

Meeting Date
March 17, 2015



ADD ON

AGENDA	
Section	Unfinished Business
Item No.	II A

AGENDA REPORT
BREVARD COUNTY BOARD OF COUNTY COMMISSIONERS

SUBJECT:	Group Health Insurance Request For Proposals
DEPT/OFFICE:	Office of Human Resources / Employee Benefits

Requested Action:

That the Board of County Commissioners review and approve the release of the attached Group Health Plan Request for Proposals.

Summary Explanation & Background:

As directed by the Board of County Commissioners, in regular session on December 16, 2014 and further discussed in special session at the Board of County Commissioner's Healthcare Workshop on January 22, 2015, the Office of Human Resource / Employee Benefits has drafted a Request for Proposals designed to request the following from the group health insurance commercial marketplace:

1. Request proposals for a narrow network health plan design offered by a single health plan provider with a five year cost guarantee.
2. Request proposals for a broad network health plan design that includes all three Brevard County hospital systems offered by a single health plan provider with a five year cost guarantee.
3. Request proposals that use the County's current group health insurance program design as a base line option and allow for deviations from that base line to be proposed.
4. Request proposals that encourage the use of innovative methods in the delivery of group health insurance coverage for a large group employer.

It is also requested that the Board review, provide input and direction to the Office of Human Resources / Employee Benefits with regard to the evaluation criteria and weighted scoring methodology proposed in this RFP.

Upon final review and approval by the Board of County Commissioners of this draft RFP, the Group Health Insurance Request for Proposals will be released. Responsive proposals will be evaluated by the Employee Benefits Insurance Advisory Committee and recommendations will be presented to the Board for consideration.

Clerk to the Board instruction:

Exhibits Attached: Group Health Insurance RFP w/ Attachments A & B; RFP evaluation criteria and weighted scoring sheet

Contract /Agreement (If attached): Reviewed by County Attorney Yes No PR

County Manager		Deputy County Manager	Department Director / Extension Gerard Visco, Insurance Director / 5-5446
Stockton Whitten		Assistant County Manager	



Tammy Etheridge, Clerk to the Board, 400 South Street • P.O. Box 999, Titusville, Florida 32781-0999

Telephone: (321) 637-2001
Fax: (321) 264-6972

March 18, 2015

M E M O R A N D U M

TO: Jerry Visco, Insurance Director

RE: Item V.A., Approval of Group Health Insurance Request for Proposals

The Board of County Commissioners, in regular session on March 17, 2015, approved releasing Group Health Plan Request for Proposals (RFP) for a narrow network health plan design offered by a single health plan provider with a five-year cost guarantee; RFP for a broad network health plan design that includes all three Brevard County hospital systems offered by a single health plan provider with a five-year cost guarantee; RFP that uses the County's current group health insurance program design as a baseline option and allow for deviations from that baseline to be proposed; and RFP that encourage the use of innovative methods in the delivery of group health insurance coverage for a large group employer.

Your continued cooperation is always appreciated.

Sincerely,

BOARD OF COUNTY COMMISSIONERS
SCOTT ELLIS, CLERK

Tammy Etheridge, Deputy Clerk

/kg

Brevard County Government 2016 Health Plan Request for Proposals (RFP)

1. Introduction

The Brevard County Government (County) is soliciting proposals for comprehensive health plan services effective for their January 1, 2016 plan year. The County is seeking proposals that demonstrate the ability to deliver high quality, cost-effective health care services with a goal of maximizing the health status of employees, retirees and covered dependents. The County is currently self-funded, but will consider alternative funding options and innovative proposals as described below. The County reserves the right to select the option(s) that best meet their needs; however the funding of the plan will be either self-funded or fully insured.

The County Health Plan RFP solicits comprehensive proposals from providers with multiple options for consideration. Vendors are encouraged to propose options that may address any or all of the following three categories of services:

1. **Option 1** - Administrative Services Only (ASO – current model)
 - a. ASO proposals are to be based on the current HRA and PPO plan designs as a baseline. In addition the County will consider proposed deviations (e.g. narrow networks, gatekeeper models) as long as costs and savings differentials from the current plans are clearly outlined.
 - b. Carriers may not have exclusivity (currently 2 carriers)
 - c. Five year guarantees must be proposed for all administrative fees and network discounts
 - d. Narrow and broad network options are requested for consideration
 - e. Pharmacy Benefit Manager (PBM) carve-out services are not requested; however pharmacy benefits may be considered if integrated with proposed medical services and if it is advantageous to the County
 - f. The County desires to partner with an ASO provider willing to guarantee year over year network pricing guarantees not to exceed a pre-defined medical trend/inflationary factor that will be reconciled at the conclusion of each plan year
2. **Option 2** - Fully Insured Program(s)
 - a. Fully insured proposals are to be based on the current HRA and PPO plan designs as a baseline. In addition, the County will consider proposed deviations as long as the premium reductions and plan design deviations from the current plans are clearly outlined.
 - b. Exclusive, integrated plan(s) with a single carrier including medical, prescription drug and behavioral health services are requested
 - c. Rates must be guaranteed or capped with maximum renewals for up to five years
 - d. A single carrier with narrow network options (e.g. less than all Brevard County hospitals) will be considered
 - e. A single carrier with broad network options (e.g. includes all Brevard County hospitals) will be considered
 - f. The County desires access to regional, statewide, national and Centers of Excellence networks that provide in-network benefit levels for routine (non-emergent) medical services; however this is not a mandatory requirement.
3. **Option 3** - Innovative Solutions
 - a. Providers/vendors are encouraged to propose and outline any innovative methods currently in place that have achieved verifiable results for consideration by the County
 - b. The County will not consider options that are not fully developed and operational and that do not include demonstrated results and multiple year cost/ performance guarantees
 - c. Innovative solutions must be administered as a part of a comprehensive health plan on either an ASO or fully insured basis

2. Instructions for Proposers

Proposers must complete the Attachments listed below based on the Options (1, 2 and/or 3) being proposed. Applicable Attachments are to be completed in full and submitted with your proposal in hard copy and electronically in the file format specified.

Attachment	File Format	Instructions
Attachment "A" – Mandatory Requirements Checklist	MS Word	Return with submission if you are proposing Option 1 or Option 2
Attachment "B" - Proposal Worksheet	MS Word	Return with submission if you are proposing Option 1, Option 2 or Option 3
Attachment "C" – Network and Formulary Disruption File	MS Excel	Return with submission if you are proposing Option 1 or Option 2
Attachment "D" – Claims Re-pricing File	MS Excel	Complete if you are proposing Option 1; however <u>do not return</u> with submission. Completed files will be subject to onsite verification as a part of the evaluation process
Attachment "E" – Medical Discount Pricing File	MS Excel	Complete if you are proposing Option 1; however <u>do not return</u> with submission. Completed files will be subject to onsite verification as a part of the evaluation process
Attachment "F" – Pharmacy Cost Proposal Worksheet	MS Excel	Return with submission only if you are proposing integrated pharmacy as a variation of Option 1 which would include integrated PBM and medical services on a non-exclusive basis

The following Exhibits are included with this Request for Proposals and provide additional information to assist in completing the proposal.

- Exhibit "A"-Employee Census as of January 2015
- Exhibit "B"-Enrollment and Claims Experience (broken out by carrier and plan)
- Exhibit "C"-2015 Funding Structure Summary
- Exhibit "D"-Summary Plan Description
- Exhibit "E"-2015 Stop Loss Coverage
- Exhibit "F"-Claims File Layout

3. Tentative Timeline

Action	Date
Release of RFP	April 2015
Deadline for Questions to Purchasing	April 2015
Addendums Out	April 2015
Proposals Due to Purchasing	May 2015
Proposal analysis sent by RobinsonBush to carriers for verification	May 2015
Proposal verifications due from carriers	May 2015
Selection Committee meeting to review responses	June 2015
Finalist Interviews	June 2015
Approval of Recommendation by the Board	July 2015
Effective Date of Coverage	1/1/2016

4. Background Information

Brevard County Government includes approximately 4,289 active individuals and retirees eligible for medical benefits. Employees are located at worksites throughout Brevard County, Florida. Employees who retire from the County are eligible for benefit continuation.

The County health plan includes the following agencies currently participating in the County's health plans:

- Board of County Commissioners
- Brevard County Sheriff
- Property Appraiser
- Court Administration
- Melbourne-Tillman Water Control District
- Tax Collector
- Supervisor of Elections
- Sebastian Inlet Tax District
- Titusville Cocoa Airport Authority
- Clerk of Court*

**Note: The Clerk of Court (COC) left the Brevard County health plan 1/1/2012 and went to a fully insured arrangement for the 2012 and 2013 plan years. They returned to the County plan on 1/1/2014. Census information and available claims detail is included in this RFP.*

Plans Offered and Enrollment Summary:

Plan	Carrier	Subscribers	Dependents	Covered Lives
HRA Plan (self-funded)	Cigna	2,209	2,233	4,442
HRA Plan (self-funded)	Health First Health Plan	694	843	1,537
PPO Plan (self-funded)	Cigna	938	756	1,694
PPO Plan (self-funded)	Health First Health Plan	234	218	452
EPO Plan (self-funded)	Health First Health Plan	214	284	498
Total on Self-Funded Plan		4,289	4,334	8,623
PBM Services for all Self-funded Plan Options	Cigna Rx			
Waive / No Coverage	N/A	401		401
Additional Options for Retirees Eligible for Medicare**				
Medicare Advantage	Health First Health Plan	219	60	279
Medicare Supplements (not on census)	United Healthcare	33		33

** It is anticipated that all retirees eligible for Medicare and their Medicare eligible dependents will be offered comprehensive fully insured options effective January 1, 2016 and will no longer participate in the County's self-funded health plan. Options for Medicare eligible retirees are not requested and will be evaluated separate from this solicitation. The County reserves the right to continue eligibility to Medicare eligible retirees at their sole discretion.*

Exhibit "D" – Summary Plan Description provides detailed information on eligibility guidelines, coverage provisions, schedules of benefits, and other plan information to develop your baseline proposal (based on the HRA and PPO plans), and any proposed deviations. The EPO plan was newly introduced in 2015 and is based on the HRA Plan but with in-network coverage only. EPO claims experience is not available for purposes of this RFP. The County may consider an in-network only option if proposed as a deviation and if the cost impact to the County is clearly described and advantageous to the County.

The County purchases specific stop loss insurance through Symetra with a \$600,000 per individual deductible and an additional aggregate pooling of \$208,000.

5. Mandatory Requirements

The following mandatory requirements have been established. Proposers that do not meet the mandatory requirements will be deemed non-responsive and will not be considered for further evaluation.

- A. The Proposer must have experience providing Administrative Services Only (ASO) services and Fully Insured health programs to one or more employers each having 1,000 or more subscribers within the past five (5) years.
- B. The Proposer must have accreditation by the National Committee for Quality Assurance (NCQA) as of the proposal due date.
- C. Administrative fees and network discounts for ASO proposals must be guaranteed for 2016, 2017, 2018, 2019 and 2020 and/or fully insured premium rates must be guaranteed or capped with maximum increases for 2016, 2017, 2018, 2019 and 2020.
- D. Proposers must agree to attend quarterly meetings to review plan performance; meet monthly to review ongoing administrative, service, and plan management issues; and make available a Medical Director for ongoing involvement in plan performance initiatives.
- E. Proposers must prepare their proposal based on the current HRA and PPO Plan designs currently administered by Cigna, Health First Health Plan, and CignaRx (PBM for all plan options).
- F. Proposers must have the ability to interface and manage eligibility directly from CBIZ, the County's current enrollment vendor, or with any future vendor selected by the County to perform these services.
- G. Web-based administrative tools must be available to the County HR department to manage eligibility on behalf of all agencies on an ongoing basis.
- H. Your Company must allow the County or a mutually agreeable firm selected by the County to conduct annual claims audits and periodic hospital bill recovery audits.
- I. Proposers for ASO services must complete medical claims re-pricing on the sample claims presented in the RFP based on the Proposer's current network discounts under contract. Only aggregate amounts are to be listed in your proposal submission with the specific discounts subject to onsite verification at the Proposer's facility as a part of the evaluation process. To the extent allowed by Florida law, specific discount information will be confidential and only used to validate the aggregate amounts.
- J. Proposers must agree to assist the County with Retiree Drug Subsidy (RDS) administration, including necessary reports to qualify for subsidy, interfacing with RDS directly for eligibility, claims submission and reconciliation for as long as the County participates in the RDS program.

6. Scope of Services

Option 1 – Administrative Services Only (ASO)

General and Administrative

1. Proposals are being sought by the County for self-funded health plan services for an effective date of January 1, 2016 with guaranteed rates and network discounts renewable for up to five (5) years.
2. The County is requesting a comprehensive, dedicated account management team to be assigned to the County to assist with claims, eligibility and day-to-day service issues. In addition, the County requests a full-time, onsite clinical coordinator (Registered Nurse or clinical equivalent) who will assist members in achieving optimal health through identification of risks, closing gaps in care, and developing health improvement strategies. The onsite clinical coordinator will also conduct educational sessions at various locations and have all necessary on-line access to clinical data. The assigned onsite clinical coordinator is subject to County approval and the County will have the right to require a replacement if performance is not satisfactory.
3. It is the intention of the County to contract with medical plan providers with accessible hours of operation and demonstrated service results to administer the comprehensive self-funded programs.
4. Proposers must conduct an external audit of health plan operations using the industry standard Statement on Auditing Standards (SAS) No. 70 or Statement on Standards for Attestation Engagements (SSAE) No. 16, Service Organizations and must agree to provide the report annually to the County and/or County auditor.
5. Web-based educational tools should be made available to Plan participants providing information on issues such as claims status, health and wellness topics, and provider / treatment cost calculators that are based on the specific plan designs of the County.
6. Proposers should assist in the preparation of the Summary Plan Description (SPD); and prepare and maintain the annual required Summary of Benefits and Coverage (SBCs) on behalf of the County.
7. Proposers should provide access to records, files, and documents related to all medical claims, administrative fees and other elements of the contract in order to conduct an annual audit. The information should be provided in an electronic format where possible.
8. Proposers should detail the audit adjustment process used in instances where claim errors are noted during an audit. This description should include whether the identified claim paid in error and related claims for that member are reimbursed to the County regardless of whether the claims can be reprocessed. In addition, the Proposer should describe the remediation efforts undertaken to identify and review similar claims for other members, and if warranted, whether these claims are refunded to the County.
9. Proposers should assist the County with annual enrollment by training the benefits staff on plans; creating County specific enrollment and educational materials; attending on-site enrollment meetings; and agreeing to accept the County's benefits enrollment files electronically on an ongoing basis.
10. Proposers should have contractual arrangements in place with external review organizations

available for member appeals in accordance with health care reform guidelines. The awarded Proposer will be responsible for facilitating all aspects of the external review process, and will provide the external review company with the claims and plan information needed for an appropriate determination to be made.

