period must also include a detailed description of the processes and systems used to verify the time between receipt of a request or new enrollment information and mailing.

Financial Penalty: A penalty of $8,000 dollars may be assessed if the requirement for mailing ID cards prior to September 1, 2013, is not met. A penalty of $4,000 may be assessed for each quarter in which fewer than 95% of ID Cards are mailed within five (5) days of the receipt of a request or new enrollment information.

10.5 ANNUAL ENROLLMENT MATERIALS

System Requirement: The vendor must meet all due date requirements as specified in this RFP for materials related to Annual Enrollment.

Financial Penalty: A penalty of $4,000 may be assessed for each violation of the due date requirements for: (1) preparation of the System-specific website; (2) distribution of plan materials; and (3) assistance with preparation of plan booklets.

10.6 CLAIMS AND FEE BILLING DATASETS

System Requirement: Vendor must comply with the requirement to transmit detailed claims data on a weekly basis and to accept the monthly dataset transmitted from System detailing the self-billed administrative fee as the method for tracking and documenting all administrative fees due from System to the vendor.

Financial Penalty: A penalty of $2,000 may be assessed for each weekly claims detail dataset that is overdue by more than 30 days, up to a maximum of $20,000 per Contract Year.

10.7 ELIGIBILITY DATASET PROCESSING

System Requirement: Maintenance eligibility datasets received from the System by 11:00 a.m. (CT) on any business day will be processed within 24 hours of receipt and System notified of the status once processed. If problems with a dataset or with the vendor's information system prevent processing of any file within 24 hours of receipt, the vendor shall immediately notify System of the issue and begin resolving the issue(s).

Financial Penalty: A penalty of $2,000 may be assessed for each successfully transmitted dataset not processed by the vendor within the specified time frame or failure to notify System of a transmitted dataset's status within the specified time frame, up to a maximum penalty of $20,000 per Contract Year.

10.8 EMERGENCY UPDATE PROCESSING

System Requirement: Valid emergency update requests from System institution staff must be processed and confirmation sent to the submitter within four (4) hours of receipt when received by 1:00 p.m. (CT) on a business day. Requests received after 1:00 p.m. (CT) on a business day or anytime on a non-business day must be processed no later than noon (CT) on the following business day.

Financial Penalty: A penalty of $1,000 may be assessed for each occurrence in which a valid update request was not processed and confirmation sent within the required time frame.

10.9 PLAN DESIGN CHANGES

System Requirement: Requested plan design changes must be implemented by the vendor with 100% accuracy following final approval and agreement between System and the vendor regarding specific expectations and effective dates.

Financial Penalty: A penalty of $5,000 may be assessed for each set-up error, up to a maximum of $20,000 per Contract Year.

10.10 CLAIMS PROCESSING

System Requirement: The vendor must meet the claims processing timeliness and financial accuracy standards as required in Section 5.11 of this RFP.

Reporting: The vendor must include in its quarterly report the total number of claims received from System participants, the total dollar amounts paid and denied, the average processing time (in days) for payment of these claims, and the percentage processed and paid within 15 days and 30 days, respectively, from date of receipt.

Financial Penalty: A penalty may be assessed by the System for failure to comply with the timeliness and financial accuracy standards applicable to claims processing as described in Section 5.10 of this RFP.

10.11 HEALTH CARE MANAGEMENT

System Requirement: The vendor must establish a Target Claims Cost (TCC) for each plan year of the Contract period as described in Section 5.11 of this RFP.

Financial Bonus/Penalty: A bonus may be earned or a penalty assessed based on the comparison of Actual Claims to TCC as described in Section 5.11 of this RFP.

10.12 PROVIDER ADDITIONS AND TERMINATIONS

System Requirement: The vendor should maintain an overall net gain of contracting providers throughout the plan year.

Reporting: The vendor must include the number of provider additions and terminations by category in its quarterly report.

Financial Penalty: No penalty is associated with this requirement.

10.13 APPOINTMENTS

System Requirement: The vendor should establish appointment standards by category. The vendor should maintain an average compliance for each category of at least 90%.

Reporting: The vendor must report their appointment standard for each category and their compliance with the standard.

Financial Penalty: A penalty of $4,000 may be assessed for each quarter in which the average appointment compliance rate is below 90%.

10.14 WRITTEN INQUIRIES

System Requirement: At least 95% of written inquiries received from participants that require a response should be responded to within five (5) business days of receipt.

Financial Penalty: A penalty of $4,000 may be assessed for each quarter in which the overall rate at which the timeliness standard for responding to written inquiries is met falls below 95%.

10.15 COMPLAINTS

System Requirement: The average time to resolve System participants' complaints should not exceed 30 calendar days, with at least 90% resolved within 15 days of the vendor's receipt of all information reasonably necessary to address the complaint.

Reporting: The vendor must report the total number of complaints received from System participants (via mail or email), the average length of time to resolve complaints, and the percentage resolved within 15 days of receipt of all reasonably necessarily information. System-specific data is required.

Financial Penalty: A penalty of $4,000 may be assessed for each quarter in which the average time to resolve complaints received from System participants exceeds 30 days or when fewer than 90% are resolved within 15 days of receipt of reasonably necessary information.

10.16 PARTICIPANT SURVEYS

System Requirement: Periodic participant surveys must be conducted. System requires that an overall average Participant Satisfaction Rate of 90% or greater be achieved for each Contract Year.

Financial Penalty: A penalty of $10,000 may be assessed for each Contract Year in which the overall Participant Satisfaction Rate as reported via survey falls below 90%.

10.17 FRAUD DETECTION

System Requirement: Automated systems and other measures sufficient to detect fraud, abuse, overpayments, wrongful or incorrect payments, and to verify enrollment should be in place.

Reporting: Any incidents of fraud, abuse, overpayments, wrongful or incorrect payments, as well as verification of enrollment, must be included in the quarterly report. The vendor must also report the total number of dollars recovered through fraud investigation activity.

Financial Penalty: No penalty is associated with this requirement.

11.0 PROPOSAL EVALUATION

Proposals submitted in response to this RFP will be evaluated on the basis of criteria described below. While the criteria, which should not be assumed to be listed in order of importance, are intended to provide the basis for an objective evaluation of each proposal, the experience and judgment of System staff and their advisors shall also be important in the selection process. The goal of the process will be to determine the organization that will provide the System with the best partner for the administration of the UT SELECT plan while maintaining a strong emphasis on providing excellent customer service and robust wellness initiatives during the term of the contract.

11.1 VENDOR LICENSURE

To be considered for selection, vendors must be licensed as a third-party administrator with the Texas Department of Insurance.

11.2 COMPLIANCE WITH THE RFP

Proposals containing deviations are strongly discouraged. If included, deviations must be specifically identified and described in detail to be considered. While a proposal with minor deviations from the RFP specifications will not be disqualified, preference will be given to prospective vendors whose proposals contain the fewest and least significant deviations from the requirements presented herein. Information about proposed unique or value-added benefits and programs that would enhance or supplement the current benefit offering specified within this RFP are welcome when presented in conjunction with confirmation that the vendor agrees to the requirements as presented in this RFP.

The System will interpret all responses to be indicating agreement with the specifications contained herein except in cases where deviations are specifically noted and described as required. Deviations will not be included in the final contract unless expressly accepted and agreed to by the System in writing and accepted by the Board of Regents. In all cases, this RFP, the vendor's RFP response, and the contract terms shall be binding.

11.3 IMPLEMENTATION TIMELINE AND CRITICAL DEADLINES

The vendor's ability to meet the required dates for critical implementation tasks as specified in the section of this RFP entitled "Implementation Timeline," will be an important consideration in the evaluation of vendor proposals.

11.4 THE CONTRACT

All proposals must include an affirmation of the vendor's willingness to accept the provisions set forth in the System's Sample Contract, included as Appendix H to this RFP. Proposals indicating that a

vendor is unwilling to sign a contract in the format prescribed by System and containing the essential terms set forth in the Sample Contract, without deviations, will not be considered.

11.5 PROVIDER NETWORK ADEQUACY AND ACCESSIBILITY

The vendor's response must include a provider network with a sufficient number of family care physicians, specialty physicians and hospitals to serve UT SELECT participants. All health care providers included in the proposed network must have signed contracts in place on or before July 1, 2013. However, the System recognizes that an organization may need to recruit additional providers in certain areas to serve UT SELECT participants. Therefore, the organization should include in its proposal a proposed action plan for additional network recruiting through December 31, 2013. The proposed provider network will be reviewed utilizing:

1) The Texas Department of Insurance (TDI) and the System criteria regarding mileage and the availability and accessibility of physicians and hospitals;
2) The vendor's access standards for:
    - Routine physicals,
    - Office visits for illness,
    - Urgent care, and
    - Emergency care;

All other factors being equal, the System will give preference to the organization with the provider network that is at least as extensive as the current network.

