

REQUEST FOR PROPOSALS:

**Military Highway Water Supply Corporation  
RFP No. 2024-01 Group Health Insurance**

Deadline: October 10, 2024

RFP Opening: October 11, 2024

Prepared by:  
Military Highway Water Supply Corporation  
HR Department

# MHWSC RFP No. 2024-01 Group Health Insurance

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## REQUEST FOR PROPOSALS

Notice is hereby given that the Military Highway Water Supply Corporation is requesting proposals for the following:

### **MHWSC RFP No. 2024-01 Group Health Insurance**

MHWSC is requesting proposals from qualified insurance carriers to provide Fully Funded Health Insurance Proposals. Interested insurance carriers may request an RFP packet via email: [mhwsc@aol.com](mailto:mhwsc@aol.com)

Competitive, sealed proposals must be submitted on or before **October 10, 2024 at 4:45pm** at HR MHWSC Office located at 4000 US Highway 281, Mercedes, TX 78570.

Military Highway Water Supply Corporation  
HR Department

## Executive Summary Notice

### MHWSC RFP No. 2024-01 Group Health Insurance

1. The purpose of this Executive Notice is to highlight the key requirements of the Request for Proposal (RFP).
2. MHWSC is requesting proposals from qualified firms to provide Fully Funded Group Health Insurance.
3. Where applicable, all companies submitting proposals must be licensed by the Texas Department of Insurance and be permitted to contract with the State or any of its subdivisions. All insurance carriers must be rated by AM Best Company.
4. Term of this contract is for one (1) year.
5. No oral interpretations will be made to any interested proposers. Each request for an interpretation shall be made in writing to the HR Department at MHWSC no later than September 30, 2024 local time. Questions must be submitted in writing via e-mail to [mhwsc@aol.com](mailto:mhwsc@aol.com)

Any form of contact by an offeror or potential offeror regarding this RFP, at any time during the solicitation process from initial advertisement through award, with the Elective Board of MHWSC or any person employed by MHWSC other than through the communication channels stipulated in the Request for Proposal, or as subsequently instructed by MHWSC through the solicitation process, may constitute grounds for rejection of their Proposal.

Thank you for your interest in this project. We look forward to receiving your proposal.

# SECTION 1

## General Information

### MHWSC RFP No. 2024-01 Group Health Insurance

MHWSC is accepting sealed proposals for Fully Funded Group Health Insurance. Competitive, sealed proposals must be submitted on or before **October 10, 2024 at 4:45pm** at the HR Department located at **4000 US Highway 281, Mercedes, TX 78570.**

By submission of a proposal, the offeror agrees, if its proposal is accepted, to enter into a contract with MHWSC in the form included in the solicitation documents, to complete all work as specified or indicated in the contract documents for the contract price and within the time parameters indicated in the attached RFP. The offeror further accepts all of the terms and conditions of the Request for Proposal.

MHWSC may award the contract to the bidder who provides goods or services at the best value. MHWSC may consider the following to determine the best value:

- (1) The ability to maintain ACA grandfathered status;
- (2) the reputation of the bidder and of the bidder's goods or services;
- (3) the quality of the bidder's goods or services;
- (4) the extent to which the goods or services meet MHWSC needs;
- (5) the bidder's past relationship with MHWSC;
- (6) the total long-term cost to MHWSC to acquire the bidder's goods or services; and
- (7) any relevant criteria specifically listed in this request for bids or proposals

### GENERAL REQUIREMENTS AND INSTRUCTIONS

#### A. Information

1. The information contained in these specifications is confidential and is to be used only in connection with preparing a proposal for the following insurance services or insurance coverages:

#### **MHWSC RFP No. 2024-01 Group Health Insurance**

2. MHWSC reserves the right to accept or reject all or any part of the proposals, waive minor technicalities, and award the proposal to best serve the interest of MHWSC. MHWSC also reserves the right to waive or dispense with any of the formalities contained herein.
3. Proposals are to be submitted on the basis of the specifications contained herein. Alternate proposals and/or deviations from the specifications may be considered, provided the alternatives are clearly explained.
4. The information contained herein is believed to be accurate and up-to-date, but is not intended to be an express or implied warranty.
5. No telephone or fax proposals will be accepted. Proposals may only be accepted if

delivered by U.S. Postal Services, Federal Express, UPS, etc. or delivered by hand. MHWSC will not be responsible for missing, lost, or late mail. Any proposals received after the specified deadline will be returned to the proposer unopened.