11. Proposers shall process and adjudicate all medical claims in accordance with the health plan document. Proposers will be held liable for claims adjudicated outside the health plan document.
12. Proposers must accept self-billing by the County for administrative fees which is based on payment of the invoice as presented and retroactive adjustments made by the County in the following month.
13. Proposers should have the ability to identify claims subject to third party liability such as workers compensation, auto accident, and coordination of benefits.

Plan Design

1. ASO proposers that include an integrated PBM option must complete the tab entitled "Formulary" contained on Attachment "C" – Network and Formulary Disruption File.
2. Baseline proposals should match the current HRA and PPO plan benefits as outlined in Exhibit "D" – Summary Plan Description, as closely as possible. Additional deviations may be proposed and must include a description of the deviation and cost impact to the plan(s).
3. Proposers should have arrangements for Complementary and Alternative Medicine services for plan members.
4. If the Proposer is including an integrated PBM option for consideration, the Proposer should disclose if they are proposing or will agree to the following:
 - a. 100% pass-thru pricing for rebates, administrative fees and other discounts/revenue received from pharmaceutical manufacturers;
 - b. Continual negotiation of MAC retail pricing and pass those savings directly to the County
 - c. Contractually agree to disclose all sources of revenue for administration of the pharmacy program
 - d. Allow auditing of all claims versus a claims sample and outline any limitations to the auditing scope and frequencies
 - e. No "spread pricing" should apply
 - f. Notify 100% of members impacted by negative formulary changes happening throughout the plan year
5. While it is anticipated that retirees and their eligible dependents that are eligible for Medicare may no longer participate in the County's self-funded plan options effective January 1, 2016, the County reserves the right to continue eligibility for those members. The Proposer should have the ability to administer the Plan on a secondary basis to Medicare, regardless of whether the retiree has enrolled in Medicare Part B. The Proposer should assist members with End Stage Renal Disease in applying for Medicare benefits.

Network Services

1. Proposers are to complete the network provider tabs included in Attachment "C" – Network and Formulary Disruption File included with this RFP and indicate each provider designated as a high performing provider or that is included in a high performance limited network, if available.
2. The networks should have 85% of providers Board Certified/Board Eligible, and an annual turnover rate of less than 3%.
3. Network gaps where in-network providers are not available in Brevard County should be disclosed in your proposal.
4. Your proposal should specify contracted services where capitation is applied. Proposers should provide encounter data for services covered under capitated arrangements.
5. Members should be held harmless from balance billing when using in-network providers, when being referred for specialty services, and for services provided by an in-network providers that are not approved by the Proposer.
6. Proposers should monitor network provider performance, based on nationally recognized quality standards, and take action when standards are not being met.
7. The County may have an interest in a Patient Centered Medical Home (PCMH) model and/or contracting with an Accountable Care Organization (ACO) and is interested in the Proposer's current and future strategies to provide these services.
8. The County may have an interest in other effective network options (e.g. narrow networks), if available, and is interested in the Proposer's current and future strategies to provide these services.
9. While not necessarily contemplated, the County may find it advantageous to direct contract with certain network providers to better meet its current and future needs. Proposers are requested to address their ability to administer a County specific provider contracting arrangement, including the ability and/or any limitations to plan design steerage. Proposers must disclose the impact to the proposed ASO fees if applicable.

Health Management

1. The County anticipates implementing an adherence-based incentive plan that requires the completion of biometric screenings and health risk assessments on an annual basis in order to qualify for Health Reimbursement Account (HRA) funding. In addition, employees enrolled in the PPO, since they do not have HRA funding, should have incentives tied to plan design (e.g. reduced deductibles) for completion of the adherence-based plan requirements. Describe your capabilities to administer the adherence-based program described above, including services offered, tracking and reporting, frequency of reporting, and any additional costs associated with administration.
2. If the County finds it advantageous to contract the biometric screening services to a third party they would prefer Proposers have the ability to receive external biometric screening data and auto-populate the health risk assessment tool for each participant.
3. Proposers should demonstrate their ability to increase preventive care utilization.
4. Proposers should demonstrate their ability to identify high risk plan members, and be able to assist them in managing their health.

5. The County desires to have a dedicated case manager assigned who will work consistently with the County to address the specific needs of seriously ill plan members. The ratio of clinicians per covered member should demonstrate capacity to meet the needs of the County's plan participants.
6. Disease management programs proposed should have demonstrated success in care outcomes and cost. The ratio of clinicians/coaches per covered member should demonstrate capacity to meet the needs of the County's plan participants.
7. Proposers should have the ability to track and manage health and wellness activities, report performance to the County, and administer incentives. Reports on the health management activities, and their effectiveness, should be provided to the County at intervals agreed upon by the County. Proposers should have the ability to administer clinical programs and interventions such as biometric screenings, health risk assessments, online education, step therapy, and prior authorizations.
8. Proposers should have the ability to assist the County with customized, targeted comprehensive initiatives to improve the health of the population. Comprehensive initiatives may include optional programs such as:
 - weight management for morbidly obese, obese, and overweight members;
 - diabetes control and prevention;
 - comprehensive cardiology program, including hypertension control and prevention
 - COPD;
 - healthy pregnancy; and
 - compliance with preventive screening guidelines.
9. Consumer educational material should be provided and/or made available via the internet, to plan members on general health issues and specific initiatives, illnesses, and diseases.
10. Proposers should demonstrate the ability to assist the County in reducing or modifying utilization where medically appropriate; and guarantee results.
11. Proposers will be expected to assist in the development and implementation of identified clinical interventions that may be desired by the County.
12. Proposers should have a Fraud, Waste and Abuse (FWA) policy that results in demonstrated success and be willing to report outcomes of the FWA program to the County on an annual basis.

Reporting and Data Interface

1. The finance and banking arrangements should include documentation for claims reimbursement and must meet the accounting needs of the County, as determined by the County.
2. The County prefers to set-up wire transfers as the initial payment methodology and move to ACH once the County has a comfort with the claims adjudication and funding process.
3. Proposers should have the capability to integrate any annual biometric screening results, specific to each member and performed by the Proposer or by an independent screening company, into the claims history and Health Risk Assessment history of each member.

4. Provide the frequency of rebate payments and include a sample detail report that will accompany rebate payments.
5. Proposers should provide a list of the standard reports that will be available to the County on a daily, weekly, monthly, quarterly or annual basis, and include sample reports with the proposal submission.
6. Proposers submitting proposals should provide eligibility, claims and utilization data on a monthly basis; and eligibility discrepancy reporting on a weekly basis via web-based employer portal.
7. Comprehensive medical and pharmacy claims and eligibility file downloads (data dumps), in a HIPAA compliant, standard industry format, should be provided to the County and their benefits consultant on a monthly basis.

Cost and Guarantees

1. In addition to customer and administrative services, claims adjudication, health management, and reporting as specifically outlined in the scope of services, Medical ASO fees should include network fees.
2. If your ASO proposal includes integrated PBM, you should present the impact to your proposed medical ASO fees that include and exclude PBM services.
3. Proposers should clearly disclose any retained fees (shared savings) for all programs such as subrogation, out-of-network fee negotiations, overpayment recoveries, etc.
4. The administrative fees proposed by Proposer shall be deemed to be inclusive of all of the services proposed. Other services not included in your ASO fees must be specified in detail in the Cost and Guarantees section of Attachment "D" – Proposal Worksheet.
5. Proposals shall be submitted net of commissions.
6. Proposers should include an implementation credit to offset any costs associated with a potential transition for issues such as file transfers, interface fees, employee education, etc.
7. Performance Guarantees and associated proposed penalties should include the following:
 - Plans loaded and tested; staff trained; and ID cards issued before 1/1/2016.
 - Plan documents and banking arrangement completion by November 1 prior to the initial year and August 15 each year thereafter. Contract negotiations should be completed by August 15 and Summary of Benefits and Coverage (SBCs) are to be completed by September 1 of each year.
 - Network Stability should include an annual turnover rate of 3% or less in Brevard County.
 - Claims Administration standards should include:
 - Financial Accuracy to be calculated by using total claims dollars processed, compared to the combined over and under payment errors, with a minimum of 99.3% accuracy.
 - Processing Accuracy of at least 99.0% of the total number of correct claims divided by the total claims processed.
 - Turnaround Time minimum of 94% clean claims in 14 calendar days and 100%

all clean claims in 30 days.

- Accurate and Timely Reporting with Monthly, Quarterly and Annual reporting due by the 20th of the following month and reports to be error free.
- Account Management standards that will demonstrate the Proposer commitment to maintain experience, dedicated account service contacts that provide ongoing and timely service to the County's Administration Staff, conduct service meetings with the County to review the status of account service deliverable and issue resolution as needed in a timely manner.
- Customer Service standards that will include average speed to answer, and call abandonment rates

Failure to meet the performance standards may result in the non-renewal or cancellation of the contract by the County, at its sole discretion.

Option 2 – Fully Insured Proposals

1. Proposals are being sought by the County for fully insured health plan services for an effective date of January 1, 2016 with guaranteed premium rates and/or maximum renewal caps for up to five (5) years. Proposals with less than five (5) year premium rate and/or maximum renewal cap guarantees will be deemed non-responsive.
2. The fully insured proposals are to be based on a single carrier offering that is based on the current HRA and PPO plan design as specified in Exhibit "D" – Summary Plan Description. The Health Reimbursement Arrangement is self-funded by the County and is not to be included in the fully insured premium rates. Proposed deviations will be considered as long as the premium reductions and plan design deviations from the current plans are clearly outlined.
3. A single carrier with narrow network options (e.g. less than all Brevard County hospitals) will be considered.
4. A single carrier with broad network options will be considered.
5. The County desires access to regional, statewide, national and Centers of Excellence networks that provide in-network benefit levels for routine (non-emergent) medical services.
6. The County is requesting a comprehensive, dedicated account management team to be assigned to the County to assist with claims, eligibility and day-to-day service issues. In addition, the County requests a full-time, onsite clinical coordinator (Registered Nurse or clinical equivalent) who will assist members in achieving optimal health through identification of risks, closing gaps in care, and developing health improvement strategies. The onsite clinical coordinator will also conduct educational sessions at various locations and have all necessary on-line access to clinical data. The assigned onsite clinical coordinator is subject to County approval and the County will have the right to require a replacement if performance is not satisfactory.
7. Rates proposed must be final based on the census and claims information provided with this RFP, see Exhibit A – Employee Census and Exhibit B – Enrollment and Claims Experience.
8. Proposals are to be submitted net of agent commissions.

9. Companies are required to provide access to the County and/or its designated consultant downloaded plan experience data on a monthly basis, attend quarterly meetings to review plan performance and ongoing service issues, and make available a Medical Director for ongoing involvement in performance improvement activities.
10. Proposers must agree to work collaboratively with any County designated vendor(s) to develop interfaces to accept electronic eligibility on an ongoing basis at no additional cost to the County. This service is currently contracted with CBIZ.
11. The selected proposer must be willing to assist the County with annual enrollment meetings as needed and participate in Health Fairs and/or other wellness activities as requested and at no additional cost to the County.
12. Proposals must include a compliant problem resolution process for member and network provider complaints and appeals.
13. The networks should have a high percentage of credentialed providers with a low turnover rate.
14. Consumer education tools should be available to provide information on general health issues and specific illnesses and diseases; as well as cost estimators to assist health plan members in selecting care providers.
15. Claims administration and eligibility information must be timely and accurate.
16. Performance standards and guarantees should be included.

Option 3 - Innovative Solutions Proposals

1. Providers/vendors are encouraged to propose and outline any innovative methods currently in place that have achieved verifiable results for consideration by the County.
2. Proposals for innovative solutions must fully developed and operational with verifiable results.
3. It is desired that proposals for innovative solutions be integrated with a health plan with the ability to be administered by an insurance carrier or ASO provider as a part of a proposed comprehensive health plan.

7. EVALUATION CRITERIA

A Selection Committee (Committee) will evaluate: the conformance to requirements of this RFP; adherence to the scope of services; and written responses to the Proposal Worksheet questions, as outlined below.

Medical Proposal Evaluation

The Committee will score all responsive proposals to determine the ranking of each company using the following criteria:

Criteria	Points
General and Administrative	0-5
Plan Design	0-5
Network Services	0-30
Health Management	0-10
Financial Reporting and Data Interface	0-5
Cost and Guarantees	0-45
Total	100

DRAFT

**ATTACHMENT "A" - MANDATORY REQUIREMENTS CHECKLIST
BREVARD COUNTY BOARD OF COUNTY COMMISSIONERS HEALTH PLAN RFP**

"Mandatory Requirements" must be present in each proposal before further consideration will be given. Below is a checklist to ensure that the Proposer understands and confirms that all "Mandatory Requirements" are included in the RFP response. If the stated requirement is included in your proposal as requested, check "Yes". If the stated requirement is not included in your proposal, check "No".

IMPORTANT NOTE: YOUR PROPOSAL WILL BE REMOVED FROM CONSIDERATION IF ANY APPLICABLE FEATURE INDICATES A "NO" CHECK OR IF ANY 'YES' ANSWER INCLUDES EXCLUSIONS.