11.6 PROVIDER NETWORK QUALITY

Based on the proposal response and any on-site visits the System may conduct, an evaluation will be made of the organization's ability to coordinate and operate high quality, cost-effective provider networks. The vendor's ability in connection with the following will be considered:

1) Management of networks in the entire UT SELECT service area - the State of Texas;
2) Accessible provider networks;
3) Network sophistication as indicated by:
    - Provider credentialing,
    - Fee contracting,
    - Utilization management,
    - Quality review, and
    - Customer service;

4) The ability for employees, retired employees and their dependents who travel or reside outside of Texas to access a national network.

11.7 Financial Strength and Stability

The System has specified a minimum net worth that is applicable for consideration as a prospective vendor under this RFP. A net worth substantially in excess of the minimum will not be considered to indicate a superior proposal. However, a net worth below the specified minimum will result in disqualification of the proposal.

11.8 Administrative Capability

Vendors will be evaluated on the basis of their demonstrated ability to provide high-quality services to the System in the management and administration of UT SELECT. All aspects of the services described herein are considered important to this evaluation, including claims administration, utilization management, data reporting capabilities, and ability to partner with the System's other contracted benefits plan vendors.

11.9 Health Care Management Incentive

The System believes that an organization's ability to provide a cost-effective managed care network is best evaluated on the basis of the target claim cost (TCC) to which the organization is willing to commit. The FY 2014 TCC formula and the trend guarantees for FY 2015 and FY 2016 provide the System with an objective basis for evaluating the cost-effectiveness of an organization's managed care network.

11.10 Operational Experience

Demonstrated experience with administering and managing comprehensive medical plans and provider networks on behalf of large employers (with more than 10,000 participants), and particularly experience with large public employer plans, will be an important consideration in the overall proposal evaluation process. Prior experience with System will also be considered in the evaluation process.

11.11 Account Management Team

A vendor's commitment to a strong and consistent Account Management Team will be an important consideration in the evaluation process.

The System considers the account service relationship to be a critical link in developing and maintaining a strong partnership dedicated towards the achievement of plan objectives. Vendors must be prepared to provide the System with account service that is at the highest levels in the industry and that is fully consistent with the System's expectations. The vendor and the System will mutually define the criteria to be used for measurement and evaluation of account service performance.

11.12 DATA MANAGEMENT

The vendor's ability to consistently and accurately provide data transmission and processing, as specified in this RFP, will be an important consideration in the selection process. Some of the key factors to be evaluated include:

- A management information system that will support the database maintenance and management reporting requirements specified herein;
- The vendor's ability to accept eligibility datasets as specified herein, to update eligibility records in a timely manner, and to promptly notify System upon the success or failure of the attempt to load each eligibility dataset received;
- The vendor's ability to implement SAML-based authentication (v2.0) or, if not, to support authentication via proxy;
- The vendor's ability to accept emergency eligibility updates via email and confirm processing of requested changes within the timeframes specified herein;
- The availability of a secure website through which System staff can view enrollment status for participants and make updates if necessary; and,
- The vendor's ability to electronically transmit claims data to System, the UT FLEX administrator, and the System's consulting actuary.

11.13 CUSTOMER SERVICE

Evaluation of the vendor's ability and willingness to provide customer service according to the standards specified in this RFP will include consideration of the vendor's:

- Customer service and data reporting capabilities;
- Ability to provide general administrative services;
- Willingness to commit to specified service and quality performance levels;
- Willingness to provide communications materials and personnel for attendance at the annual Benefits and Human Resources Conference for HR and Benefits Office staff from all System institutions (usually held in Austin for 2-3 days during June of each year) and for attendance at Annual Enrollment meetings for employees and retirees (generally approximately 25 – 30 meetings beginning in late June and continuing through the entire month of July) held at locations throughout the state;
- Ability to develop and maintain a customized, System-specific website for UT SELECT; and,
- Ability to meet the Electronic Information and Resources (EIR) Warranty requirements described in the "Communications Requirements" section of this RFP.

11.14 ADMINISTRATIVE FEE

The System expects to receive proposals from several highly qualified vendors, all of which can provide high-quality, cost-effective service. For these, a distinguishing factor will be the vendor's

proposed administrative fee. While cost is a key consideration, the System is not required to select the proposal with the lowest price.

11.15 Privacy and Security of System Data

The vendor must demonstrate its ability to safeguard the privacy and security of System data, collected or maintained by the vendor on System's behalf, in compliance with applicable law and System's own privacy and security requirements.

11.16 Electronic and Information Resources (EIR) Warranty

The vendor must demonstrate its ability to comply with the accessibility requirements set forth in the Electronic and Information Resources Warranty as described in Section 8.10 of this RFP.

11.17 Other Factors

Based on responses provided, other factors will be considered during the evaluation process, including but not limited to the following:

- An organizational structure and a delivery mechanism that have demonstrated the ability to deliver high-quality, cost-effective management and administration of the UT SELECT medical plan;
- Information obtained from the vendor's list of references;
- A demonstrated commitment to fully support the System's "Living Well" program through targeted initiatives and ongoing collaboration with the System and other contracted vendors; and,
- System also reserves the right to request that representatives from vendors determined to be finalists meet with System representatives (at a location to be determined by System) to clarify responses and answer questions related to this RFP. System may also choose to conduct site visits with selected finalists. System will utilize information gained during any such meetings and site visits with selected finalists during the evaluation process.

12.0 INTERROGATORIES

12.1 DEVIATIONS FROM THE RFP

1) Identify any provision in your response that does not conform to the standards described in the RFP and the provisions of the sample contract. For each deviation, provide the specific location in the response and a detailed explanation as to how the provision differs from the RFP standards and why.

12.2 ORGANIZATIONAL INFORMATION

Please provide the following details:

2) The vendor's full legal name, address, telephone number, and the URL for the corporate website.

3) The name, title, mailing address, telephone number, fax number, and email address for:

   a) The vendor's contact person for this RFP;

   b) The person authorized to execute any contract(s) that may be awarded, include documentation verifying that this individual has the authority to do so;

   c) The person who will serve as the vendor's legal counsel;

   d) The actuarial/financial expert(s) responsible for preparation of items in this response, who must be available to respond to inquiries made by System or its consulting actuary and provide any requested information concerning such items;

4) Names of all officers and directors and percentage of ownership in the company, if applicable. Are any of these individuals contracting providers in the proposed network?

5) If applicable, a description of the parent company of the vendor as well as any subsidiaries and/or affiliates, including whether each is publicly or privately owned.

6) Type of incorporation (for-profit, not-for-profit, or nonprofit); publicly or privately owned.

7) State of incorporation.

8) A copy of the vendor's current certificate of authority, issued by the Texas Department of Insurance, to operate as a third-party administrator in the state of Texas.

9) The vendor's 14-digit State of Texas Vendor ID number.

10) Is the vendor required to maintain any other license(s)? If so, please describe and confirm the validity of any required license(s).

11) Copies of recent ratings and reports issued by independent rating organizations or similar entities (e.g., Best's, Moody's, Standard & Poor's, etc.) regarding the vendor.

12) A copy of the vendor's most recent audited financial statement.

13) A copy of the vendor's current SSAE No. 16 report.

12.3 FINANCIAL INTERESTS

14) Provide the names and addresses of all parties who would receive compensation as a result of the vendor's selection under this RFP, including, but not limited to, consulting fees, finder's fees, and service fees.

15) State the name and address of any sponsoring, parent, or other entity that provides financial support to the vendor. Include an indication of the type of support (i.e., guarantees, letters of credit, etc.) provided as well as the maximum limits of additional financial support from other entities. If applicable, provide a copy of the sponsoring organization's most current audited financial statement.

16) Is the vendor presently actively considering or subject to any mergers with and/or acquisitions of or by other organizations? If so, provide specifics. Affirm that the vendor agrees to notify the System immediately upon reaching any form of binding agreement in connection with any merger, acquisition or reorganization of the vendor's management.

17) Please disclose any contractual relationships with affiliates that could present a conflict of interest with the vendor's role as administrator of the UT SELECT plan.