## B. Legal

All parties submitting proposals are expected to comply with federal, state and local insurance laws and regulations relative to the preparation and submissions of insurance proposals. Specifically, the services to be provided are expected to be in compliance with the Americans with Disabilities Act (ADA), Family Medical Leave Act (FMLA), Health Insurance Portability and Accountability Act (HIPAA), insurance laws and insurance regulations. All proposals that are submitted will be presumed to be in compliance with all applicable laws.

## C. Submitting of Proposals

1. Respondents shall submit three (3) copies of their response, one (1) original marked "**ORIGINAL**," and two (2) copies marked "**COPY**" individually. Proposals must be delivered or mailed to MHWSC, **HR Department, address: 4000 US Highway 281, Mercedes, TX 78570**. in a sealed envelope **on or before the bid opening date and time**. Soft copies will be reviewed only if the original and sealed copies were submitted on time.

**Sealed proposals must be marked clearly on the exterior of the package:**

**Respondents company information; and**

### **SEALED PROPOSAL:**

MHWSC RFP No. 2024-01 Group Health Insurance

Due Date & Time: October 10, 2024 at 4:45pm

Opening Date & Time: October 11, 2024

## D. Time Frame

1. September 16, 2024 The specifications will be available at the Purchasing Department
2. September 30, 2024 Deadline to submit requests for interpretations/questions
3. October 10, 2024 Sealed proposals are due at 4:45pm
4. October 16, 2024 MHWSC Administration Presentation to MHWSC Board

## E. Proposals

1. Proposals must be clearly explained and identified. All costs, including optional programs, must be clearly stated and summarized. Exceptions to or deviations from the specifications **must** be explicitly identified.
2. Multiple proposals from the same carrier/insurance company will not be accepted.
3. Each party submitting a proposal is asked to screen their designated proposals for correctness and compliance with the specifications. They shall include an inventory list of products submitted attached to each proposal.
4. Proposal is to be based on duplication of the existing Plan of Benefits. Any deviations must be clearly identified and explained. All proposals will be assumed to have been

submitted without any deviations unless clearly noted.

5. The proposal must clearly state the agent/agencies accompanying the proposal offering. In addition, please include service work, capabilities, and value added programs to be provided by the agent/agencies as part of the submitted proposal.
6. The contents of the proposals shall be kept confidential during the process of negotiations.

F. Disqualification and Rejection of Proposals

Failure to comply with the requirements or the procedures set forth herein, or to satisfy the insurance and servicing criteria as set forth in the specifications, may result in disqualification. It is not intended that exceptions to the specifications will, in and of themselves, result in disqualification.

G. Selection of Vendor

MHWSC reserves the right to reject any or all of the proposals, in whole or in part; to waive any informality in any proposal, and to accept the proposal which, in its discretion, is in the best interest of MHWSC.

H. Authorized Signature

All proposal forms must be signed by persons who have legal authority to bind the insurer and administrator to the services that are proposed.

I. Enrollment

The selected Provider will be expected to provide knowledgeable licensed agents to explain benefit provisions during enrollment meetings to be conducted during the month of enrollment. The selected Providers will also be responsible for providing enrollment materials prior to the employee benefit enrollment meetings.

J. Conflict of Interest Questionnaire

MHWSC requires entities and their listed agents seeking to contract and/or contracting with MHWSC for the sale of goods or services, and their agents, to complete, sign and file a Conflict of Interest Questionnaire (Form CIQ) with MHWSC. If the bidder, a principal of the bidder, or agent listed by the bidder has a business relationship with MHWSC or with a MHWSC Board Member, the name of or business must be disclosed on the enclosed CIQ form. If the bidder or a principal of the bidder has no business relationship with MHWSC, write/type in "none" in the form and write/type in the name of the bidder and person acting for the bidder and sign the CIQ form. A blank CIQ form is enclosed and should be completed, signed and submitted with your bid. If you are not sure how to fill in the CIQ form, contact your attorney for advice.

## CONDITIONS

1. At completion of enrollment, MHWSC is to be provided with a master payroll deduction list that includes age, benefit amount and premium for both employee and dependent, if applicable.
2. Future Renewal rates must be explicitly explained and received by MHWSC seventy-five (75) days prior to the renewal date of November 1<sup>st</sup>.
3. The Insurance Company must have an A.M. Best rating of A- or better.
4. Tentative effective date is dependent on award date.