Mandatory Requirements Checklist		
Feature	Yes	No
1. Does your company currently or has your company previously provided Administrative Services Only (ASO) services, fully insured program(s), or innovative solutions you are proposing to one or more employer groups each having 1,000 or more subscribers within the past five (5) years?		
2. Does your company maintain accreditation by the National Committee for Quality Assurance (NCQA)?		
3. Confirm that your company's ASO administrative fees and network discounts are guaranteed for 2016, 2017, 2018, 2019 and 2020 and/or your company's fully insured premium rates are guaranteed or capped with maximum renewal increases for 2016, 2017, 2018, 2019 and 2020.		
4. Will your company agree to attend quarterly meetings to review plan performance; review ongoing administrative, service, and plan management issues; and to make available a Medical Director for ongoing involvement in plan performance initiatives?		
5. Confirm your proposal is based on the current HRA and PPO Plan designs currently administered by Cigna, Health First Health Plan, and CignaRx (PBM for all plan options).		
6. Confirm your Company's ability to interface and manage eligibility directly from CBIZ, the County's current enrollment vendor, or with any future vendor selected by the County to perform these services.		
7. Confirm your Company's web-based administrative tools will provide the ability for the County HR department to manage eligibility on behalf of all agencies on an ongoing basis.		
8. Will your company allow the County or a mutually agreeable firm selected by the County to conduct annual claims audits and periodic hospital bill recovery audits?		

Mandatory Requirements Checklist

Feature	Yes	No
9. For ASO proposals only, has your company completed Attachment "D" – Claims Re-pricing File based on the current network discounts under contract and does your company agree that only aggregate amounts are to be listed in your proposal with the specific discounts subject to onsite verification at your company's facility as a part of the evaluation process?		
10. Does your company agree to assist the County with Retiree Drug Subsidy (RDS) administration, including necessary reports to qualify for subsidy, interfacing with RDS directly for eligibility, claims submission and reconciliations for as long as the County participates in the RDS program?		

I certify that the responses herein are accurate.

Name of Firm (Proposer)

Signature

Printed Name/Title

Date

**ATTACHMENT "B" – PROPOSAL WORKSHEET
BREVARD COUNTY BOARD OF COUNTY COMMISSIONERS
HEALTH PLAN RFP**

Section 1 - General and Administrative (0-5 points)

Company Information	
Proposer/Company Name	
Primary Contact Person Name:	
Phone No:	
Fax: No:	
E-mail Address:	

Indicate the proposal options you are submitting for consideration by the County		Yes	No
Option 1 – Administrative Services Only (ASO) – Complete Attachments A through F			
Option 2 – Fully Insured Program(s) – Complete Attachments A, B, and C			
Option 3 – Innovative Solutions – Complete Attachment B, Section 7			

# Years Providing Health Plan Administrative Services in Brevard County	# Employer Groups (Fully Insured and Self-Funded) in Brevard County over 1,000 Lives	Total # Covered Lives in Brevard County	Total # Covered Lives in State of Florida

List below three (3) references of your Company where Administrative Services Only (ASO) services and/or Fully Insured products were provided to employers with 4,000 or more subscribers within the past five (5) years.

Client	Contact Name	Phone #/ Email Address	# Years of Contractual Relationship	Number of Enrolled Employees

List all contracts in which your firm was terminated by a government agency in the last five (5) years.

Client	Dates Contracted	Reason for Termination

List the name of each employee that your Company will assign to assist in the administration of the County's Plan.

Medical and Pharmacy Account Executive	Account Service Manager	Medical Director	Pharmacy/Clinical Director	Implementation Manager	Name	Location	Years with Company	Client Load

Company:

Provide your response to the following issues:

Issue	Response
1. Confirm your company is proposing medical benefit administration services and that you will begin implementation upon award by the County Commission with an effective date of January 1, 2016.	
2. Will your Company provide an onsite, full-time clinical coordinator as specified in the Scope of Services?	
3. Describe any additional staff you will dedicate to the County to assist with issues such as banking/finance, eligibility, health and wellness, etc.	
4. State your member call in medical customer service location and hours of operation.	
5. List the percent of customer service calls that result in problem resolution on the initial call.	
6. For 2014, indicate your medical performance results in the following categories (format indicated in parenthesis): a. Clean claims processed within 10 days (percentage); b. Clean claims processed within 30 days (percentage); c. Average claims turnaround time (number of days); d. Claims coding accuracy (percentage); e. Claims dollar accuracy to include over and under payments (percentage); f. Average speed of telephone answer (number of seconds); g. Average telephone call abandonment rate (percentage)	<p>a</p> <p>b</p> <p>c</p> <p>d</p> <p>e</p> <p>f</p> <p>g</p>
7. List the percent of medical claims received electronically and claims completely adjudicated electronically versus manually broken out by physician and facility claims.	
8. Indicate whether your claims processing system or patient record captures and can report on the following: a. Laboratory values specific to the member; b. Compliance with periodic physicals and preventive diagnostic services specific to the member; c. Plan sponsored biometric screening values specific to the member performed by a third party vendor selected by the County; d. Prescription medication adherence and compliance.	<p>a.</p> <p>b.</p> <p>c.</p> <p>d.</p> <p>e.</p>
9. Proposers must conduct an external audit of health plan operations using the industry standard Statement on Auditing Standards (SAS) No. 70 or Statement on Standards for Attestation Engagements (SSAE) No. 16, Service Organizations and must agree to provide the report annually to the County and/or County auditor.	

Company:

Issue	Response
<p>10. Confirm your proposal is based on the HRA and PPO Plans as shown in Exhibit "D" Summary Plan Descriptions and that you have identified any deviations or plan design options that would result in cost reductions. Deviations should be described in detail and the estimated percentage impact to the County plan costs should be provided.</p>	
<p>11. Confirm that web-based eligibility administration will be available to the County on an ongoing basis.</p>	
<p>12. Describe how your Company will assist the County in reconciling eligibility discrepancies between what is being reported and what is contained in your Company's eligibility files.</p>	
<p>13. List the online consumer tools your Company will provide to assist members with obtaining claims information, health and wellness topics, provider quality, medical and pharmacy pricing calculators, and plan information. Confirm these tools will provide information to members specific to the County's plans and plan designs.</p>	
<p>14. Confirm your Company will assist in the preparation of the Summary Plan Description (SPD); will prepare the annual Summary of Benefits and Coverage (SBC), and/or Certificates of Coverage.</p>	
<p>15. Access to annual claims audits and periodic hospital bill recovery audits are critical to the County and are included as Mandatory Requirements in this solicitation. Please list any specific limitations with respect to audits that your Company imposes for the scope of the audit, audit periods, access to data, etc.</p>	
<p>16. Please detail the audit adjustment process used in instances where claim errors are noted during an audit. This description should include whether the identified claim paid in error and related claims for that member are reimbursed to the County regardless of whether the claims can be reprocessed. In addition, the Proposer should describe the remediation efforts undertaken by the firm to identify and review similar claims for other members, and if warranted, whether these claims are refunded to the County.</p>	
<p>17. Describe your hospital bill auditing procedures, including thresholds that trigger an audit and how potential recoveries are made.</p>	
<p>18. Confirm your Company will assist with the annual enrollment process, development and printing of customized enrollment materials, and describe any additional assistance your Company will provide during annual enrollment.</p>	

Company:

Issue	Response
19. Confirm your Company will accept the County's benefits enrollment files electronically from a third party enrollment on an ongoing basis.	
20. Confirm your Company has contractual arrangements in place with external claims review organization(s) to conduct final appeal determinations on behalf of the County members and that your company will be responsible for facilitating all aspects of the review process.	
21. Describe your claims adjudication process compliance with the health plan document. What safeguards are in place to ensure claims are processed in accordance with the plan document and how are funds reimbursed to the County if it is determined that claims were adjudicated incorrectly? What documentation will be provided by the County to verify and reconcile the corrections?	
22. Describe the methods your Company uses to identify claims with potential third party liability such as workers compensation, auto accident, and coordination of benefits with other primary insurance.	

Section 2 - Plan Design (0-5 points)

Issue	Response
1. If you are proposing integrated PBM services, and for all fully insured proposals, confirm that you have completed the tab labeled Formulary on Attachment C and included the list in your response in MS-Excel format as requested.	
2. Confirm your Company has the ability to administer the current HRA plan design and list any deviations of coverage comparing your administrative capabilities to the Health Plan Summary Plan Descriptions included with this RFP as Exhibit "D" - 2015 Summary Plan Description. Fully insured proposers are also encouraged to propose an alternative, cost effective plan design for consideration. If proposing an alternative plan design, please include a full description of the plan benefits and associated premium rates which must be guaranteed as specified in this RFP.	
3. Describe your Company's arrangements for Complimentary and Alternative Medicine (CAM) services not covered under the Plan.	
4. If you are proposing integrated PBM services, confirm your Company has the ability to accumulate medical and pharmacy	

Company:

	<p>member costs toward the deductible and out of pocket maximums and that any overpayments by members will be reconciled by your Company and reimbursed to the member.</p> <p>5. Describe arrangements you have where members have access to discounts on medical related services not covered under the plan.</p>
a	6. If you are proposing integrated PBM services please confirm the following and/or list any deviations:
b	a. 100% pass-thru pricing for rebates, administrative fees and other discounts/revenue received from pharmaceutical manufacturers are guaranteed
c	b. You will continually negotiate MAC retail pricing and pass those savings through directly to the County
d	c. You will contractually agree to disclose all sources of revenue for administration of the pharmacy program
e	d. You will allow auditing of all claims versus a claims sample and outline any limitations to the auditing scope and frequencies
a	e. You will not apply "spread pricing"
b	7. If you are proposing integrated PBM services, regarding your Company's drug formulary list, indicate:
c	a. Frequency and timing of formulary changes
d	b. Method to notify employer, including summary of member impact
e	c. Method to notify specific members impacted d. Method to notify providers e. Availability of formulary via hard copy and on website
	8. Confirm that your Company can administer the Plan on a secondary basis when a retiree or their enrolled dependent is eligible for Medicare, regardless of whether they have enrolled in Medicare Part B.
	9. Will your Company identify and assist members with End Stage Renal Disease in applying for Medicare benefits?
	10. Will your Company perform required testing and make appropriate recommendations to ensure the County benefits for mental health and substance abuse coverage meet all requirements under the Mental Health Parity and Addiction Equity Act?

Section 3 - Network Services (0-30 points)

Issue	Response																																																														
<p>1. Confirm you have completed the network disruption analysis included in the tabs labeled "Facilities", "Physicians" and "Pharmacy" in Attachment "C" and have returned it in MS - Excel format as requested.</p>																																																															
<p>2. Confirm that you have provided a complete alphabetic list of in-network providers in Brevard County, including specialty and city. If you have a narrow network option, include a separate alphabetic list of in-network providers and provide an estimated savings the County should achieve if they move to a narrow/high performance network.</p>																																																															
<p>3. Indicate the total number of in-network Family Practice/Internal Medicine, Pediatric, OB/GYN, all other Specialist physicians in the following counties and percent Board Certified/Board Eligible (BC/BE) in each: (note: count each physician only one time)</p>	<table border="1"> <thead> <tr> <th rowspan="2">County</th> <th colspan="2">Family Practice/IM</th> <th colspan="2">Pediatrics</th> <th colspan="2">OB/GYN</th> <th colspan="2">Specialist</th> </tr> <tr> <th>Total #</th> <th>% BC/BE</th> <th>Total #</th> <th>% BC/BE</th> <th>Total #</th> <th>% BC/BE</th> <th>Total #</th> <th>% BC/BD</th> </tr> </thead> <tbody> <tr> <td>Brevard</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Orange</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Osceola</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Volusia</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Indian River</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> </tbody> </table>	County	Family Practice/IM		Pediatrics		OB/GYN		Specialist		Total #	% BC/BE	Total #	% BC/BE	Total #	% BC/BE	Total #	% BC/BD	Brevard									Orange									Osceola									Volusia									Indian River								
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<p>4. Indicate the number of U.S. states in which you have a provider network available; and also provide the total number of providers contracted throughout the nation.</p>																																																															
<p>5. What is your Company's primary care and specialist provider turnover rate in the most recent 12 months for which you have data? Please specify the time period used.</p>																																																															
<p>6. Is a network available on a regional and national basis for members traveling outside of Brevard County, and for retirees and dependents living outside the area in order to receive in-network coverage?</p>																																																															
<p>7. Do you have a contracted Centers of Excellence (COE) network? How are members directed to use these COE's?</p>																																																															
<p>8. List the inpatient hospital facilities in Brevard, Orange, Osceola, Volusia and Indian River Counties participating in your network by County.</p>																																																															
<p>9. Indicate any network gaps (no provider contracts) in Brevard County for services such as hospital based physicians, pediatric subspecialties, and other specialties. Indicate how these services will be provided if no network contracts exist on January 1, 2016.</p>																																																															
<p>10. List any provider contracts with Brevard County Area hospitals, free standing facilities, and large physician groups</p>																																																															

Company:

Issue	Response
<p>that expire or will be renegotiated in the 2015 or 2016 calendar years.</p>	
<p>11. If the County identifies a provider currently in their network not currently contracted with your Company will you agree to attempt contracting?</p>	
<p>12. List the contracted services where a capitation fee is applied. Will you provide encounter data for services covered under your capitation arrangement?</p>	
<p>13. Do your contracts with providers include language that protects the member from balance billing when using in-network providers, when being referred for specialty services by an in-network provider, and for services provided by an in-network provider that are not approved by the Company? How do you specifically address in-network surgeons using non-contracted surgical assistants?</p>	
<p>14. Do your hospital contracts include protections for members receiving ancillary professional care from hospital based providers (i.e., pathology, radiology, emergency, and anesthesia) not contracted with your Company? If yes, please describe how claims are adjudicated and the impact to the County and member costs.</p>	
<p>15. Describe how medical services are provided for members traveling outside the United States.</p>	
<p>16. How do you communicate with providers on Plan design changes, Evidence based medical guidelines; Provider performance profiles?</p>	
<p>17. How does your Company determine provider performance and what action is taken when standards are not met?</p>	
<p>18. How and when will you notify the County of any pending provider terminations?</p>	
<p>19. If you are proposing integrated PBM services, provide the name, location, and years your Company has used the current mail order pharmacy facility.</p>	
<p>20. If you are proposing integrated PBM services, provide your Company's specialty pharmacy facility name, location, and years of service for your Company.</p>	
<p>21. If you are proposing integrated PBM services, describe your Company's normal delivery service of mail order and specialty medication (including delivery method and time of day) and indicate any additional cost for prescription requests with expedited service. Please indicate whether the delivery services are through a specific provider or selected from a list of providers.</p>	

Company:

Issue	Response
22. Is your Company moving in the direction of providing access to Patient Centered Medical Home(s) in the Brevard County area? If so, when do you anticipate this model would be available and how do you feel this would impact the County?	
23. Is your Company moving in the direction of contracting with Accountable Care Organizations in the Brevard County area? If so, when do you anticipate this type of model would be available and how do you feel this would impact the County?	
24. Does your Company have cost effective network options (e.g. narrow networks) that the County could consider implementing as a cost effective option? If yes, describe.	
25. If the County found it to be advantageous, would you have the ability to administer a direct provider contract arrangement specific to the County? Could you administer a County specific plan differential to create steerage to those County specific providers? Disclose any impact to the proposed ASO fees if applicable.	