18) Disclose any network medical facility in which your organization, or any subsidiary or sister organization, maintains a majority ownership or controlling interest.

19) Is the vendor owned by or are there any understandings or financial agreements in place with health professionals? Describe the steps the organization has taken to ensure that such relationships do not create actual or potential conflicts of interest as well as the action plan in place for addressing unforeseen conflicts as they arise.

20) Identify by name and address all persons or entities that hold a 20% or greater ownership interest in the vendor.

12.4 REFERENCES

21) List as references five major employers for whom you provide PPO services. System is particularly interested in employers located in Texas and in public entities. For each employer, include:

    a) The name and telephone number of a representative of the employer who is familiar with the services you provide;

    b) The nature of your relationship with the employer, i.e., insurer, administrator, reinsurer, manager of provider network; and,

    c) The number of employees and dependents for whom PPO benefits are administered and the total amount of claims paid annually.

    Note: Your response to this request officially authorizes System to discuss services provided for these employers and authorizes the employers to provide such information to System.

12.5 LEGAL AND REGULATORY HISTORY

22) Describe any litigation, regulatory proceedings, and/or investigations completed, pending or threatened against the vendor and/or any of its related affiliates, officers, directors, and any person or subcontractor performing any part of the services being requested in connection with the Contract during the past five (5) years. Identify the full style of each suit, proceeding or investigation, including county and state, regulatory body and/or federal district, and provide a brief summary of the matters in dispute, current status and resolution, if any.

23) Describe any investigations, proceedings, or disciplinary actions by any state pharmacy regulatory agency against the vendor and/or any of its related affiliates, officers, directors and any person or subcontractor performing any part of the services being requested in connection with the Contract during the past five (5) years. Identify the full style of each suit, proceeding or investigation including county and state, regulatory body and/or federal district, and provide a brief summary of the matters in dispute, current status and resolution, if any.

12.6 PRIVACY PRACTICES; HIPAA COMPLIANCE

24) Please provide a detailed description of the vendor's HIPAA Privacy and Security Compliance programs as these would apply to System data. Include information on workforce training and monitoring. Describe all policies and practices implemented to ensure the privacy of all confidential information as defined in the Contract, including but not limited to protected health information as defined by the HIPAA privacy rule, employee/participant information, or other confidential information about the System and its participants. Include a link to the vendor's HIPAA policies and Notice of Privacy Practices as well as a brief description of any HIPAA violations alleged against the vendor by consumers or the Department of Health and Human Services, including the outcomes. (See section 12.23 for additional questions regarding Information Security.)

25) Confirm that the vendor is currently in compliance with all HIPAA requirements, in particular, confirm compliance with the rules and regulations applicable to data transmission and privacy, and the organization's willingness to comply with future changes.

26) Provide the name of vendor's HIPAA privacy officer and a description of his or her qualifications.

12.7 HUB POLICY COMPLIANCE

27) Confirm that three original versions of the HUB subcontracting plan, based on details included within this RFP and requirements included as Appendix I to this RFP, have been completed and submitted with this proposal.

28) Provide the name, mailing address, telephone number, fax number, and email address of the person in the vendor who can answer questions from System regarding the submitted HUB documents.

12.8 CONFIRMATION AND ACKNOWLEDGEMENTS

29) Confirm that the vendor understands, has the ability to, and will comply with all of the requirements included within each of the following sections of this RFP:

   a) General Requirements (Section 2.0);

   b) Substantive Terms of the Sample Contract and Contract Requirements (Section 4.0);

   c) Financial Requirements (Section 5.0);

   d) Benefits, Network, and Program Requirements (Section 6.0);

   e) Operational Requirements (Section 7.0);

   f) Technical and Data Exchange Requirements (Section 8.0);

   g) Communication Requirements (Section 9.0); and,

   h) Performance Standards and Penalties (Section 10.0)

12.9 FINANCIAL REQUIREMENTS

30) Provide the following aggregate claims information for 2011 and the first two quarters of 2012 (ending with June, 2012):

   a) Total claims paid under all health plans administered or insured;

   b) Total claims paid under all managed care plans;

   c) Total claims paid under health plans insured or administered in the State of Texas; and

   d) Total claims paid under managed care plans in Texas.

31) Describe any network provider risk pools to be utilized in the administration of UT SELECT and the manner in which System would financially participate in the settlement of such risk pools.

32) Does the vendor agree to submit and receive all payments made to and from System through ACH or other electronic fund transfer methods? Confirm that the vendor will provide written notice to System at least 30 days in advance of the effective date of any changes to the banking information associated with electronic fund transfers to and from System.

33) Does the vendor agree to assume responsibility for the escheatment process in accordance with Texas law for any payments disbursed on behalf of the PDP?

12.10 GENERAL ADMINISTRATION

34) Are all administrative services performed internally? If the vendor contracts with a management company for some or all of its administrative services, please specify the name of the company, the services provided and the method of reimbursement.

35) Where is the primary administrative facility located?

36) Provide the names and titles of the vendor's administrative support staff that will administer the UT SELECT plan, including the total number of full-time equivalent employees and which employees are located in Texas. What is the turnover rate among this staff for the past two (2) years?

37) What are the vendor's contingency plans and procedures for providing back-up service in the event of strike, natural disaster, backlog, or other event that might interrupt, delay, or disrupt service? Provide a copy of the vendor's disaster recovery plan and/or business resumption plan, including results of the vendor's most recent test of the plan.

12.11 BENEFITS ADMINISTRATION

38) How long has the vendor been providing managed health care services? What types of managed health care services are provided, i.e., PPO, POS, HMO, etc.?

39) Provide the vendor's total commercial enrollment as of September 1, 2011, and September 1, 2012. Provide a statement of the vendor's capacity to enroll new participants and the likelihood of any future limitations on enrollment.

40) Confirm that the vendor has the ability to administer the benefits as outlined in the Benefits Guide (included as Appendix B to this RFP).

41) Describe the vendor's transition plan for UT SELECT participants currently under case management with acute care needs whose provider is not in the vendor's network. Include a copy of any forms applicable to transitional benefits and address each of the following conditions in the response:

    a) Pregnancy in the third trimester;

    b) Terminal illness;

    c) Pre-scheduled, pre-certified surgery to be done on or after September 1, 2013;

    d) Psychiatric treatment (for a limited period of time of not more than 60 calendar days);

    e) Acute care following trauma or recent surgery; and

    f) Chemotherapy.

42) Describe the vendor's process for implementing plan design or benefit changes. How much advance notice is required for a change to be programmed into the vendor's information systems? What quality assurance measures are in place to ensure the accuracy of such programming?

43) Confirm that the vendor has the ability to administer benefits with an in-area classification for all Medicare-eligible retirees, regardless of residential zip code, should System decide to implement such a change to the benefits structure.

44) Describe in detail the vendor's process for handling Medicare Secondary Payer (MSP) claims. Include how the vendor works with CMS, the process to resolve claims and offer assistance with any federal funding offsets that may have occurred as a result of CMS assuming UT SELECT was primary. Do you maintain direct contact with CMS or their third party administrator? How long has your MSP unit been supporting this area as part of your vendor agreements?

45) Describe in detail the facilities, personnel, and procedures the vendor intends to use to service those functions required for the UT SELECT plan other than the processing of claims. This response should include a description of:

   a) Personnel that will be available to confer with the System's consulting actuaries concerning financial issues,

   b) Legal and other expertise available to represent the vendor in administrative hearings and litigation, including subrogation, and to assist the System in the execution of its duties under the Contract, and

   c) The vendor's internal processes to deal with participant grievances.

12.12 Mental Health and Substance Abuse Services

46) Describe the vendor's mental health and substance abuse program, including the following aspects:

   a) The methods by which a participants access care for mental health and substance abuse issues, including a description of the vendor's triage process;

   b) A description of the structural and functional aspects of the vendor's mental health and substance abuse case management services, including how such services lend to long-term stability of a patient.

   c) The utilization management activities conducted in connection with the program;

   d) The network development and management services applicable to mental health and substance abuse providers;

   e) The cost management techniques applied to mental health and substance abuse services;

   f) The reimbursement arrangements in place with mental health and substance abuse facilities; and

   g) The quality assurance techniques used to ensure that participants receive cost effective, high quality care.

47) Do you subcontract any services associated with mental health or substance abuse care? If so, identify the subcontractor and provide a detailed description of their program.