## **RATE HISTORY**

### **Group Health Insurance**

MHWSC currently provides medical benefits through a fully funded benefit program. MHWSC current group insurance carrier is Blue Cross Blue Shield. Below is a 4 Year Rate History:

Please find below the rate history with Blue Cross Blue Shield and United Healthcare:

### **Blue Cross Blue Shield**

#### **2020-21** (November 1, 2020) (Rate Decrease)

	MM26	MM07
Employee Only	\$558.50	\$710.53
Employee + Sp.	\$1,198.83	\$1,525.17
Employee + Ch.	\$1,098.02	\$1,396.93
Employee + Fam.	\$1,738.31	\$2,211.53

### **United Healthcare**

#### **2021-22** (November 1, 2021) (Rate Decrease)

	Low Medical Plan Option 2	High Medical Plan Option 1
Employee Only	\$568.52	\$635.17
Employee + Sp.	\$1,220.34	\$1,363.41
Employee + Ch.	\$1,117.73	\$1,248.77
Employee + Fam.	\$1,769.52	\$1,976.97

### **Blue Cross Blue Shield**

#### **2022-23** (November 1, 2022) (Rate Increase)

	MM26	MM11
Employee Only	\$542.88	\$639.75
Employee + Sp.	\$1,247.53	\$1,470.11
Employee + Ch.	\$964.60	\$1,136.71
Employee + Fam.	\$1,669.24	\$1,967.07

### **Blue Cross Blue Shield**

#### **2023-24** (November 1, 2023) (Rate Increase)

	MM26	MM11
Employee Only	\$569.61	\$667.40
Employee + Sp.	\$1,308.89	\$1,533.61
Employee + Ch.	\$1,012.06	\$1,185.83
Employee + Fam.	\$1,751.36	\$2,052.05

# SECTION 2

## Proposer Questionnaires

### General Questionnaire

#### RFP No. 2024-01 Group Health Insurance

All respondents must reply to the questionnaire under each category for which they are providing a proposal. (Please reproduce these questions when supplying your answers.)

1. Describe Your Organization.
  - a. Name: \_\_\_\_\_
  - b. Complete Address: \_\_\_\_\_
  - c. Contact Person: \_\_\_\_\_
  - d. Telephone Number: \_\_\_\_\_
  - e. Email Address: \_\_\_\_\_
  - f. Year Founded: \_\_\_\_\_
  
2. Please provide your most recent published financial statement and/or Best Insurance rating. Also, provide financial size category.
  
3. Is eligibility available online to Human Resources staff? Is online enrollment available with electronic data feed capabilities? If so, please include a list of those benefit admin systems.
  
4. Will there be a dedicated customer services unit for MHWSC? If so, where will it be located and how will it be staffed?
  
5. Do you have on-line access to network provider listings and locations to assist members with provider selection?

6. Contracted vendors will keep MHWSC supplied with needed enrollment materials, as well as current provider directories. Please supply sample of material.
7. The contracted vendor will provide an adequate supply of brochures, mail order supplies or whatever type of marketing material is used for MHWSC to be distributed to employees at no additional cost. Please confirm.
8. What is the average turnaround time for supplying ID cards directly to participants after a complete enrollment submission?
9. Does your plan currently offer on-line access to claims and eligibility information? Is there a separate charge for this to the plan?
10. Please provide a GEO Access report within your proposal.
11. Please indicate any tech and/or wellness credits with your proposal.
12. Please describe and include employee facing marketing materials for any employee engagement and wellness programs within your proposal.

# SECTION 3

## Forms

### REFERENCE FORM

The following information shall be required to accompany all bid submittals.

1. Your company's complete business address and phone number.

Company name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

2. A minimum of 3 references (local preferred).

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

**CONFLICT OF INTEREST QUESTIONNAIRE**  
**For vendor doing business with local governmental entity**

**FORM CIQ**

This questionnaire reflects changes made to the law by H.B. 23, 84th Leg., Regular Session.

This questionnaire is being filed in accordance with Chapter 176, Local Government Code, by a vendor who has a business relationship as defined by Section 176.001(1-a) with a local governmental entity and the vendor meets requirements under Section 176.006(a).

By law this questionnaire must be filed with the records administrator of the local governmental entity not later than the 7th business day after the date the vendor becomes aware of facts that require the statement to be filed. See Section 176.006(a-1), Local Government Code.

A vendor commits an offense if the vendor knowingly violates Section 176.006, Local Government Code. An offense under this section is a misdemeanor.

**OFFICE USE ONLY**

Date Received

**1 Name of vendor who has a business relationship with local governmental entity.**

**2**  **Check this box if you are filing an update to a previously filed questionnaire.** (The law requires that you file an updated completed questionnaire with the appropriate filing authority not later than the 7th business day after the date on which you became aware that the originally filed questionnaire was incomplete or inaccurate.)