Section 4 - Health Management (6-10 points)

Issue/Service	Response
1. The County anticipates implementing an adherence-based incentive plan that requires the completion of biometric screenings and health risk assessments on an annual basis in order to qualify for Health Reimbursement Account (HRA) funding. In addition, employees enrolled in the PPO, since they do not have HRA funding, should have incentives tied to plan design (e.g. reduced deductibles). Describe your capabilities to administer the adherence-based program described above, including services offered, tracking and reporting, frequency of reporting, and any additional costs associated with administration.	
2. If the County finds it advantageous to contract biometric screening services to a third party, do you have the ability to receive biometric screening data from an external vendor, track completion, and auto-populate the health risk assessment tool for each participant?	
3. Describe your Company's ability to increase preventive care utilization and provide your results over the last 5 years.	
4. Describe your Company's ability to identify high risk plan members. What proactive steps does the Company take to mitigate their impact on the plan's performance? Provide your results over the last 5 years.	

Company:

Issue/Service	Response
<p>5. What criteria are used to identify a member for case management? Will you assign a dedicated case manager who will work consistently with the County to address the specific needs of seriously ill plan members? What is your staffing ratio of clinician to covered members?</p>	
<p>6. Identify the Disease Management programs your Company will include as a part of the ASO fees proposed, indicate how potential participants are targeted, indicate how members are contacted, and how physicians are notified regarding specific patients. What is your staffing ratio of clinician/coach to covered members?</p>	
<p>7. Provide results of your Disease Management program including:</p> <ul style="list-style-type: none"> a. Participation results for the past year (% engaged); b. Demonstrated return on investment; c. Improvements in utilization compliance. 	<p>a</p> <p>b</p> <p>c</p>
<p>8. Can your Company track activities and engagement in comprehensive health management programs and administer incentives such as plan design differentials to specific members enrolled? (e.g. reduced costs for enrollment in a diabetes program)</p>	
<p>9. Describe any additional innovative clinical programs and interventions you have in place that the County might consider, including a description of the program, associated costs, and performance /ROI guarantees.</p>	
<p>10. Will your Company provide a 24-hour nurse line that will be included in your ASO fees?</p>	
<p>11. Describe how your Company will assist the County in reducing or modifying utilization where medically appropriate. Identify any results that will be guaranteed as part of this proposal.</p>	
<p>12. Will you provide the County with consumer educational material in both hard copy and via web-based tools for members on general health issues and specific initiatives and identified disease states?</p>	
<p>13. If you are proposing integrated PBM services, describe how your prescription drug program promotes the use of generic drugs in lieu of prescribed brand name drugs if commercially available and consistent with the dispensing pharmacist's judgment and State and Federal laws.</p>	
<p>14. If you are proposing integrated PBM services, describe the step therapy and prior authorization programs your Company has available for consideration by the County. If there is an additional cost for these programs, please indicate such costs in Section 6 below. List any Return on Investment guarantees.</p>	

Company:

Issue/Service	Response
15. If you are proposing integrated PBM services, describe your approach to providing cost containment for dispensing of specialty medications. What clinical support is provided by the specialty pharmacy and what plan design strategies are recommended?	
16. If you are proposing integrated PBM services, provide information on how your Company identifies members who may be fraudulently using and/or abusing benefits. Does your company have a Fraud, Waste and Abuse program? Provide a sample list of these programs and demonstrated successes.	
17. If you are proposing integrated PBM services, indicate how your Company monitors medication adherence and what steps your Company will take to improve compliance.	
18. If you are proposing integrated PBM services, indicate how your Company will identify high risk pharmacy use and actively manage polypharmacy issues.	
19. If you are proposing integrated PBM services, what is your Company's strategy toward compound drugs and how do you effectively manage cost and utilization of these medications?	
20. If you are proposing integrated PBM services, describe how your Company identifies members and physicians who may be fraudulently using and/or abusing medications, e.g. narcotics. What action would your Company take once identified?	

Section 5 – Financial Reporting and Data Interface (0-5 points)

Issue/Service	Response
1. Indicate the timeline for payment of ASO fees and/or fully insured premiums under your Company's proposal.	
2. Describe the banking arrangement your Company is proposing for the payment of claims, and indicate the supporting documentation that will accompany the request for payment.	
3. If you are proposing integrated PBM services, is the banking arrangement different for pharmacy claims? If so, please describe the differences.	
4. Indicate the frequency of claims payments being proposed including any pre-funding requirements of your Company.	
5. Indicate the method used by your Company for the request for funding for claims payment (i.e. claims issued for payment or for check amounts clearing the bank)	
6. Does your Company have the ability to upload biometric screening data from a third party vendor into the member health record and auto-populate the member's health risk assessment?	

Company:

Issue/Service	Response
7. If you are proposing integrated PBM services, list the frequency of rebate payments that will be made to the County, when payments will begin after the start of the Plan, and provide a sample detail report that will accompany rebate payments.	
8. List the standard reports that will be available to the County on a daily, weekly, monthly, quarterly or annual basis, and include sample reports with the proposal submission.	
9. Does your Company agree to provide eligibility, claims and utilization data on a monthly basis; and eligibility discrepancy reporting on a weekly basis via a web-based portal?	
10. Does your Company agree to provide comprehensive claims and eligibility file downloads (data dumps), in a HIPAA compliant, standard industry format, to the County designated representative and the County's benefits consultant on a monthly basis including all fields listed in Exhibit "F" – Claims File Layout? Please indicate any fields that will not be available in the monthly data file.	
11. Confirm that you will provide the County with comprehensive claims and eligibility data files on a monthly basis including encounter data of any capitated services for the data fields as specified?	
12. Indicate the reports your Company will provide that will summarize performance in areas such as large case management, disease management, and gaps in care.	
13. Indicate the documentation your Company will provide for 3 rd party network discount negotiations and indicate how it will be reported to the County. Include any savings withheld for any negotiated discounts.	
14. If you are proposing integrated PBM services, indicate the reports your Company will provide for medication adherence.	
15. If you are proposing integrated PBM services, and if requested by the County, indicate the services your Company will provide to assist the County with Medicare Part D attestation, necessary reports, and eligibility and claims submission. List any additional costs associated with these services in Section 6 below.	
16. Confirm that your Company agrees to provide the County access to all records, files and documents related to all medical and (if applicable) pharmacy claims, administrative fees and other elements of the contract. The information is to be provided in an electronic format where possible. Electronic records should include sufficient data to reconcile any claims funding payment requested to the County.	

Company:

Section 6 - Cost and Guarantees (0.45 points)

The following provides a summary of the current enrollment by plan and paid claims experience.

Current Plan Participation Based on the census provided in Exhibit "A" – Census. Note: all participants on the census currently enrolled in the EPO plan are included in the applicable tiers for the HRA Plan counts below. Base your ASO and Fully Insured premium rates on these counts and do not modify in your proposal.

Plan Type	Employee Only	Employee + Spouse	Employee + Child(ren)	Employee + Family	Total Subscribers	Total Members
HRA	1,368	524	613	612	3,117	6,477
PPO	688	148	134	202	1,172	2,146
Total Enrolled in Self-Funded Plan	2,056	672	747	814	4,289	8,623

Paid Claims Summary – see Exhibit "B" – Claims Experience for claims and enrollment by month and claims lag report.

OPTION 1 – Administrative Services Only

1. List your Company's proposed Administrative Services Only (ASO) Fees. Your ASO fee should be inclusive of all administrative and network management services. Any service not included in the ASO fee must be disclosed in your response to question 4 below.

The Plan Administrative Services Only (ASO) fees are to be stated and guaranteed for 2016, 2017, 2018, 2019 and 2020 and quoted on an incurred claim basis. Claims administration for run out claims following termination of the contract is to be included in the Per Subscriber Per Month (PSPM) fees as proposed. Use the "Subscriber" counts provided in this document to calculate the PSPM total costs.

	Administrative Services Only (ASO) Fees				
	2016	2017	2018	2019	2020
Subscribers					
Fee Per Subscriber Per Month	\$	\$	\$	\$	\$
Total ASO Monthly Cost	\$	\$	\$	\$	\$
Total ASO Annual Cost	\$	\$	\$	\$	\$

2. If applicable, if the County finds it advantageous to move to your proposed integrated medical/PBM model with multiple carriers, what impact will this have on the ASO fees proposed above?

	2016	2017	2018	2019	2020
Fee Per Subscriber Per Month	\$	\$	\$	\$	\$

Company:

3. Medical Discounts and Trend - Complete the following sections using the claims data found in Attachment "D" - Claims Repricing File. Only provide your Company's aggregate amounts. All amounts, summaries, reports, and discounts listed will be subject to verification. The verification process will be conducted, at your Company's facility, with your Company's specific data being kept confidential to the extent allowed under Florida law. Only the aggregate amounts as verified will be disclosed.

a. Claims Re-pricing. Using the claims information found in Attachment "D" - Claims Repricing File, complete the chart below by listing the aggregate allowable cost for each category. You must complete the re-pricing exercise; however do not submit this detailed information with your proposal. The responses provided below are subject to validation by reviewing the completed re-pricing file and provider contracts onsite at your facility as a part of the evaluation process.

Category	Total Billed Amount	Billed Amount Re-priced	Total Allowable Aggregate Cost
Inpatient Hospital			
Outpatient Facility			
CPT Codes			
Total Amount			

a. Provider Discount Pricing. Using the utilization and cost information provided in Attachment "E" - Medical Discount Pricing File, indicate your Company's current average percent medical network discounts for the service categories listed below. You must complete the worksheets provided in Attachment "E"; however do not submit this detailed information with your proposal. The responses provided below are subject to validation by reviewing the completed worksheets in Attachment "E" and provider contracts onsite at your facility as a part of the evaluation process. Indicate the minimum discounts your Company will guarantee for 2016, 2017, 2018, 2019 and 2020 with no corridor included in the guarantee.

Network Provider Category	Total Billed Charges	Current % Discount from Billed Charges	Guaranteed % Discount for 2016	Guaranteed % Discount for 2017	Guaranteed % Discount for 2018	Guaranteed % Discount for 2019	Guaranteed % Discount for 2020
Facility							
Ancillary							
Professional							

b. Medical and Prescription Drug Trend. List your Company's medical and prescription drug trends for the Brevard County geographical area in the following calendar years. Will your Company agree to a "not to exceed" Medical Cost Increase year over year based on a proposed factor that will be reconciled each year and will you provide remuneration to the County if increases exceed the increases proposed?

Medical Trend	Medical Cost Increase (Medical Trend)	Prescription Drug Cost Increase (Rx Trend)	Overall Cost Increase (Overall Trend)	Indicate your not-to-exceed medical cost increases year over year and indicate how you will provide remuneration if the not-to-exceed limits are not met
2013				2017 %
2014				2018 %
2015 Anticipated				2019 %
2016 Anticipated				2020 %

Company:

4. Pharmacy Guarantees. If your Company is proposing integrated Pharmacy Benefit Manager (PBM) services as a part of your ASO proposal you must complete the following section. Pharmacy discounts, rebates, dispensing fees and administrative fees are to be guaranteed for 2016, 2017, 2018, 2019 and 2020. Keep in mind your Company will only provide pharmacy benefit management services to those members enrolled in your proposed plan(s), which is anticipated to be a slice of the enrollment. The County, at its sole discretion, may contract with multiple medical ASO providers and may continue to carve-out PBM services. Single Source Generics are generic drugs in the first 6 month exclusivity period following a Brand drug losing its patent. Single Source Generic discount guarantees are to be included in the Generic Discount/Rx from AWP. Discounts are to be applied to zero balance claims, where the member copayment equals to total cost of the drug, but are to be excluded from the guarantees. 100% of the rebates received should be shared with the County. The lesser of Usual and Customary fees, or the guaranteed discounts, are to apply.

a. Pharmacy Pricing Guarantees.