12.13 HEALTH CARE MANAGEMENT

48) Describe the manner in which you conduct the following activities and how the results of such activities are used in the health care management process:

   a) Development of profiles of primary care physicians' practice and referral patterns;

   b) Monitoring of frequently used services;

   c) Review of physician coding patterns;

   d) Identification of procedure codes requiring 100% review, including a current list of codes subject to such review; and

   e) Review of certain types of claims on a standard basis.

49) How does the vendor measure quality of care and how is that communicated to participants?

50) Describe how data gathered by tracking various elements of patient care is used in the overall measurement of provider efficiency and patient outcomes.

51) What strategies does the vendor currently use and what new innovative strategies does the vendor plan to use to improve quality of care and control costs?

52) Describe the vendor's process for determining Experimental and Investigational procedures and the sources used to develop support or denial of services.

53) How does the vendor determine when a procedure is no longer Experimental and Investigational? How often is this process reviewed?

54) Does the vendor have the ability to make online consultations available for use in non-emergency situations? If so, what is the fee structure associated with such consultations?

55) Describe the methodology for establishing medical protocols for your managed care network and the extent to which protocols are used in the management of health care. Include a description of how a health care provider obtains approval to deviate from the protocols when treating a patient with complications.

56) Describe the orientation and training process for providers joining the vendor's network with regard to such issues as plan participant eligibility, utilization review procedures, billing, and quality improvement responsibilities.

57) Describe the organizational relationship between corporate, regional, and local medical management, including any distinct responsibilities that pertain to each and a summary of the functions handled at each level.

58) Describe the responsibilities and expertise of each member of the medical management staff assigned to each network location, including an indication of whether each member is an employee versus independent contractor and full-time versus part-time.

59) Describe the interaction of the vendor's Medical Director and staff with the provider network, including any arrangements involving medical protocol committees, utilization review groups, etc.

60) Provide a detailed description of the vendor's experience with the following:

    a) Integrated delivery systems such as Patient-Centered Medical Homes, Accountable Care Organizations and affiliated provider groups.

    b) Alternative reimbursement arrangements.

12.14 NETWORK ADMINISTRATION

12.14.1 GENERAL ISSUES

61) Describe your network management operations. If your organization contracts with a network management company or leases the network from another entity, provide details of that arrangement.

62) Describe the type of provider network (group, IPA, mixed) the vendor offers, if applicable.

63) Describe the professional, general liability, malpractice, fidelity, etc., insurance requirements for each type of provider in the vendor's network.

64) Confirm that the vendor's provider contracts allow for compliance with all requirements of this RFP and the Contract.

65) Have your provider network discounts been evaluated and compared against those of other vendors by an independent third party? If so, provide a copy of the applicable documentation. A summary prepared by the vendor will not be considered adequate.

66) For your broadest PPO network, provide the provider discounts for 2012, 2011, and 2010, excluding Medicare.

67) Does the vendor currently have contractual arrangements with non-network providers? If so, provide the following information concerning those contracts:

    a) Summarize the key provisions of those contracts related to participant access.

    b) Describe the reimbursement arrangements applicable to contracted non-network providers. Quantify the difference in reimbursement between (i) the level provided under these arrangements and (ii) network reimbursement for similar specialties in the same geographic region.

    c) Provide a file in the format described in Appendix E for contracted non-network providers.

68) What percentage of UT SELECT claims for services provided by hospital-based physicians (radiologists, pathologists, anesthesiologists and ER) do you expect to be provided by network providers?

69) Does the vendor maintain contractual relationships of any kind with health care providers other than those in managed care networks? If so, describe these relationships fully. System is particularly interested in contracts that guarantee discounted fees, no balance billing, etc. for UT SELECT participants using non-network providers. Are these networks considered wrap networks and do you share in a percent of any savings associated with these networks? If you use a third party vendor to establish a wrap network, please describe the relationship with the third party and any discounts or shared savings. If applicable, do the wrap networks balance bill patients?

70) When determining network discount and utilization, what factors are used in this calculation?

71) Does your network discount calculation exclude any claims? Please identify any of the following that are excluded and include any applicable dollar thresholds:

a) Medicare claims

b) Out-of-Network claims

c) Catastrophic claims

d) Claims where the paid amount equals the billed charges

e) Mental Health and substance abuse claims

f) Durable Medical Equipment and anesthesia

g) Subcontracted, rental or wrap network claims

h) Claims from contracting providers where the billed amount equals the allowed

i) Claims from non-contracting providers where the billed amount equals the allowed

j) Large claims

k) Stop loss claims

l) Specialty facilities

m) Pathology

n) Radiology

o) Neonatology

72) List any additional exclusions not identified in the previous item. What percentage of total claims do the excluded claims represent in your book of business?

73) Is network utilization based on how a claim was paid or submitted?

74) Are the networks utilized in the disruption analysis identical to those utilized in the discount analysis? If no, detail the differences.

75) Do you utilize capitated networks (ex. behavioral health)? If yes, do you retain a percentage of the savings? If yes, what percentage?

76) Do you negotiate large balance bills on behalf of participants? If yes, do you retain a percentage of the savings? If yes, what percentage? How are the savings and withhold tracked and reported?

77) In what situations may a participant be balance billed for costs exceeding the allowed amount?

78) Do you retain a percent of savings related to duplicate claim denials?

79) Are you willing to provide a quote without any shared savings?

80) When using GeoAccess, do you use third-party networks such as subcontracted, rental or wrap networks. Are these types of networks included in your disruption analysis?

81) Do you have high performing providers in your network and if so, how do you promote these high performing doctors to your participants? Are there indicators in the provider director showing these providers are considered high performing? How do you define "high performing?"

82) What is your average utilization of your high performing providers? Do you have specific strategies for directing care to these providers?

83) Provide network utilization (based on dollars paid) for 2012, 2011 and 2010. Specifically identify what claims are included in the calculation for network utilization.

12.14.2 Provider Credentialing

84) Describe the general credentialing and re-credentialing process and minimum criteria for all health care providers, including whether independent verification of hospital staff privileges, licenses, board certification, etc., is included and whether peer evaluation and on-site inspections are part of the process.

85) Provide copies of sample contracts used for each type of health care provider and each network location.

86) How does the vendor assure that a provider will make an adequate portion of the practice available to in-area participants?

87) Are Centers of Excellence utilized for the provision of certain high cost, highly specialized procedures? If so, confirm how Centers of Excellence facilities are selected and credentialed, where are they located, what procedures are referred to these facilities, etc.

88) Describe the professional liability insurance requirements for each type of health care provider in your network. What professional liability and general liability insurance coverages are required of your hospitals and ambulatory surgery centers?

89) What is the average annual turnover rate for participating health care providers?

12.14.3 PROVIDER CONTRACTING

90) Discuss the current financial arrangements with network providers and what percent of the TPA's contracts are paid using one of the following methods:

Hospitals and other institutional providers:

Payment Method	Percentage of Contracts
Discount off charges	
Case rates, including but not limited to, episode based bundled payments	
Diagnostic Related Groups	
Per Diem	

Primary care physicians and specialists:

Payment Method	Percentage of Contracts
Capitation	
Fee Schedules	
Discount off charges	
Other	

Behavioral health providers (psychiatrists, psychologists, licensed clinical social worker, etc.):

Payment Method	Percentage of Contracts
Capitation	
Fee Schedules	
Discount off charges	
Other	

91) Discuss the various types of contractual stop-loss or other special reimbursement arrangements vendor utilizes in connection with outlier claims incurred at a facility provider. Provide information concerning the prevalence of each type of arrangement, applicable thresholds, enhanced reimbursement rates, limitations and any other relevant information.

92) Provide a complete description of the development and maintenance processes for determining the vendor's separate allowable amount profiles for network and non-network physicians. How often are the profiles updated? Describe how the vendor's allowed amounts

are calculated and reported. Include any assumptions, such as network efficiency, used in the calculation of allowed amounts.

93) Provide information concerning the most common out-of-network reimbursement bases used by the vendor in Texas?

   a) The information should be provided separately for facilities and professional providers.

   b) Among professional providers, the information should be provided separately for hospital-based and non-hospital based providers.

   c) Reimbursement should be expressed relative to Medicare reimbursement levels

   d) Reimbursement should be compared to that of similar network providers.

94) Describe the options available to System to reimburse out-of-network providers. Can the vendor vary out-of-network reimbursement by region and/or specialty?

95) Discuss the TPA's ability to administer unique financial reimbursement arrangements with providers, including, but not limited to, hospitals and physician hospital organizations, that have different discounts from the TPA's current agreement.