**3 Name of local government officer about whom the information is being disclosed.**

\_\_\_\_\_  
 Name of Officer

**4 Describe each employment or other business relationship with the local government officer, or a family member of the officer, as described by Section 176.003(a)(2)(A). Also describe any family relationship with the local government officer. Complete subparts A and B for each employment or business relationship described. Attach additional pages to this Form CIQ as necessary.**

A. Is the local government officer or a family member of the officer receiving or likely to receive taxable income, other than investment income, from the vendor?

Yes       No

B. Is the vendor receiving or likely to receive taxable income, other than investment income, from or at the direction of the local government officer or a family member of the officer AND the taxable income is not received from the local governmental entity?

Yes       No

**5 Describe each employment or business relationship that the vendor named in Section 1 maintains with a corporation or other business entity with respect to which the local government officer serves as an officer or director, or holds an ownership interest of one percent or more.**

**6**  Check this box if the vendor has given the local government officer or a family member of the officer one or more gifts as described in Section 176.003(a)(2)(B), excluding gifts described in Section 176.003(a-1).

**7**

\_\_\_\_\_  
 Signature of vendor doing business with the governmental entity

\_\_\_\_\_  
 Date

## Request for Taxpayer Identification Number and Certification

**Give Form to the  
requester. Do not  
send to the IRS.**

▶ Go to [www.irs.gov/FormW9](http://www.irs.gov/FormW9) for instructions and the latest information.

Print or type. See Specific Instructions on page 3.	<p><b>1</b> Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.</p>	
	<p><b>2</b> Business name/disregarded entity name, if different from above</p>	
	<p><b>3</b> Check appropriate box for federal tax classification of the person whose name is entered on line 1. Check only <b>one</b> of the following seven boxes.</p> <p><input type="checkbox"/> Individual/sole proprietor or single-member LLC</p> <p><input type="checkbox"/> C Corporation</p> <p><input type="checkbox"/> S Corporation</p> <p><input type="checkbox"/> Partnership</p> <p><input type="checkbox"/> Trust/estate</p> <p><input type="checkbox"/> Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=Partnership) ▶ _____</p> <p><b>Note:</b> Check the appropriate box in the line above for the tax classification of the single-member owner. Do not check LLC if the LLC is classified as a single-member LLC that is disregarded from the owner unless the owner of the LLC is another LLC that is <b>not</b> disregarded from the owner for U.S. federal tax purposes. Otherwise, a single-member LLC that is disregarded from the owner should check the appropriate box for the tax classification of its owner.</p> <p><input type="checkbox"/> Other (see instructions) ▶ _____</p>	<p><b>4</b> Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):</p> <p>Exempt payee code (if any) _____</p> <p>Exemption from FATCA reporting code (if any) _____</p> <p><small>(Applies to accounts maintained outside the U.S.)</small></p>
	<p><b>5</b> Address (number, street, and apt. or suite no.) See instructions.</p>	<p>Requester's name and address (optional)</p>
	<p><b>6</b> City, state, and ZIP code</p>	
	<p><b>7</b> List account number(s) here (optional)</p>	

### Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN*, later.

**Note:** If the account is in more than one name, see the instructions for line 1. Also see *What Name and Number To Give the Requester* for guidelines on whose number to enter.

<b>Social security number</b>					
<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 25%; border: 1px solid black; height: 20px;"></td> <td style="width: 5%; text-align: center;">-</td> <td style="width: 25%; border: 1px solid black; height: 20px;"></td> <td style="width: 5%; text-align: center;">-</td> <td style="width: 40%; border: 1px solid black; height: 20px;"></td> </tr> </table>		-		-	
	-		-		
<b>OR</b>					
<b>Employer identification number</b>					
<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 15%; border: 1px solid black; height: 20px;"></td> <td style="width: 5%; text-align: center;">-</td> <td style="width: 85%; border: 1px solid black; height: 20px;"></td> </tr> </table>		-			
	-				

### Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

**Certification instructions.** You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions for Part II, later.

**Sign Here**

Signature of U.S. person ▶

Date ▶

### General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

**Future developments.** For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to [www.irs.gov/FormW9](http://www.irs.gov/FormW9).

### Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following.

- Form 1099-INT (interest earned or paid)

- Form 1099-DIV (dividends, including those from stocks or mutual funds)
  - Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
  - Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
  - Form 1099-S (proceeds from real estate transactions)
  - Form 1099-K (merchant card and third party network transactions)
  - Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
  - Form 1099-C (canceled debt)
  - Form 1099-A (acquisition or abandonment of secured property)
- Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

*If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See What is backup withholding, later.*

# **SECTION 4**

## **Benefit Exhibits**

### **EXHIBITS**

**Attached are the following exhibits:**

- Exhibit A – Certificate of Coverage – Both Plans
- Exhibit B – SBC – Both Plans
- Exhibit C – Census
- Exhibit D – Claims History