Retail Pharmacy Discounts and Fees	30 Day Retail Guarantees				
	2016	2017	2018	2019	2020
30 Days					
Generic Discount/Rx from AWP					
Generic Drug Dispensing Fee/Rx					
Brand % Discount from AWP					
Brand Drug Dispensing Fee/Rx					
Brand Drug Rebate/ Brand Rx					
Administrative Fee					

Retail 90 Pharmacy Discounts and Fees	Retail 90 Guarantees			
	2016	2017	2018	2019
Over 84 Days				
Generic Discount/Rx from AWP				
Generic Drug Dispensing Fee/Rx				
Brand % Discount from AWP				
Brand Drug Dispensing Fee/Rx				
Brand Drug Rebate/ Brand Rx				
Administrative Fee				

Mail Order Pharmacy Discounts and Fees	Mail Order Guarantees			
	2016	2017	2018	2019
Over 84 Days				
Generic Discount/Rx from AWP				
Generic Drug Dispensing Fee/Rx				
Brand % Discount from AWP				
Brand Drug Dispensing Fee/Rx				
Brand Drug Rebate/ Brand Rx				
Administrative Fee				

Company:

Specialty Pharmacy Discounts and Fees	Specialty Rx Guarantee				
	2016	2017	2018	2019	2020
% Discount from AWP					
Drug Dispensing Fee/Rx					
Drug Rebate/ Specialty Rx					
Administrative Fee					

b. Pharmacy Cost Guarantee Worksheet

Confirm that your Company has completed the Pharmacy Cost Guarantee Worksheet, Attachment "F", and it is included with your response.

c. Generic Fill Rate Guarantee. Indicate the generic fill rate your Company will guarantee for the following years. Guarantees are to be factored on a dollar for dollar basis for any shortfall.

Generic Fill Rate Amount of Guarantee	2016	2017	2018	2019	2020
	%	%	%	%	%

5. Indicate whether the following services are included in your proposal and base ASO fee:

Service	Included in Proposal (Yes/No)	Indicate any additional cost beyond ASO Fee	Limitations (must be disclosed)
Current plan design administration			
Plan design options that outline deviations			
Full time clinical coordinator (RN or clinical equivalent) onsite at the County			
Dedicated account management team			
Attendance at quarterly monthly administrative and plan management meetings			
Annual enrollment training and on-site enrollment meeting participation			
Run out claims administration following termination of contract			
On line capability for eligibility additions, changes and deletions with HR staff capability for all participating agencies			
Weekly eligibility discrepancy reports			
Eligibility data interface with the County (currently CBIZ) on an ongoing basis			
Monthly comprehensive eligibility, claims and utilization experience downloads			
Retroactive eligibility and claims reprocessing			
Printing and distribution of ID cards initially and when plan deductibles, co-pays, and co-insurance changes are made and replacement cards are issued			
On line access to provider network directory			
Assistance in development of Summary Plan Descriptions and development and			

Company:

Service	Included in Proposal (Yes/No)	Indicate any additional cost beyond ASO Fee	Limitations (must be disclosed)
maintenance of Summary of Benefits and Coverage (SBC's)			
Web-based access to administrative tools for network providers to access member coverage details			
Web-based administrative tools for members to view specific plan information and access claims history and educational tools on provider network, cost comparisons and wellness issues			
Provider network administration			
Administration of County specific direct provider contract(s) if desired by the County			
Claims adjudication, including review and defense of appealed claims, up to the external claims review			
External claims administration and selection of review agency for medical and pharmacy appeals			
Cost of external claims review			
Legal defense of claims appeals involving decisions your Company made			
Fraud, Waste and Abuse program			
Third Party Liability Recovery (subrogation) services			
Coordination of Benefits recoveries			
Credit Balance Recovery services			
Hospital Bill Audit services			
Facility Reasonable and Customary (R&C) charge determination services			
Out-of-network discount negotiation services			
Access to records and staff necessary to conduct annual external audits conducted by the County or its designated auditing firm			
Monthly full claims detail to County designated representative and County's benefits consultant			
Monthly reporting of large dollar claims to independent stop loss insurance carrier and submission of all data necessary for claims recovery to the County			
Administration of Retiree Drug Subsidy (RDS) services including assistance with actuarial attestations, monthly eligibility and cost report, reconciliation			
Predictive modeling and ongoing outreach and management of members at risk			
Case management with a dedicated case management nurse working closely with the County			
Disease Management programs			
Healthy Pregnancy Program			
Assistance with health management program design and implementation			
Annual Health Fair participation			
Wellness educational materials – electronic and printed			
24-hour Nurse telephone line			

Company:

Service	Included in Proposal (Yes/No)	Indicate any additional cost beyond ASO Fee	Limitations (must be disclosed)
Online Health Risk Assessments			
Biometric screenings onsite at various County locations			
Activity tracking for wellness and health management activities and administration/tracking of Health Reimbursement Account (HRA) funding			
Administration of value based benefit design for participation in health management programs			
Ability to upload biometric screening results from a third party vendor to the individual member health record and ability to auto-populate the member's health risk assessment			
Pharmacy clinical prior authorization program and review			
Pharmacy step therapy program and review			
Pharmacy retrospective utilization review			
Pharmacy clinical review for medical necessity			
Formulary disruption letters to 100% of impacted members when changes occur			
Targeted letters to members on pharmacy-related issues (any additional costs should be quoted on a per letter basis)			
Pharmacy patient safety audits at point of sale			
Claims data requests for GASB and other state and federal reporting requirements			
Online report access with query capabilities including detailed eligibility, claims and utilization data			
Rx direct member claims reimbursement (paper claims)			
Rx open file transfers to new vendor using industry standard formats at termination			
Provide all required notifications and data necessary to comply with any out-of-state requirements, e.g. New York Surcharge.			
List any additional services your Company will perform that have not been previously disclosed that will result in additional administrative charges to the County or any additional fees for your Company			

6. List any Implementation Funds that you will allocate to the County to offset transition costs associated with your program. Please specify the total dollar amount proposed and specify any limitations in how the County can utilize these funds.
7. List any annual wellness funds you are proposing for the County to use to implement programs intended to improve health. Describe any limitations and requirements in the use of wellness funds.
8. Confirm that no commissions are included in your proposal to any agent, broker, or consultant.

Company:

9. **Performance Guarantees:** List your proposed performance guarantees, including a description of the guarantee and measurement and dollar amount at risk for each of the categories listed below.

Area of Guarantee	Description of Guarantee	Metric Required to Meet Guarantee	Dollar Amount at Risk
Implementation			
Plan Implementation (plans loaded, tested; staff trained; eligibility accurate and ID cards issued before 1/1/2016)			
Plan document, contract, and banking arrangement agreement completion			
Network Stability			
Provider turnover rate			
Administration			
Claims Financial Accuracy			
Claims Processing Accuracy			
Clean Claims Turnaround Time			
Timely Reporting			
Timely Data Transfer			
Satisfaction			
Account management satisfaction survey scores			
Employee satisfaction survey scores			
Telephone Responsiveness			
Average speed of answer			
Percent of issues answered on initial call			
Call abandonment Rate			
Other performance guarantees you will provide			

OPTION 2 – FULLY INSURED PROGRAM

1. Based on the current HRA Plan design only (assume 100% enrollment in the HRA plan), provide your Fully Insured Premiums for 2016, 2017, 2018, 2019 and 2020 using the following assumed subscriber counts.

Tier	Subscribers	2016 Monthly Premiums	2017 Monthly Premiums	2018 Monthly Premiums	2019 Monthly Premiums	2020 Monthly Premiums
Employee Only	2,056	\$	\$	\$	\$	\$
Employee and Spouse	672	\$	\$	\$	\$	\$
Employee and Children	747	\$	\$	\$	\$	\$
Employee and Family	814	\$	\$	\$	\$	\$
	4,289					
Total Monthly Premium		\$	\$	\$	\$	\$
Total Annual Premium		\$	\$	\$	\$	\$
Indicate the maximum % renewal increase		%	%	%	%	%

2. Indicate below whether the services outlined are included in your fully insured premiums. If you will provide the service and it is not included in the premium, please indicate the cost of the additional services, including the expected annual cost.

Service	Included in Proposal (Yes/No)	Limitations (must be disclosed)
Current plan design administration		
Plan design options that outline deviations		
Full time clinical coordinator (RN or clinical equivalent) onsite at the County		
Dedicated account management team		
Attendance at quarterly monthly administrative and plan management meetings		
Annual enrollment training and on-site enrollment meeting participation		
On line capability for eligibility additions, changes and deletions with HR staff capability for all participating agencies		
Weekly eligibility discrepancy reports		
Eligibility data interface with the County (currently CBIZ) on an ongoing basis		
Monthly comprehensive eligibility, claims and utilization experience downloads		
Printing and distribution of ID cards initially and when plan deductibles, co-pays, and co-insurance changes are made and replacement cards are issued		
On line access to provider network directory		
Certificates of Coverage and Summary of Benefits and Coverage (SBC's) and other regulatory required documents sent to all participants at their home address		
Web-based access to administrative tools for network providers to access member coverage details		
Web-based administrative tools for members to view specific plan information and access claims history and educational tools on provider network, cost comparisons and wellness issues		

Company:

Service	Included in Proposal (Yes/No)	Limitations (must be disclosed)
Administration of County specific direct provider contract(s) if desired by the County		
Legal defense of claims appeals involving decisions your Company made		
Fraud, Waste and Abuse program		
Monthly full claims detail to County designated representative and County's benefits consultant		
Administration of Retiree Drug Subsidy (RDS) services including assistance with actuarial attestations, monthly eligibility and cost report, reconciliation		
Predictive modeling and ongoing outreach and management of members at risk		
Case management with a dedicated case management nurse working closely with the County		
Disease Management programs		
Healthy Pregnancy Program		
Assistance with health management program design and implementation		
Annual Health Fair participation		
Wellness educational materials – electronic and printed		
24-hour Nurse telephone line		
Online Health Risk Assessments		
Biometric screenings onsite at various County locations		
Activity tracking for wellness and health management activities and administration/tracking of Health Reimbursement Account (HRA) funding		
Administration of value based benefit design for participation in health management programs		
Ability to upload biometric screening results from a third party vendor to the individual member health record and ability to auto-populate the member's health risk assessment		
Pharmacy clinical prior authorization program and review		
Pharmacy step therapy program and review		
Pharmacy retrospective utilization review		
Pharmacy clinical review for medical necessity		
Formulary disruption letters to 100% of impacted members when changes occur		
Pharmacy patient safety audits at point of sale		
Claims data requests for GASB and other state and federal reporting requirements		
Online report access with query capabilities including detailed eligibility, claims and utilization data		
Rx open file transfers to new vendor using industry standard formats at termination		
List any additional services your Company will perform that have not been previously disclosed that will result in additional administrative charges to the County or any additional fees for your Company		

3. Premium Build-up and Assumptions for 2016 Fully Insured Premiums

Category	2016 Estimated Cost Per Category
Incurring medical claims	\$
Incurring pharmacy claims	\$
Claims Administration	\$
Premium Taxes	\$
Pooling Charges	\$
ACA Fees	\$
Other Administrative fees (please list)	\$
Total Estimated Cost for 2016	\$

Performance Guarantees: List your proposed performance guarantees, including a description of the guarantee and measurement and dollar amount at risk for each of the categories listed below.

Area of Guarantee	Description of Guarantee	Metric Required to Meet Guarantee	Dollar Amount at Risk
Implementation			
	Plan Implementation (plans loaded, tested; staff trained; eligibility accurate and ID cards issued before 1/1/2016)		
	Certificates of Coverage and contracts completed		
Network Stability			
	Provider turnover rate		
Administration			
	Claims Financial Accuracy		
	Claims Processing Accuracy		
	Clean Claims Turnaround Time		
	Timely Reporting		
	Timely Data Transfer		
Satisfaction			
	Account management satisfaction survey scores		
	Employee satisfaction survey scores		
Telephone Responsiveness			
	Average speed of answer		
	Percent of issues answered on initial call		
	Call abandonment Rate		
Other performance guarantees you will provide			

Company:

Section 7 - Innovative Solutions

The following section is to be completed by providers/vendors outlining innovative methods currently in place that have achieved verifiable results for consideration by the County. The County will not consider options that are not fully developed and operational in Brevard County that do not include demonstrated results and cost/performance guarantees. Innovative solutions must be administered as a part of a comprehensive health plan on either an ASO or fully insured basis.

<p>1. Is your Innovative Solutions proposal integrated as a part of a comprehensive health plan (ASO or fully insured) that includes ongoing management of member eligibility, claims administration, network services, health management, performance reporting, contracting and performance guarantees? If so, please describe.</p>	
<p>2. Provide an overview of your Innovative Solutions proposal including associated costs, guarantees on performance/return on investment, and requirements, if any, that would be placed on the County to implement and administer your program.</p>	
<p>3. How long has the Innovative Solution you are proposing been operational?</p>	
<p>4. Provide a summary of verifiable results that have been achieved for an employer similar in size to the County, including employer references.</p>	
<p>5. If your Innovative Solutions proposal includes a network of providers, please provide a comprehensive list of the providers currently contracted with your firm.</p>	
<p>6. Provide any additional information about your Innovative Solutions proposal that you feel would be worth consideration by the County in this RFP process.</p>	

As an officer of the Company, I certify that the information contained in our proposal worksheet is accurate, and our Company will be bound by the contents of our proposal.

Signature: _____ Date: _____

Name: _____ Title: _____

Company:

HEALTHCARE PLAN DESIGN

THE KEY TO SUBSTANTIALLY REDUCING COSTS

Presented to:



Presented by:
David Brooks, Principal
Monique Miller, Principal

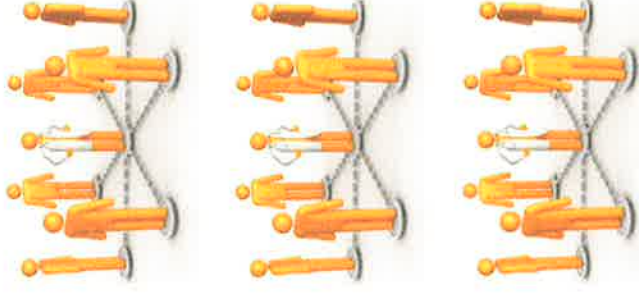
Back House
Consulting

1978 Us Highway 1
Rockledge, FL 32955
(321) 428-2020
www.BackHC.com

WHAT ARE YOU SENDING OUT FOR BID?



You have a discount network.



Can this really offset 8% increase per year AND lower costs? These all look pretty much the same...

You are asking for networks with slightly better discounts.