96) Describe the utilization review and cost containment procedures conducted by network providers. Confirm that these are the responsibility of the providers and not the participants when care is rendered in-network.

97) What are the minimum time periods included in your health care provider contracts concerning:

   a) Provider's notice to not accept new patients?

   b) Provider's intent to terminate?

   c) Vendor's intent to terminate?

   d) Provider's required continuation of care to existing network participants following provider's termination from the network?

98) Furnish your established standards for access to appointments for 1) routine physicals, 2) office visits for illness, 3) urgent care, and 4) emergency care. For each of the above categories, in what percentage of cases does your organization satisfy the established access standard?

99) Describe your processes for monitoring:

   a) Adequacy of patient care;

   b) Appropriateness of utilization of health care services, including under-utilization as well as over-utilization;

   c) Adequacy of health care providers, participant access to health care providers, including your access standards for routine, urgent, and emergency;

d) Health care provider satisfaction; and

e) Adequacy of claims service.

12.14.4 PROVIDER ACCESSIBILITY

100) Describe the service area(s) currently covered by the vendor's managed care network. If the network service area does not presently include the entire State of Texas, discuss the process for extending the network service area to include the entire state and provide a time frame in which the vendor intends to complete this process.

101) Confirm that electronic documentation has been included with the vendor's response demonstrating that the proposed provider network contains a sufficient number of health care providers to serve UT SELECT participants and has been provided as requested in Section 6.8.4 of this RFP and further detailed in Appendix E to this RFP, including separate documentation for each of the following, with indication of any providers not currently accepting new patients: 1) primary care providers, 2) specialty care providers, 3) behavioral health providers and 4) hospitals.

102) If the vendor's network is not currently adequate to provide the access and services described herein, discuss the process for expanding the network, including how much expansion the vendor anticipates, and provide a timeframe for completing the expansion process.

103) Will provider networks in other areas of the country be available to UT SELECT participants living or visiting out of state? If so, specify the areas served by such networks.

104) Is the vendor approved by TDI for reciprocity arrangements? If yes, identify the locations approved and describe any such arrangements the vendor has in place.

105) Describe the methodology used to evaluate patient access to healthcare providers for each network.

106) How many family care physicians and specialty care physicians participate in the vendor's organization?

107) What percentage of each network's physicians are Board certified? Board eligible?

108) Confirm the vendor's ability to comply with System's requirement that in-network access be available for all UT SELECT participants at all System medical facilities (U. T. Health – Houston, U. T. Health Science Center – San Antonio, U. T. Health Center – Tyler, U. T. Medical Branch – Galveston, U. T. M.D. Anderson Cancer Center, and U. T. Southwestern Medical Center – Dallas).

109) Describe how the vendor ensures that participants can get assistance with selecting a provider as needed.

12.15 UTILIZATION REVIEW

110) Provide a detailed description of the utilization review program to be used in connection with UT SELECT, including but not limited to the following details:

a) If applicable, the name, address, and telephone number for any contracted third party providing utilization review services;

b) The location and hours of operation of the vendor's utilization review facility or facilities;

c) Confirmation as to whether licensed personnel are on duty at all utilization review facilities during all hours of operation;

d) The types and numbers of licensed professionals and the number of support staff involved with the utilization review program;

e) The credentials and qualifications required for utilization review nurses;

f) The number of telephone lines associated with the utilization review program;

g) A description of how the vendor ensures compliance with the statutory requirements concerning utilization review;

h) The percentage of utilization review referral and authorization requests that are referred to the vendor's Medical Director;

i) The methods used to establish utilization review protocols and the frequency of review for these protocols;

j) The utilization review procedures utilized by network health care providers;

k) The process available to health care providers for the appeal of denied claims;

l) The types and frequency of utilization review reports that will be provided to System.

12.16 DISEASE MANAGEMENT

111) Describe the vendor's current disease management programs. Do you subcontract any services associated with disease management? If so, identify the subcontractor and provide a detailed description of their program.

112) How are participants identified as candidates for the vendor's disease management programs? Include a description of how your disease management, health and wellness programs, and internal medical management functions interact to facilitate early identification and intervention. Additionally, please address specifically the resources and information utilized in the identification of possible concerns involving mental health or situations that may involve substance abuse.

113) Once identified as potential candidates for disease management, what factors would trigger efforts by the vendor to connect participants with Case Management, System's Living Well resources, and/or Disease Management resources?

114) Describe the process by which the vendor would work to ensure that participants are connected with the appropriate program based on their specific circumstances, including those situations where potential issues with mental health or substance abuse have been identified.

115) Please provide a brief description (no more than 500 words) of the processes in place at the vendor that integrate data from multiple sources (e.g., medical and pharmacy claims, completed health risk assessments, diagnostic test results, etc.) in support of disease management and overall wellness efforts.

116) Describe key changes made to any aspect of the vendor's disease management programs during the past year as well as any changes planned over the next year or two.

117) Please provide sample quarterly and ad hoc reports that demonstrate the vendor's reporting capabilities in relation to disease management and other care management programs.

12.17 Wellness Benefits and Value-Based Benefits Design (VBBD)

118) Describe the wellness programs and/or tools offered by the vendor that would be available to UT SELECT participants.

119) Describe key changes made to any aspect of the vendor's wellness programs during the past year as well as any changes planned over the next year or two.

120) Provide an internal assessment of the return on investment (ROI) associated with the vendor's wellness programs, including details regarding the timing of measurable returns. Describe how assessment of ROI informs decisions about the vendor's ongoing investment in wellness programs, including defining scope and objectives, expectations regarding participation, reporting efforts, etc.

121) Please detail any wellness programs currently being offered by the vendor that are designed to improve the health and well-being of all individuals, including healthy and low-risk individuals. Do you subcontract any services associated with wellness programs? If so, identify the subcontractor and provide a detailed description of their program.

122) Please provide details regarding any consumer support programs the vendor currently has available to provide coaching and educational support to individuals with specific chronic conditions. Indicate whether these programs are managed directly by the vendor or provided by a subcontractor.

123) What specific attributes of the vendor's wellness programs are designed to attract and engage those participants whose health habits or status place them at risk (as opposed to those without known risk factors, i.e. the "worried well"), even though they are not presently experiencing adverse health effects?

124) What referral sources or other factors will the vendor rely on to identify individuals who would benefit from participation in System's Living Well health and wellness programs and services?

125) Does the vendor track and refer participants to specific wellness programs on an individual level? For example, for a participant identified as having type-2 diabetes, high cholesterol, and high blood pressure, would the vendor make specific recommendations to the participant regarding programs such as completing System's Living Well Health Risk Assessment or enrolling in online nutrition classes?

126) Please describe the specific steps that the vendor would take and the criteria that would be used to support participants during their pregnancy.

127) Describe any processes the vendor has in place with contracted physicians to help the physician engage the participant in pre-natal programs.

128) Please describe examples of specific projects and initiatives that demonstrate the vendor's ability to collaborate with clients and other vendors, such as HRA administrators, around improving the health and well-being of plan participants.

129) Is improved productivity (including reductions in lost work days, disability and workers' compensation costs, and presenteeism) a factor that the vendor actively considers and tracks as part of the overall wellness services offered to employer group plans? If so, how are results in this area measured? Please provide examples, if available, of employer groups where productivity data has been gathered and used to guide adjustments to the implementation of the vendor's wellness programs.

130) Please describe the vendor's view of the role of the employer and the investment necessary in partnering with a TPA to maximize participation in wellness initiatives and beneficial outcomes. Include a discussion of the vendor's position with regard to the appropriate use of incentives tied to wellness programs.

131) Please describe your organizations view of the effectiveness of Value-Based Benefits Design (VBBD) to improve the health status of covered lives and reduce the plans costs.

132) Please describe the specific steps that the vendor would take and the criteria that would be used to help an employer determine whether VBBD would be a beneficial strategy to pursue with regard to their PDP.

133) Describe in detail the vendor's capabilities to assist with evaluating VBBD as a plan design option by:

   a) Aggregating HRA data with medical and pharmacy claims data, mining the data for VBBD opportunities, and modeling the impact of VBBD plan options;

   b) Including additional data in the overall analysis, such as long-term and short-term disability claims, and personal health assessment survey results; and,

c) Providing a comprehensive assessment of the results of the data analysis described above and assisting with interpreting those results.