Employee Salary History



Category	Oct-07 (actual)	Oct-08	Oct-09	Oct-10	Oct-11	Oct-12	Oct-13	Oct-14 (actual)	Oct-15*	% Change (Est)
Avg. Full-Time Salary	\$39,628	\$39,628	\$39,628	\$39,628	\$40,619	\$40,619	\$41,431	\$39,927	\$39,927	0.8%
Additional Cost Shifted to Employees										
Avg. Premium Contribution	-768	-828	-816	-948	-1,176	-1,164	-1,128	-1,120	-1,392	81%
Avg. Out of Pocket Expenses	-1,022	-1,054	-1,164	-2,119	-2,465	-3,067	-3,067	-3,305	-3,877	279%
Salary Adjustment (2.5%)	0	0	0	0	991	0	829	0	0	
Furlough Impact (2.5%)	0	0	0	-991	0	0	0	0	0	
FRS Contribution (3.0%)	0	0	0	0	-1,219	-1,219	-1,243	-1,198	-1,198	
Social Security Payroll Tax Cut	0	0	0	0	812	812	0	0	0	
Total Additional Cost Shifted to Employees	-1,790	-1,882	-1,980	-4,058	-4,047	-4,537	-5,438	-5,624	-6,467	261%
Net Average Salary	\$37,838	\$37,746	\$37,648	\$35,570	\$36,572	\$35,982	\$35,993	\$34,303	\$33,460	-12%
Consumer Price Index (CPI)	2.85%	3.84%	-0.36%	1.64%	3.16%	2.07%	1.46%	1.70%	1.70%	14.66%
	6.69%	6.33%	7.97%	11.13%	13.20%	14.56%	16.36%	18.06%	18.06%	
	(4,116,401)	(2,651,111)	(2,508,451)	(8,108,301)	(4,520,461)	(5,381,711)	(6,073,781)	(6,532,821)	(7,210,781)	
Total Impact on Salary	\$36,709	\$35,095	\$35,140	\$32,412	\$32,051	\$30,620	\$29,919	\$27,771	\$26,249	-28%

SIGNIFICANT COST SAVINGS CAN BE ACHIEVED THRU INNOVATIVE PLAN DESIGN

- Healthcare industry is setup to perpetuate the same approach
 - Cost-shifting is neither innovative nor sustainable
 - Incentives are setup to make it hard to find true “out-of-the-box” thinkers
 - Brevard Consultant allowed to make money on county purchases.
- Out-of-the-Box Solutions Require Specialized Expertise
 - Highly Complex, Requires Significant Interaction with County Staff
 - Must be Clearly Defined to get Responses from RFP Process
- Back House offers up to 12 plan designs, based on customer needs
 - Ranges from Defined Contribution (good to establish baseline costs) to concierge medical solutions

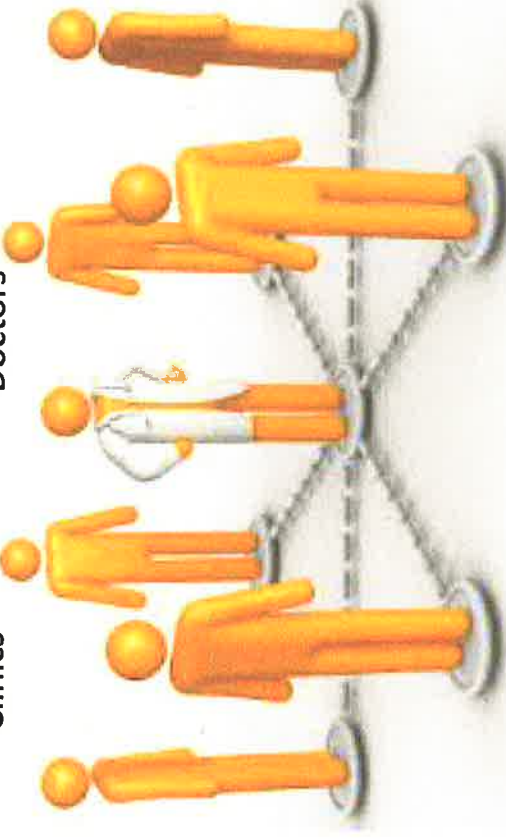
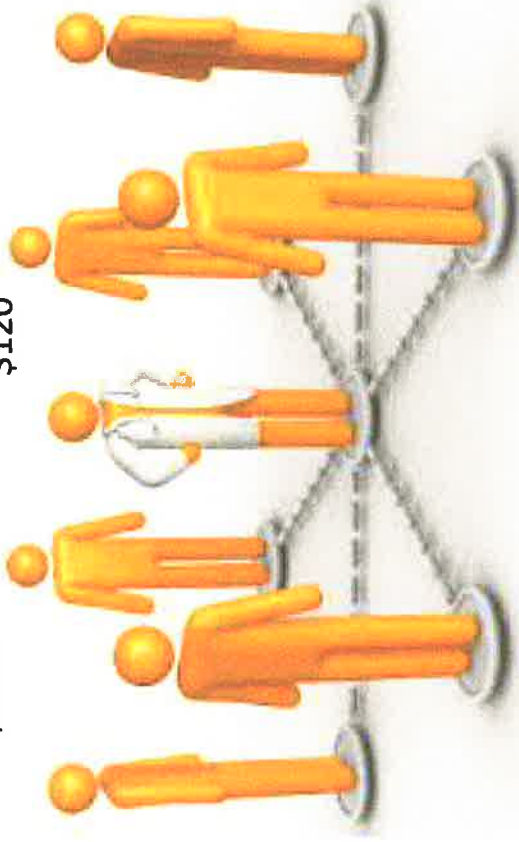
LOWER COSTS REQUIRE CHANGING BEHAVIORS: PARTICIPANTS AND PROVIDERS

Emergency Room:
\$1200

Medical Clinic:
\$120

Brevard County
Clinics

Dedicated Concierge
Doctors



Drive participants to lowest
cost options thru incentives.

Drive provider costs down thru
competition + new solutions.

WHAT DOES IT MEAN TO YOU? CURRENT 2016 PLAN FORECAST COST: \$69 MILLION

OR You Can Explore Innovative Plan Designs...

- **Option 1 – Combine with School Board
Estimated Savings: \$10M**
- **Option 2 – Innovative Pricing Model
Estimated Savings: \$13.5M**
- **Option 3 – Defined Contribution
Estimated Savings: \$20M**
- **Option 4 – Dedicated Medical Resources
Estimated Savings: \$9M**

**THESE SAVINGS CAN
HAPPEN WITH
MINIMAL IMPACT
ON THE LEVEL OF
CARE AND
CONVENIENCE
ENJOYED BY
COUNTY
PARTICIPANTS
TODAY.**

BREVARD CAN REDUCE COSTS + MAKE EMPLOYEES HAPPIER

- **Step 1 – Move 65+ Participants off Plan thru Individual Counseling + Communications**
Cost: \$42 per Participant (saves county + participants money while providing better benefits)
- **Step 2 – Develop criteria up to 6 Innovative Models to include in Healthcare RFP**
Cost: \$25K + 1% of realized first-year savings
Time estimate: 30 days
- **Step 3 – Change Role of Existing Consultant to Actuarial Only**
Estimated Savings: \$50K per year (or send to RFP to replace)

SAVING MONEY DOES NOT MEAN REDUCING BENEFITS. COSTS CAN BE LOWERED WHILE IMPROVING PARTICIPANT SATISFACTION THRU INNOVATION.



February 23, 2015

Mel Scott
2725 Judge Fran Jamieson Way, Bldg. C
Viera, FL 32940

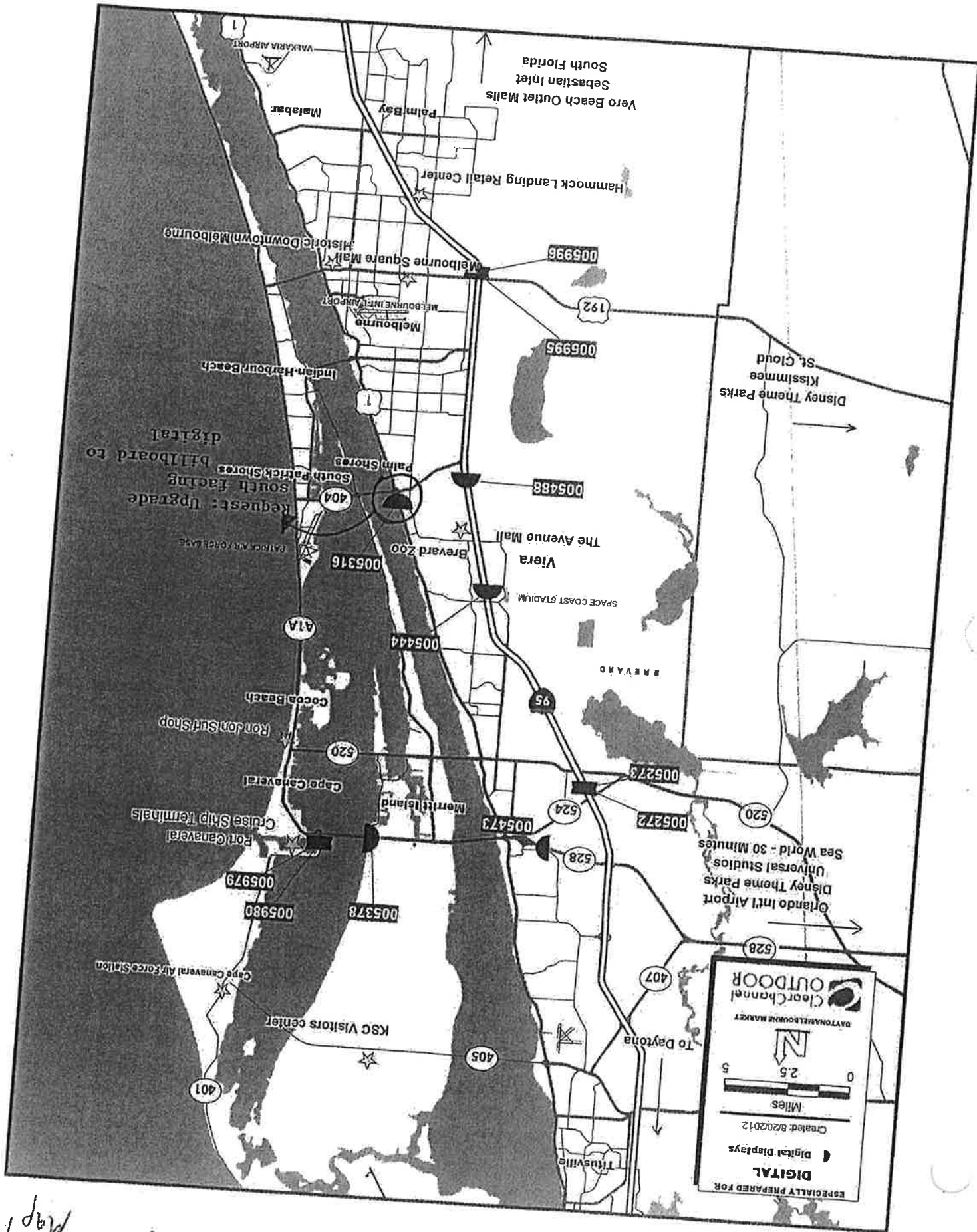
Mr. Scott,

Clear Channel Outdoor is requesting to amend the settlement agreement to Move Digital Board 5444 (Site 2 Exhibit 3 of the Third Amendment) to the backside of Digital Board 5316 (Site 4 Exhibit 5 of the Third Amendment).

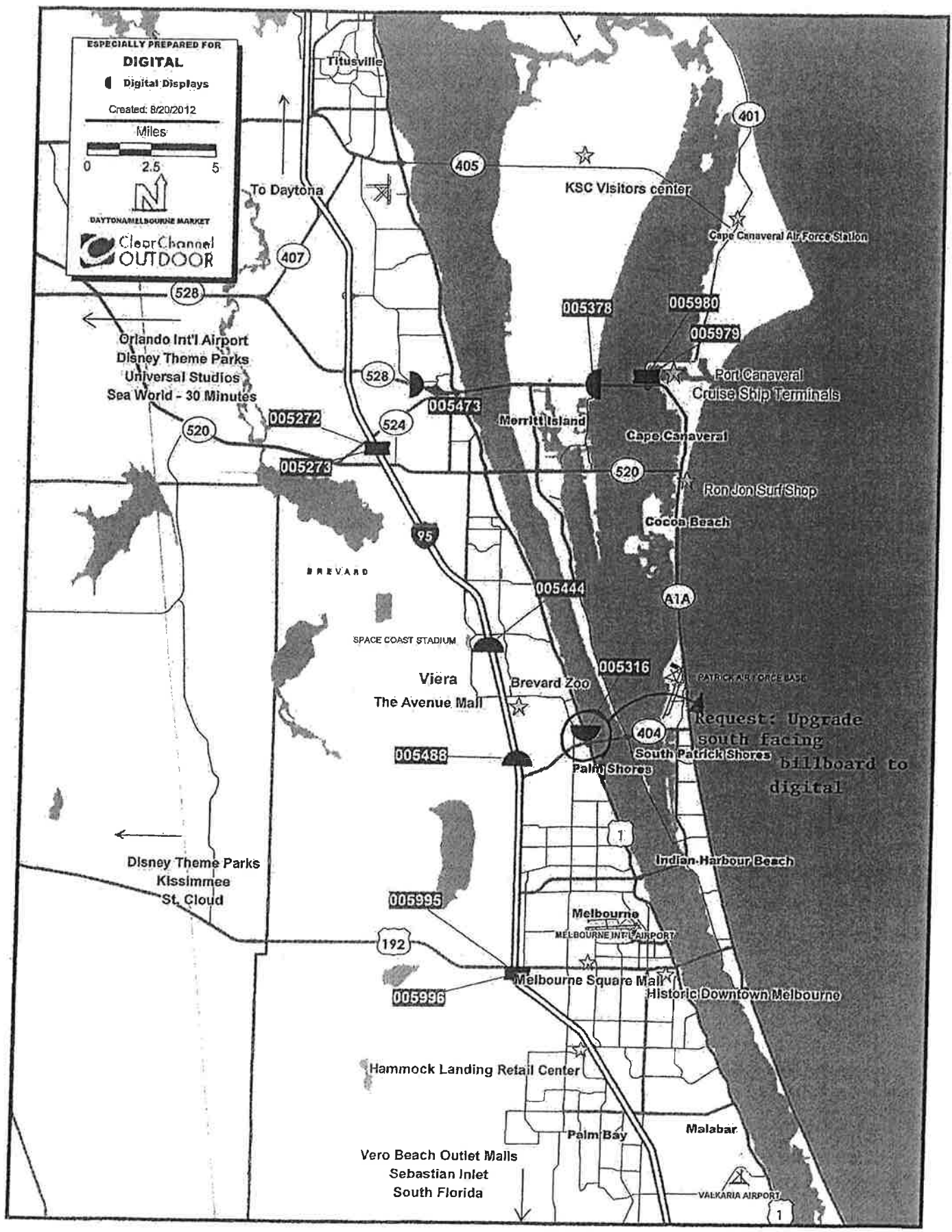
Regards,

A handwritten signature in black ink, appearing to read 'Matt Ashley'.