134) Describe in detail the vendor's capabilities to implement and administer a VBBD plan that:

a) Waives or reduces copayments/coinsurance for specific services based on various criteria; and/or,

b) Waives or reduces copayments/coinsurance for preventive services such as immunizations and vaccines;

135) Detail any specific mechanisms used to assure that different units of the vendor, the plan sponsor, and other vendors all coordinate to offer a smooth-running VBBD plan.

136) How many accounts does the vendor currently support that have implemented some aspect of VBBD?

137) If applicable, please provide the names of three accounts that have implemented a VBBD plan with the vendor, with at least one being available to enrollees for more than 12 months.

138) If applicable, please describe any issues that have arisen with the implementation of VBBD concepts and how the vendor addressed those issues.

139) Please provide sample quarterly and ad hoc reports that demonstrate the vendor's reporting capabilities in relation to wellness and VBBD programs.

12.18 Implementation and Account Teams

140) Provide a list of individuals who will comprise the vendor's implementation team along with a résumé and complete contact information for each team member. Identify the individuals who will be primarily responsible for handling details related to each of the following categories:

a) Information systems and technology, including specifically benefits programming, claims processing, and eligibility data processing;

b) Customer service;

c) Communication materials;

d) Appeals process;

e) Transitional benefits; and,

f) Financial functions, including payments and reconciliation.

141) If applicable, describe in detail any previous significant issues with contract implementation the vendor has experienced and all measures the vendor took to remedy the situation.

142) Provide a list, beginning with the most recent, of any performance assessments incurred by the vendor during the last ten (10) years, or the life of the company if less than ten (10) years. Separate by governmental and nongovernmental clients indicating the reason for the assessment and the amount paid.

143) Briefly outline the vendor's account management philosophy. Please include information about how the team members are compensated by the vendor.

144) Where would the primary person responsible for account and client management associated with System's contract be located? Will any Account Management Team members be located in Austin?

145) How many other contracting customer organizations is the assigned account manager currently servicing and how many total participants are represented by those organizations?

146) What is the vendor's account manager/executive turnover rate for the last twelve (12) months?

147) Describe the overall organization, location, and structure of the Account Management Team that will provide ongoing program support for the UT SELECT plan. Please provide a résumé for each team member, including current professional responsibilities and length of employment with the vendor.

148) Confirm that the System will be notified of any change in the dedicated Account Management Team. Describe the efforts the vendor makes to discourage turnover of Account Management Team personnel responsible for oversight of major group accounts.

12.19 CUSTOMER SERVICE

149) Describe the vendor's customer service unit, including the manner in which it is accessed, days and hours of call center operation, and the location of the customer service call center(s) that will provide service to UT SELECT participants.

150) Are any major changes currently planned or anticipated for the customer service organization or facilities (e.g., moving to a different location, reorganizing or merging units)? If so, please describe.

151) Will the vendor provide a separate toll-free telephone number for System participants?

152) Provide sample(s) of proposed UT SELECT ID cards which include, at a minimum, the participant's name and Benefits ID, the customer service phone number, the UT specific website and pertinent benefits copayment information. The sample(s) should feature a font which clearly differentiates between the letters and numbers L, I, 1, O and 0.

153) How many telephone lines and support staff will be dedicated to customer service and claims processing for the UT SELECT plan?

154) Describe the vendor's ability to track and monitor customer service metrics on an account-specific basis.

155) How are after-hours calls to customer service handled?

156) Does the vendor's customer service system support TTY, also known as TDD (Telecommunications Device for the Deaf) technologies?

157) How does the vendor's customer service system support Spanish-speaking participants? What other languages can the vendor's customer service system support?

158) Does the vendor's customer service unit include nurses or physicians who will be performing services in connection with the Contract?

159) How will the customer service unit be staffed? What is the turnover rate for vendor's non-management call center staff?

160) Briefly describe the training that each employee or representative receives to provide customer service. Include the length of time it takes to advance from training to a qualified Customer Service Representative (CSR).

161) How does the vendor ensure that its CSRs are providing timely and accurate information?

162) How does the vendor monitor first-call resolution and participant inquiries that do not get resolved?

163) Does the vendor's customer service inquiry system allow CSRs to enter information and provide the ability for CSRs to review previous notes to better assist participants?

164) Can CSRs view historical claims information online to assist participants? Will participants be able to view their claims information online via the vendor's System-specific website? Will designated System staff members have online access to claims information for System participants so that specific claims can be reviewed and/or specific reporting requested?

165) Does the vendor record all phone calls and notify all parties that their conversations are being electronically recorded and stored? If not, how many calls are recorded, and what criteria are used in their selection?

166) Will System have the ability to listen to customer service calls in Austin?

167) Describe how the vendor handles written inquiries. Are they always responded to in writing?

168) What is the vendor's current standard for response time with respect to questions requiring written communication?

169) Describe the vendor's problem resolution policies.

170) Describe the vendor's procedures for handling and escalation of customer service complaints.

171) Confirm that the vendor's proposal contains no provision for "binding arbitration" in a complaint procedure and that no such provision shall be utilized with regard to System participants.

172) Describe the customer complaint tracking system that the vendor utilizes. How long has this system been in place?

173) Describe any changes that are planned or scheduled within the next 36 months for the vendor's computer systems, including Customer Support changes, and provide timelines for when the changes will be implemented to the existing computer system.

12.20 CLAIMS ADMINISTRATION

174) Confirm that, as described in Section 13.0 of this RFP and further detailed in Appendix C, the vendor has provided the requested electronic documentation of the allowable amount and network status information in response to the detail claim files included as Appendix D-3.

175) Please provide a sample claim form.

176) Confirm that System will have a specific high-level contact for issues regarding UT SELECT claims administration and indicate where this contact will be located.

177) Please provide a detailed description of the vendor's facilities and procedures for processing claims, including the following:

a) The location where will claims be processed and hours of operation;

b) The size and composition of the staff that will be assigned to process UT SELECT claims;

c) Your hiring and training practices for claims examiners, processors, and data entry operators;

d) The claims processing system to be utilized and how long the system has been in operation;

e) Any procedures used expedite claims processing, such as electronic claims submission;

f) Any arrangements designed to reduce or eliminate participant responsibility for filing claims;

g) Procedures for processing claims incurred outside of Texas, including international claims;

h) Any contractual agreements with providers in other states and countries that would result in savings for UT SELECT participants living outside of Texas;

i) The steps performed to coordinate processing of claims using both network and non-contracting providers; and,

j) How network and out-of-network claims are integrated for data accumulation purposes.

178) How does the vendor's claim processing system interact with enrollment and utilization review information?

179) Can the vendor match System enrollment against other client enrollment to identify dual coverage? If so, explain the verification process and identify other clients that currently access this process.

180) Describe any other review procedures in place to identify dual coverage.

181) What dollar threshold triggers a requirement that an individual claim payment be approved by a claims supervisor?

182) What parameters are used to determine when detailed audit of a claim is required?

183) What processes are used to identify potential subrogation claims? Please explain your subrogation process in detail. Do you guarantee a percent of recoveries through claim audits or subrogation?

184) How long will claims records specific to UT SELECT be maintained?

185) For the claims office that would be processing claims for System participants, please provide the following statistics for all claims paid by the vendor for 2011:

	Company Standard	Actual
Claims payment accuracy rate		
Claims processing accuracy rate		
Financial accuracy rate		
Processing time (COB claims)		
Processing time (non-COB claims)		
Average turnaround time (all claims)		

186) Confirm that the vendor's proposal contains the claims appeal procedures as outlined on pages 37 – 45 of the UT SELECT Benefits Guide, included as Appendix B to this RFP.

187) Does the vendor administer episode-based bundled payments? If so, please respond to the following items:

a) Discuss the disadvantages and advantages of the vendor's bundled payment approach;

b) Discuss how the vendor mitigates the risks associated with the difficulties of a bundled payment approach;

c) Discuss the method used to distribute payments to providers.

188) What is bundled in the global payment for an episode of care?

189) Does the vendor administer a medical home program? If so, please respond to the following items:

a) Discuss the disadvantages and advantages of the vendor's medical home program;

b) Discuss how the vendor mitigates the risks associated with the difficulties of a medical home program;

c) Discuss the method used to distribute payments to providers.

12.21 COST CONTAINMENT

190) Describe the preauthorization process that will be applicable tor UT SELECT participants. What services do you suggest be preauthorized?

191) Explain in detail how your organization detects overcharges, unnecessary or extensive hospitalization, unnecessary medical treatment, and other forms of misuse or abuse of medical services.