Matt Ashley
VP Real Estate and Public Affairs
Clear Channel Outdoor – Daytona/Melbourne
321-726-6611
MattAshley@clearchannel.com



Map 1



Meeting Date
3/17/2015

BREVARD COUNTY BOARD OF COUNTY COMMISSIONERS

Unfinished Business V A / attachment

AGENDA REPORT
 BREVARD COUNTY BOARD OF COUNTY COMMISSIONERS

SUBJECT:	Reducing county healthcare costs and supplementing the innovative solutions component of the county's healthcare solutions request for proposal (RFP).
DEPT/OFFICE:	

Requested Action:

In order to get out-of-the-box solutions that will have a meaningful impact on the county's rising healthcare costs, Brevard should engage independent experts, who have no monetary interest in promoting one type of healthcare solution over another, to conduct a thorough plan design assessment, make recommendations, and create bid criteria for up to six (6) non-standard designs that can be included in the Innovative Solutions section of the county healthcare RFP.

Summary Explanation & Background:

The county's healthcare costs have been increasing every year and are projected to rise another 8% next year. For the past several years, some of the increased costs have been shifted to the employees. Now, according to a slide presented by Brevard's HR Director in a recent budget meeting, the average, inflation-adjusted employee salary has gone from about \$37,000 per year to about \$26,000 per year. This has led to a number of good employees to seek employment elsewhere.

Brevard County's healthcare costs are unsustainable, and the problem cannot be solved by simply shopping for a provider network that offers a slightly higher discount. Problems of this magnitude are solved by exploring innovative plan designs that change both provider (through competition) and participant behaviors (through properly incentivized choices), without negatively impacting the level of benefits participants receive.

The county's benefits consultant is not contractually prevented from earning commissions and other incentives for products purchased by Brevard County. This could interfere with their interest in presenting truly out-of-the-box solutions. The only way to get innovative plan designs is by hiring an independent consulting firm that is *not* also a broker.

Back House Consulting (BHC) is a Brevard-based company. Owners, Monique Miller and David Brooks, are here to share the findings of their investigation into ways the county can lower healthcare costs. David has been consulting Brevard County Schools, serving as the Benefits Committee Representative for School Board Member, Andy Ziegler. Members of the County Commission heard about David's work and asked him to share his experiences to see if any of the successful changes made at BCS could be applied to Brevard's healthcare plan. Those conversations evolved into much more comprehensive discussions that included the county's Director of HR and Director of Benefits.

The county supplied BHC with the data needed to conduct an analysis of its healthcare plan. BHC has some recommendations for the Brevard BOCC and wishes to present them at the March 17, 2015 meeting. A presentation outlining these findings was submitted with this request.

Clerk to the Board instruction:

Exhibits Attached: PDF of Presentation Slides, Contract

Contract /Agreement (If attached):	Reviewed by County Attorney	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	PR	<input type="checkbox"/>
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County Manager Stockton Whitten	Assistant County Manager Mel Scott	Department Director / Extension
------------------------------------	---------------------------------------	---------------------------------

	Assistant County Manager Venetta Valdengo	
--	--	--

V.A

Monique Miller

From: Monique Miller <mmiller@backhc.com>
Sent: Monday, March 16, 2015 10:30 AM
To: 'Whitten, Stockton E'
Cc: 'Lewis, Sally A'; 'Abbate, Frank B'; 'Visco, Gerard'
Subject: RE: Citizen's Request Agenda Report Form for 3/17/15 BCC mtg.

Mr. Whitten,

Thank you for your interest in Back House Consulting and our presentation material for Tuesday's County Commission meeting. Please find our responses directly under each of your question, below:

• **How long has Back House been in business?**

Back House Consulting (BHC) is a member of the Verus family of companies, which was established here in Brevard County in 2010. The Verus family of companies is comprised of: Verus Wealth Management, Verus Insurance Partners and BHC. BHC was established specifically to address the market's demand for a separation between companies that exclusively provide healthcare, benefits and insurance expertise and those that work as a broker or other commission-based entity.

• **Would you provide me a listing of your 5 largest clients?**

Given the sensitive nature of our work, we have strict confidentiality agreements in place with our customers. Once our prospective role is clarified, if needed, we would gladly seek disclosure approval from clients that are relevant to the size and scope of the opportunity with Brevard County.

• **Are you suggesting that the County's consultant is receiving brokers fees from our products?**

We are simply pointing out that the County's consultant's contract does not prohibit them from receiving broker or other fees for products purchased by the County. The RFP issued to choose the County's consultant specified that the vendor selected was forbidden from receiving commissions or any other type of incentive pay for the products purchased by the County. Oddly, this language did not find its way into the contract. In order to explore every option for lowering healthcare costs, we feel it is critical that this conflict of interest be removed from the County's relationship with its existing or any other consultant.

Additionally, we can only judge the County's healthcare consultant on the results it has produced. The county has experienced increasing costs every year while shifting some of those costs onto those that are least able to absorb them – the county employees, who have not had a raise in years. We have concluded that the consultant is ineffective because it has failed to produce the desired result: lower healthcare costs.

• **Do you both consult for the School Board and also sit on the Benefits Committee? "David has been consulting Brevard County Schools, serving as the Benefits Committee Representative for School Board Member, Andy Ziegler."**

David Brooks, BHC Principal, was selected by Andy Ziegler because of the industry knowledge David brings to the BPS Benefits Committee. As a member of that Committee, David has donated over 200 hours of his time researching and consulting on the BPS insurance challenges. He does this exclusively as a concerned taxpayer and citizen volunteer. None of the Verus companies, including BHC, has benefitted monetarily, either directly or indirectly, from David's work at the school board.

• **You suggest the possibility of some huge savings with little to no detail on page 6 of the PowerPoint slide presentation. Will you be providing additional details at the meeting?**

Absolutely. We will provide information about how we arrived at our conclusions and describe the plan design alternatives we listed in the presentation.



David Brooks has been helping individuals and business owners reach their financial goals since 1999. As the first Certified Healthcare Reform Specialist in Florida, he is one of the foremost experts on the Affordable Care Act and its effects on businesses.

As a serial entrepreneur, David relates to the regulatory and other challenges today's businesses face. He is the host of Dollars & Sense, a weekly television program on Bright House channel 49, and he hosts a weekly radio show in Vero Beach.

David is a respected national speaker; his expertise and training in the arena of Elder Care Planning and PPACA ("Obamacare") have led him to conduct numerous educational workshops throughout the country with the goal of educating as many people as possible. His role as educator extends to community and government leaders. David has earned the following licenses: Series 3, 7, 9, 10, 24, 31, 63, 65 and 66, as well as Life, Health

and Annuity insurance licenses in multiple states.

David moved to Central Florida to attend college in 1986. He was a successful entrepreneur in the restaurant industry prior to his career in financial service. David has been married to his lovely wife, Melissa, for over 22 years, and they have two sons, Drew and Noah. David has coached youth soccer for several seasons, as well as volunteered for several local charities. He has served on the Board of Directors for the local chapter of the American Red Cross and was the Chairman of the Board for the March of Dimes.



Monique Miller has a long track record of finding innovative solutions to business problems and has enjoyed a successful career in the computer industry for over 20 years. She has held strategic, senior roles in leading firms like Hewlett Packard, where she managed The Walt Disney Company account, and Florida's own Citrix Systems. Her work has taken her all over the world, including a four-year posting in France, where Monique opened and managed an American software company's offices in Southern Europe and the Middle East. In 2014, Monique ran for the Florida Senate.

As a Principle of Back House Consulting (BHC), Monique is following up on a promise she made during her campaign for political office: Help restore America's foundation by helping restore its small and medium-sized businesses. BHC is committed to helping companies and government entities save money and operate more efficiently by minimizing the impact of imposed regulations.

Monique met her husband of 15 years through their shared love of SCUBA diving. She is an active member of the community, serving on many boards and committees. As a political analyst and business expert, she regularly speaks publicly and appears on television and radio.

Monique earned a Masters of Business Administration (MBA) from Emory University's Goizueta Business School, graduating Beta Gamma Sigma (highest honors). She studied physics and math as an undergraduate at Loyola University New Orleans.

Pasco School Board considers expanding employee health clinics



Lisa Buie, Times Staff Writer

Tuesday, August 12, 2014 4:03pm

LAND O'LAKES — Four school-based clinics have saved the Pasco County School District so much in health care costs since they opened in 2011 that officials want to expand the program.

"We think there's some pent-up demand," said Kevin Shibley the district's executive director for administration.

School Board members learned Tuesday at a workshop that the four clinics, in Land O'Lakes, Dade City, New Port Richey and Hudson, have saved the district \$9.2 million over the past three years. Annual claims filed with the district's insurance carrier, Florida Blue, also have decreased from 186,000 before the clinics opened to 137,649 this past year. Employees have also saved a total of \$2.7 million on health care.

Administrators propose opening a new clinic in Wesley Chapel to accommodate the growth in that area and expanding the one in Land O'Lakes. They also want to explore a partnership with the Pasco County Sheriff's Office that would allow the two groups to participate and split the costs.

"I've been on the board for six years, and I think this is one of the most significant decisions the board has made," board member Joanne Hurley said of the clinics. "It's a feather in our cap."

Board member Cynthia Armstrong called the clinics "a win-win" for administrators and staff.

"Employees actually said 'Wow, you're helping us save money' and we said 'Wow, you're helping us save money.' "

In 2011, the School Board approved spending about \$1.5 million a year to operate three school-based clinics, offering free appointments and medications, in addition to preventive wellness programs for employees. The idea was that the district would save money in the long run by reducing insurance claims and related expenses.

In 2012, the district saw its claims drop by more than \$2 million, with per-employee costs down by nearly 5 percent. Its rates did not increase as much as expected, allowing the board to use savings to reduce the number of furlough days imposed on employees.

Pasco School Board considers expanding employee health clinics 08/12/14
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Tweet

16

17



Commenting Guidelines



Abuse Policy



Due to demand, we are using a different link today than originally planned for the AIC & Apex Benefits Cost Plus Presentation scheduled for today at 2:00 PM EDT.

The new link is <https://attendee.gotowebinar.com/register/7984630704790441217> After going to this site, you will be allowed to register. You will receive a confirmation from "Apex Academy" with the dial in information and website link.

The Association of Indiana Counties in conjunction with Apex Benefits Group hopes you can join us on Thursday October 10 as we roll out a new program to help counties reduce their health insurance costs.

Initial information about the program will be available on a webinar Thursday October 10th at 2:00 p.m. EDT or you can contact Shawna Schwegman anytime to set up an appointment with your county to review this new option.

The new program, called Cost Plus, is an aggressive plan that reimburses health care facilities a reasonable cost but ensures the consumer reimburses an amount related to actual cost of the service.

Most insurance plans offer discounts off of prices that have been increased exorbitant amounts over actual cost. You the consumer never get to see the "mark-up" over actual cost of health care.

Read this *Indianapolis Star* article <http://www.indystar.com/apps/pbcs.dll/article?AID=2013309140045> to better understand how hospital charges vary widely for the same services.

Cost Plus "negotiates up" from the amount the facility actually incurred to perform a service. Most insurance companies "negotiate discounts down" after a facility has increased its fees hundreds of times above actual cost.

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Cass County has been using the plan for 18 months with great success and great savings. Please join the October 10 webinar or contact Shawna Schwegman at sschwegman@apexbg.com or 317 254-1600. For more information on the plan, visit the AIC's website.

Fisher: V.A., Unfinished Business, we got a card, we got a card, one care on that, but if staff wants to go ahead and introduce it and then we'll bring up the individual interested in talking.

Abbate: Good morning Commissioners. We're here as a follow up to the meeting on March 3rd where the Board was considering the draft to group health insurance RFP. The Board asked us to obtain some additional input from potential vendors. Mr. Visco sent you a memo dated March 16th, which provided a summary of the feedback that was received. We are looking for further Board direction so that we can appropriately move forward with sending the RFP for group health insurance out. We are in a position, if you review the memo what you'll see is that the input received was fairly minimum. There was a request for additional information for another couple of bullets to clarify a couple of items. Staff would be, if the Board so directs, prepared to incorporate all of that feedback as it was contained in that memo and move forward. We also are looking forward to any additional feedback that the Board might want to offer.

Fisher: Okay. I'm going to go ahead and call up David Brooks.

Brooks: Morning, I have my partner Monique Miller with me as well.

Fisher: Okay, if you'll introduce yourself, sir, for the record that would be great.

Brooks: Yes, David Brooks. I reside in Indian Harbour Beach, 522 McGuire Boulevard, and our business is located in Rockledge, Florida. My partner's going to hand out a quick presentation to you that if you're so inclined to engage you further in explaining it. Just, first and foremost as concerned citizens we believe that there's significant savings that can be obtained through our healthcare plan.