192) Provide a detailed description of the procedures and systems that the vendor uses to prevent, deter, detect and investigate fraud or related issues, and explain how such processes will be applied in connection with UT SELECT.

193) Confirm that the vendor agrees to comply with any additional policies System may develop in connection with the detection and prevention of fraud or abuse.

194) Discuss how the vendor would communicate with the participant, provider, or vendor once a fraud or abuse issue has been identified. How will such information be reported to the System?

195) Discuss the vendor's policies and procedures for addressing situations in which benefits have been utilized after a participant's benefits have ended (e.g., due to a delay with updating participant data or similar issue). Provided that the vendor receives adequate notice of termination from System, will the vendor guarantee that UT SELECT will not be billed for claims that processed after a participant's UT SELECT coverage has terminated?

196) Describe the vendor's experience in providing cost-containment enhancements to current and former clients.

12.22 QUALITY ASSURANCE

197) Describe the vendor's quality assurance (QA) program. Include or address the following as part of the description:

a) The name of the designated senior executive responsible for the program;

b) The vendor's current QA policies and procedures;

c) The extent of the Medical Director's involvement in the program;

d) The extent of participating health care providers' involvement in the program;

e) Quality of clinical care and quality of service issues;

f) The composition and activities of the quality assurance committee;

g) The number and expertise of staff dedicated to quality assurance;

h) The methodology utilized by each network to evaluate quality;

i) Procedures used to address providers who do not meet the standards of quality, including for the removal of such providers from the network; and

j) A description of how quality assurance requirements are incorporated into provider contracts.

198) Describe the vendor's processes for monitoring the adequacy of customer service and claims service. How often are surveys specific to these functions conducted? Please provide a copy of the most recent results.

199) Does the vendor currently perform overall participant satisfaction surveys? If so, does an outside organization perform the surveys? Are health care providers notified of the results? Please provide a copy of the latest survey and its results, if applicable, including the percentage of participants who indicated that they were "satisfied" or "very satisfied" with the overall program.

12.23 INFORMATION SECURITY

200) Please provide a detailed description of the vendor's information technology security program that would be applicable to System data collected and/or maintained by the vendor. Include, at a minimum, the following details:

a) Does the vendor have an information security plan in place, supported by security policies and procedures, to ensure the protection of information and information resources? If so, provide an outline of the plan and note how often it is updated. If not, describe what alternative methodology the vendor uses to ensure the protection of information and information resources.

b) Describe the procedures and tools used for monitoring the integrity and availability of the information systems interacting with the service proposed, detecting security incidents, and ensuring timely remediation.

c) Describe the physical access controls used to limit access to the vendor's data center and network components.

d) What procedures and best practices does the vendor follow to harden all information systems that would interact with the service proposed, including any systems that would hold, process, or from which System data might be accessed?

e) If the vendor were selected, would the vendor agree to a vulnerability scan by System of all information systems that would interact with the service proposed including any systems that would hold, process, or from which System data might be accessed? If the vendor objects to a vulnerability scan, describe in detail the reasons for objection.

f) Does the vendor have a data backup and recovery plan, supported by policies and procedures, in place for the hosted environment? If so, provide an outline of the plan and note how often it is updated. If not, describe what alternative methodology the vendor uses to ensure the restoration and availability of System data.

g) Does the vendor encrypt data backups? If so, describe the methods used to encrypt backup data. If not, what alternative safeguards will the vendor use to protect System data backups against unauthorized access?

h) Does the vendor encrypt data in transit and at rest? If so, describe how that security is provided. If not, what alternative methods are used to safeguard data in transit and at rest?

i) What technical security measures does the vendor propose to take to detect and prevent unintentional (accidental) and intentional corruption or loss of System data?

j) What safeguards does the vendor have in place to segregate System and other customers' data to prevent accidental or unauthorized access to System data?

k) What safeguards does the vendor have in place to prevent the unauthorized use, reuse, distribution, transmission, manipulation, copying, modification, access, or disclosure of System data?

l) What administrative safeguards and best practices does the vendor employ with respect to staff members (vendor and third-party) who would have access to the environment hosting all information systems that would interact with the service proposed, including any information systems that would hold, process, or from which System data may be accessed, to ensure that System data and resources will not be accessed or used in an unauthorized manner.

m) Describe the procedures and methodology in place to detect information security breaches and notify customers in a manner that meets the requirements of HIPAA and Texas breach notification laws.

n) Describe the procedures the vendor has in place to isolate or disable all information systems that would interact with the service proposed, including systems that would hold, process, or from which Institution data might be accessed, when a security breach is identified?

o) Describe the safeguards in place to ensure that all information systems that would interact with the service proposed, including any systems that would hold, process, or from which System data might be accessed, reside within the United States.

p) What additional administrative, technical, and physical security controls does the vendor have in place or plan to put in place?

12.24 Data Exchange and Processing

201) Confirm that the vendor can accept and properly manage eligibility and other key UT SELECT data using the dataset layouts as described in this RFP, including the Benefit Enrollment and Maintenance Transaction Set (ASC X12N 834) as well as the claims and administrative fee billing datasets.

202) Confirm that the vendor will transmit the weekly claims file as specified in this RFP using the HIPAA "Health Care Claim: Medical" Transaction Set (ASC X12N 837) format for the file and records.

203) Confirm that the vendor has the capability to accept data via SFTP on a real-time basis.

204) Confirm that the vendor has the ability to comply with the user-authentication requirements for the System-specific UT SELECT website as described in this RFP, including the use of SAML-based authentication (v2.0).

205) Describe the vendor's ability to provide automated notification upon receipt of eligibility data as well as automated, timely notifications confirming either successful load or failure to load for each eligibility dataset received from System.

206) Explain how the vendor plans to ensure that it meets all requirements regarding protecting the confidentiality of Social Security numbers as outlined in this RFP, including the requirements of Section 35.58 of the Texas Business and Commerce Code, CONFIDENTIALITY OF SOCIAL SECURITY NUMBER.

207) Describe the vendor's experience with automated enrollment systems, including any specific automated systems that the organization has worked with.

208) Explain how data is entered into the vendor's eligibility system. Provide a data flow diagram of the process to receive, audit, and load eligibility datasets, including an indication of whether the diagram refers to a current or proposed system. If documenting a proposed system, the anticipated implementation date should be included.

209) What is the location of the computer system that maintains and hosts the vendor's eligibility system and data? Is a third-party application used for entering data into the vendor's eligibility system or was proprietary software developed in-house?

210) Upon receipt of eligibility datasets from System, can the vendor's eligibility system produce a detailed error report indicating which records have been accepted for loading and which have been rejected? Will such reports be provided following each eligibility transmission?

211) Discuss the staffing and capabilities of the vendor's team that would be responsible for managing information systems and data for UT SELECT.

212) How soon after receiving eligibility data from the System would any updates be reflected in the vendor's eligibility system?

213) Describe the vendor's process for implementing changes to the benefit plan design. How much advance notice is required for a change to be made in the vendor's information system?

214) What quality assurance processes are integrated into the vendor's information systems to ensure accurate programming of the initial benefit plan design and to improve the accuracy of programming related to plan design changes during the contract period?

215) Confirm the vendor's ability to accept emergency updates to UT SELECT eligibility, as specified in this RFP. Additionally, please describe the vendor's ability to provide a website allowing designated System staff to view eligibility and make emergency eligibility updates directly in the vendor's database when necessary.

216) Confirm that the vendor will comply with the requirement to provide a monthly dataset to System including details as specified for all UT SELECT ID cards issued during the prior month.

12.25 COMMUNICATIONS

217) Provide samples of proposed communication materials to be used in administering the UT SELECT plan for plan year 2013 – 2014 as required by Section 9.2 of this RFP along with additional sample communication materials as described.

218) Explain in detail the resources and procedures to be applied in connection with UT SELECT communications and the services that will be available at no additional cost to System regarding development and dissemination of communications materials.

219) Discuss the vendor's experience with the innovative use of communication tools and techniques to improve participant engagement and increase participation in disease management programs, opt-in case management programs, and wellness offerings. Include examples of unique approaches to participant communications and a discussion of how results from specific communication campaigns aimed at increasing engagement are measured.

220) Describe any enhanced tools and programs currently offered by the vendor in support of participant communication efforts, such as mobile integration features offered through the vendor's website (e.g. option to send provider information direct to mobile device), smart phone applications, etc. Include a discussion of applicable direct costs to the plan or participants in conjunction with the use of such tools.

221) Will the vendor provide personnel who will attend employee/retiree meetings during Annual Enrollment on a statewide basis? Would the vendor be willing to provide personnel for meetings held outside of regular business hours in order to accommodate System institutions that have 24-hour facilities? How many meetings will vendor personnel be available to attend?

222) Confirm that the vendor will assist the System in developing necessary materials for disseminating UT SELECT information to employees and retirees during the System Annual Enrollment period.

223) Confirm that the vendor will provide the System with a preview of all communications designed to notify participants of features or issues regarding UT SELECT prior to disseminating any communications directly to participants.

224) Describe how System and UT SELECT participants will be notified about changes in network providers. How much notice is provided to participants when a provider's contract is terminated by the vendor?

12.26 ELECTRONIC AND INFORMATION RESOURCES (EIR) WARRANTY

225) Confirm that the vendor understands and will comply with the required technical specifications for the System-specific website as specified in this RFP and that the Electronic and Information Resources (EIR) Accessibility Checklist, included as Appendix J to this RFP, has been completed and included with this response.

12.27 PERFORMANCE STANDARDS AND REPORTING

226) Describe the vendor's current reporting capability. Provide samples of utilization and administrative performance reports currently available to contracting plans. How often are reports prepared? Describe the method that the vendor would use to determine the cost of any special reports that might be requested by System.

227) Confirm that the vendor is able to provide all of the detailed information required in the quarterly Administrative Performance Report template, included as Appendix F to this RFP. Please provide copies of sample administrative performance reports meeting the requirements.

228) If the vendor is unable to provide any of the information requested in the Administrative Performance Requirements Report template included as Appendix F to this RFP, please describe in detail any information that cannot be provided and explain why it cannot be provided.

229) Describe the vendor's ad hoc reporting capability. Will System have the capability to conduct online queries of the vendor's database in order to generate its own ad hoc reports and extract specific information? Describe the software system required to facilitate such access and the availability of the vendor's online reporting package for System access.

230) Describe any unique reporting capabilities that differentiate the vendor from its competitors.

231) Confirm that the vendor can routinely provide reports at no additional cost containing all of the information included in the exhibits in Appendix D of the RFP, including, but not limited to:

a) Trend reports showing monthly, quarterly and annual changes in various utilization and cost indices such as days per thousand;

b) Claim cost reports by age, sex, dependent status and geographic location;

c) Utilization reports by geographic location;

d) Claim payment lag reports by type of service (IP facility, professional, etc.);

e) Distribution of annual claims per subscriber by amount of payment;

f) Annual detailed utilization analyses based on location, procedure, diagnosis, and setting;

g) Claims amounts paid on each individual plan participant for claims incurred during the fiscal year; and

h) Utilization by provider.

232) Confirm that the vendor can provide normative data against which System can benchmark the UT SELECT plan.

233) Confirm that the vendor understands that the failure to meet specific performance standards may result in the assessment of associated performance penalties, as described in this RFP.

13.0 PROVIDER REIMBURSEMENT RESPONSE

Appendix D-4 of this RFP is an Excel file containing five (5) forms, which are to be completed by your organization and submitted electronically with the proposal. The forms request information regarding the vendor's provider network and network reimbursement.

Form 1: Requests information regarding the number of network providers for selected provider types for certain areas of Texas, including both the current number of network providers and the vendor's projected number of network providers as of September 1, 2013 if the vendor were to be selected to administer the UT SELECT plan.

Form 2: Requests information regarding the type(s) of reimbursement arrangements used by the vendor in selected areas. Indicate with an "x" which type(s) of reimbursement are utilized.

Form 3: Contains selected professional physician procedure codes (CPT) for certain areas of Texas. For each procedure in each service area, provide the vendor's average network allowable charge for the vendor's broadest PPO network as of September 1, 2012. Provide a global, unmodified fee for all procedures other than lab and radiology. For lab and radiology procedures (other than chest x-ray), provide a modifier 26 (professional only) fee. For chest x-ray, provide a global, unmodified fee. If the vendor utilizes multiple fee schedules in a particular area, provide the average fee weighted by the percentage of current membership. If the vendor utilizes capitation in their professional reimbursement methodology for certain physicians, so indicate.

Note: System reserves the right to validate by audit the vendor's submitted reimbursement amounts.

Form 4: Requests information regarding the effective dates of the current physician fee schedules for selected areas of Texas.

Form 5: Requires completion with the vendor's allowable charge for each of the claims included in Appendix D-3, a zipped archive containing twelve (12) claims data files and an Excel document with file description details. Additional details regarding the claims files are included in Appendix C. Specific instructions regarding the required format for the response, including the provider network status and allowed amount at the time of each claim, are included on the form.

The information provided in the claims file should be adequate to determine the allowable charge. The vendor is not to provide payment amounts, only allowable charges. A detailed description of the methodology used to re-price these sample claims must be provided along with a detailed example of repricing an individual claim. If the vendor utilizes capitation in their reimbursement methodology for certain facilities, so indicate.

Note: The System reserves the right to validate by audit the vendor's submitted allowable charge amounts for these sample claims.

14.0 TARGET CLAIMS COST RESPONSE

As specified in Section 5.12 of this RFP. The vendor must provide a Target Claims Cost (TCC) for in-area claims. The TCC will be used in the calculation of the health care management performance incentive. Provide all information as specified below in relation to the TCC.

14.1 FORMULAS

a) Specify the formula and enumerate the variables to be used in developing your final FY 2014 TCC on or before February 1, 2013

   Variables are limited to actual FY 2013 claims and the composition of FY 2014 in-area enrollment as discussed herein. All other factors including trend, network usage assumptions, plan design adjustments, network utilization/price adjustments, and factors used to adjust for demographic and geographic changes must be guaranteed for the term of the Contract.

   NOTE: The Projected FY 2014 TCC requested below should be based on the current UT SELECT benefit structure. If the benefit structure is revised for FY 2014 or for a subsequent plan year, the adjustment factors for benefit change will be subject to good faith negotiation.

b) Specify the formula and enumerate the variables to be used in developing your FY 2015 and FY 2016 TCCs. Maximum in-area trend factors must be guaranteed as indicated in Section 14.3 below.

14.2 PROJECTED FY 2014 TCC

Based on the formula specified in Section 14.1, project the FY 2014 TCC. Provide detailed documentation regarding your projection.

FY 2014 TCC	$_____ PEPM[1]

[1]Per Employee/Retired Employee Per Month

14.3 FY 2015 AND FY 2016 MAXIMUM GUARANTEED TRENDS

Specify the maximum guaranteed trends to be used in projecting the TCC for FY2015 and FY2016. These are the maximum rates that will be used; the actual rates will be subject to good faith negotiation.

FY 2015 Maximum Guaranteed Trend	_____
FY 2016 Maximum Guaranteed Trend	_____

15.0 ADMINISTRATIVE FEE PROPOSAL

15.1 GUARANTEE

Specify the guaranteed administrative fee per employee / retired employee per month.

FY 2014	$_____ PEPM
FY 2015	$_____ PEPM
FY 2016	$_____ PEPM

15.2 ALLOCATION TO CATEGORIES

List the applicable portion of the overall proposed administrative fee allocated to each of the categories below.

Utilization Review[1]	$_____ PEPM
Claims Processing[2]	$_____ PEPM
Network Management	$_____ PEPM
Behavioral Health Program[3]	$_____ PEPM
General Administration[4]	$_____ PEPM
Communication	$_____ PEPM
Other[5]	$_____ PEPM
TOTAL	$_____ PEPM

[1]Includes all cost containment activities.
[2]Includes subrogation related costs and related legal expenses as well as Coordination of Benefits.
[3]Includes any amounts paid to a behavioral health subcontractor for administrative services.
[4]Includes actuarial, legal, underwriting, reporting and other technical assistance.
[5]Specify.

16.0 SIGNATURE PAGE

In accordance with the attached proposal(s), _____ hereby agrees,
(Print Name of Organization)
if selected by The University of Texas System, to enter into negotiations for a Contract to provide administrative services for UT SELECT for at least the three year period beginning September 1, 2013. I have read the RFP from which this page is taken and verify that the above named organization can meet the requirements outlined.

The number of addenda reviewed before submitting this proposal: _____

The name of the primary contact person regarding this proposal is:

_____

Title: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Telephone #: _____ Fax #: _____

Printed name of the individual signing this form:

_____

Title: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

I hereby certify that I have the authority to bind the above named organization.

_____ _____

Signature Date