Miller: Hi, Monique Miller, Melbourne Beach, Florida. So first of all, thank you for the time. We've been working with some of the Commissioners because of, I think everybody shares a great concern over the increasing healthcare costs that the County's really trying to get a handle on; and so we've been exploring some, let's say unusual options and I applaud the Commissioners for putting in the RFP a section exploring innovative solutions. Unfortunately, it's really a difficult thing for somebody to respond to. So in order to get vendors to respond to the RFP appropriately and actually get some meaningful responses that the County can act on, there has to be a lot more information put into that section. In other words, you really have to kind of define what these things would be, what criteria's is associated with each model. So what we do is plan designs, and so we brought you today some examples. We've been working for the past month and a half, and I want to thank Jerry and Frank for all of their help in getting us lots and lots of data over the last two months to put together some of these plan designs that we've identified that would be good candidates for the County. It's something you should consider including in the RFP in the innovative solutions section, but with more specific criteria so vendors can respond.

Brooks:

So if we start on the second page of the presentation that we sent you there. Typically, you know, we put the question there what are you sending out for bid? If you always ask for what you've always had you'll always get what you've always got, and you're not going to get any innovative solutions. The discount model unfortunately is really broken in the health insurance industry. The HMO model was very popular in the 80's. That was broken quickly on the capitation model. Industry moved to a PPO model, which is where you have a select provider network where you then would be able to negotiate better terms. Those networks are now so increased that they encompass almost every provider, so there's no distinction from those networks, so there's no real discounts. It's an illusion. The retail price is simply marked up and you get your discount back down. We believe you need to look at healthcare in a different manner. If you go to the third page you'll see a slide from the presentation presented a little over a month ago from this County on the employees' salaries. Eight years ago the salaries have not changed from your employees hardly at all yet they're out-of-pocket exposure has gone up over 350 percent for their benefits. So we believe that is an urgent problem. Flipping quickly to the next page as time is of the essence here. I want to make sure that you're aware and understand fully one of the taxes from the Healthcare Reform Act is the Cadillac Tax and how it affects this County and what the taxpayers are going to be on the hook for in two years and seven months; and I also put a comparison in there for another large entity right here across the street is the Public Schools Plan so you can have some comparison numbers. In 2018, the threshold is any individual single employee that gets health insurance through work, if the value of that premium, total premium, from both the employer and employee is over \$10,200, there's a 40 percent exercise tax starting in 2018. So, if you'll flip to the next slide you'll see that that tax on Brevard County taxpayers for your plan will be \$6,400,000 in 2018. It will equal over \$21,000,000 in the first three years alone, and it's going to be over \$35,000 10 years in. This is unsustainable and I believe you understand the taxpayers simply will not allow you to continue to spend that kind of money. You're also putting more weight on the backs of your employees as we previously discussed. If you'll flip to the next page, some quick facts on your own plan. You have 4,426 employees, over 8,000 lives on the plan. The total spent for the 2014, including all out-of-pocket exposure of these employee premiums from everybody was \$65 million roughly. The Cadillac Tax is going to add another \$21 million by 2020. Sixty-four percent of these costs are paid by the taxpayer of Brevard County. The rest is being pushed off to the employees and other services. Brevard County's health plan total costs were \$14,600 per active eligible employee. You have over 600 retirees currently 65-plus on your plan; and your plan's forecasts are to set to increase a little over eight percent per year. Going to the next slide, we believe significant savings can be achieved through innovative design because unfortunately the healthcare industry set up for you to keep asking for the same thing, so they simply say we'll give you a

bigger discount but they model the price up a little bit higher; and whether you're aware or not, is all procedures at all hospitals must be reported to CMS. It is public knowledge what these procedures cost. We believe you can negotiate in a different manner significantly reduce your cost. I don't have time to get into the specifics, but I can show you line-by-line exactly on which items, what procedures, what they cost in every hospital in our County. This information is readily available. We typically, Back House offers up to 12 solutions for our private clients. We're not going to suggest 12 different plan designs for Brevard County, but we would, flipping to the next page, suggest several designs. So how do you compare the cost savings? Well, a great benchmark is simply to look at the ACA Act and what it provides through healthcare.gov. A silver plan here in Brevard County, which means 70 percent coverage for the employee . . . or covered by the plan, are about 30 percent exposure for the employee, which is better than what you currently have. A 45-year old employee making your average of \$39,927 for the entire County, which would cost them \$3,744 a year in premium on the public's website. You would then be responsible if you did not have a health plan of a \$2,000 per employee fine per year for not offering healthcare benefits. We believe you could afford to do this an even increase significantly the wages you pay the employees and save over \$15 million. Now we're not suggesting that's the plan that you go with. We're suggesting that you look at this as an honest benchmark of where we have to get to with what money we're spending, and the beneficiaries of our taxpayer dollars. So, if you'll flip to the next page . . .

Fisher: Keep going, go ahead. Go ahead, go ahead, I'm going to let you . . .

Brooks: The benchmarks as you can see there if you'll flip to the next page, the ACA penalty annually will be \$2,000. If you were to give an average employee a \$4,500 raise, you would then have increased payroll taxes of \$360. You would then lose FICA savings on the premium deductions you were gathering from those employees of \$180 annually. So you're actual costs to do that would be \$7,040 per employee, saving the County \$3,397 per employee, for a total of just over \$15 million. Now, some may be skeptical and say what would that mean to the employee? If you'll flip to the next page, let's talk about the cash flow your actual employees, the people that you're pushing more burdens onto now.

Miller: The price that we quoted there for that is actually for one person, sorry. The price that we quoted for that plan on the, if you get through the healthcare.gov is actually for one employee and one dependent because you do have a 2:1 ratio.

Brooks: No, that actually a single. We can show family numbers. We didn't have time to go into that, but they would get more premiums back as well. But if you'll simply look at this page, the benchmark, if they were to purchase that plan, the employee would then be out-of-pocket \$3,744, but if you gave them a raise of \$4,500, they would also then have \$852 if they were a single employee premium

credits back to their paycheck that you're currently taking from them. They would lose FICA savings of \$68 and they would have increased payroll taxes of approximately \$900. Meaning the average employee would have net take home after tax pay of \$639 annually in their pocket saving collectively your employees \$2.8 million a year. And again, we're not necessarily suggesting this is your first course of action, but this is a benchmark to show where you need to design your plan and what we need to be getting close to. Moving to the next slide, an immediate item that you could make some significant headway is your seniors currently on your plan. You have over 600 retired seniors on your plan. If they stay on the medical plan the benefits are costing \$438 a month. Seniors need to be educated that the day they turn 65, and we had a discussion personally with Curt Smith on this very issue, when you turn 65 Florida is an age in state. When you buy a Medicare supplemental plan, you have one opportunity at age 65 to guarantee the lowest rate for the rest of your life. Waiting one year costs the average senior \$30 for every month that they are alive. So, you need to have someone educate those employees. We would do that for you, and we'll get to that in a minute.

Fisher: I'll give you a couple of more minutes, and then wrap up please.

Brooks: Yes, sir. So the next solution we'll provide to you is for you to analyze examining combining back with Brevard County Schools, which is something this organization did from 2000 to 2006 I believe. Brevard County Schools plan has had a recent change in leadership. You have new members on the board who are active and open to this idea, and you have a director of benefits who is currently resigning June 30th, so there's never been a more opportune time to maybe take this seriously and look at combining the plans for increased purchasing power. You would add your 8,000 lives to their 11,700 lives currently on their plan to give you almost 20,000 lives to get better purchasing power no matter what your plan design ends up. We believe that this, if you were to look at their model plan, which cost 9,500 employees instead 12,500-plus for yours would save over \$10 million instantly, including several million dollars for transition costs. So, the next slide quickly just tells you that lower cost behavior traditionally what you do on the left side of that slide is you would drive participants through co-pay design, facilities management, they're going to have a lower cost if you go to this place instead of that place, etc.; but that only gets you part of the way. On the right side of that slide what we're talking about is utilizing clinics, even concierge doctors, and better changing the habits of the providers and the facilities and how you interact with them, not just changing your participant's behavior; but if you change the behavior of the providers you can achieve significant cost savings. So, what does this mean to you is that currently 2016, next slide, shows your plan is forecast to cost \$69 million total next year. We believe with the four options shown on the page you could save easily a minimum of \$10 million and you could combine several of these together. The immediate action is the senior citizens, or the plus 65's

active and retired that are on the plan. If you jettison them from the plan with proper communication and education, you could save \$2 million annually right away. We would educate these employees for as little as \$42 per employee, all 65 year olds currently now, and all, every employee who comes, six months prior to their 65th birthday, we get a sit down, a professional consultation one on one so they understand their options. I believe we're running out of time there, so.

Miller: So in conclusion, we're asking that you consider waiting 30 days and allow us to put this type of criteria into the RFP so you can get meaningful responses from the innovative solutions section of the RFP.

Fisher: Okay, thank you.

Miller: You have any questions for us?

Fisher: Commissioner Infantini, you got a question?

Infantini: I think it was an excellent presentation. I had met with the individuals before, David and Monique, I'm sorry, but I didn't have all of this comprehensive information; and I've got to say at first I was very, very skeptical, I was, I was very skeptical, but it appears they have the ability to add a great deal of value to our plan and perhaps save us a tremendous amount of money.

Fisher: Okay, staff, you look like you're ready to respond. You have any comments?

Abbate: Yeah, Commissioners, what I would suggest to you is that, you know, we have looked at, and brought forward to this Board, many of the concepts that were just discussed. We did it in the past year. We looked at the defined contribution. We did it with the Employee Benefits Advisory Committee where each of you has an appointee on that Committee. We brought all that information forward. We attempted last year to remove all of the retirees from the health plan and what the associated costs were, and staff has attempted to be diligent in following the Board Policy direction. So a lot of the concepts, including the over 65, as a matter of fact we brought not only forth to you last year, we brought it forth again this year and sought the Board recommendation's that we go out for the over 65 and do separate RFP with that, which the Board approved a couple of months ago. So I believe that staff has attempted to be diligent in following the Board direction and the concepts that have been discussed, and I would suggest the RFP that we have put out there specifically follows the direction the Board gave, which was to make it so broad that anyone, including, you know, the people who just spoke who want to put a package together and a proposal, this RFP most definitely provides the opportunity for someone to do that and in the innovative section that we have put forth.

Fisher: Okay. Mr. Whitten is that your . . . all right. My concern is that we went out to RFP. We gave staff direction to allow the marketplace to determine what is out there, and for us to have kind of an open eye about it. So I think the RFP

process is going to allow that to happen. I talked to Monique on the phone. Back House Consulting kind of seems like that is something that is more of a consultant role that might need to be played down-the-road when we go out for, you know, RFP process for the new consultant, whoever going to handle our (unclear). I think that comes out in 2016. We're looking at who's going to advise us on our health insurance and stuff; but today's discussion is really about getting an RFP on the market and allowing people to come back with solutions. I can tell you now from a policy standpoint, I know ways we can cut our health insurance in a big way, but that's a whole policy decision, and you know, if we got to the point that we didn't want to cover spouses anymore, that's a huge savings to the County. If we got to the point that we didn't want to 65 and over, that's a huge savings, but I don't think from a policy standpoint this Board's ever felt like politically that they wanted to do that. Now, as we go out and get these RFP's and we come back, we might have some dialogue about that and decide if we want to make some of those hard decisions, but as of right now politically and policy wise, I think staff is just doing what's been directed by the Board in the past, and what we ask them to do in the future. So, Commissioner Anderson and then Commissioner Barfield.

Anderson: No, but the one thing that we learned, I learned last time was the education component, especially for the retirees. When this conversation came up last year, me and Jerry actually went to the Brevard County, I think it was the retired Sheriff meeting that they had, and there's a lot of misconceptions out there. I think some of the retirees don't realize they're losing money and getting less service right now. So, it's kind of like what the consultant just said, you know that one-on-one education concept. I know somebody could bid that in the innovative solutions part of the RFP, but it's something we need to look strongly at. There's just a misconception. It's a tough thing to get through with some of these retirees that they're not doing themselves any favors. So, that's just my opinion.

Fisher: Well, the retirees are . . . You know, as we get older we like less change, and so that's a change, you know, and they're just not comfortable with the change. There's some fear with the whole Obamacare and all that stuff too. Commissioner Barfield.

Barfield: Yeah, when you look at the numbers they're presenting, the savings, I mean, we've got to make some changes like that. We're going to have to. It's getting out of control. We all know that, but one of the most important things we got to do is figure out how we're going to give our employees raises; and if we can save some other places, we can find places where we can shave enough off to at least. We owe our employees a raise, but we can't sacrifice the benefits either. I believe though after reading everything, I actually believe with the RFP innovative side, I believe it will be evaluated correctly and I believe we have every opportunity to put all of that in there, because we have to approve all of

this, and with people on this Board, we understand the criticality of this. So we know we're going to have to really work hard to get these costs down; and the issue with the health care, it's not the healthcare, it's the healthcare insurance program. You're right on when you say that, David. It's not that. So, we've got to look at a lot of innovative ways, but I believe the RFP as it is, I believe, I believe you all can respond, the industry can respond, because we all know the importance to this. We can't go on as we have gone before. So, I'm okay with it.

Fisher: All right, Commissioner Smith.

Smith: You're okay with what?

Barfield: The RFP.

Smith: Okay, this is way over my head. It's over my pay grade. Health insurance just . . . David said, I don't know what I'm doing. I opted out of Medicare, because I was told well, just sign up for our plan here and cancel your . . . so now that's, that's gone for me. I can't get back in unless I pay a premium to get into my Medicare. So I don't know what questions to ask. All I know is that looking at your plan this morning, it really, really has some excellent opportunities for us to save money and look at this from a different perspective, and I know Jerry and Frank are really, really savvy guys. So, I'm sure that somehow we can get these numbers to the point where everybody's happy, but we need direction; and so we're giving you the opportunity through the RFP, and Frank, you said you can incorporate the ideas that they've given us?

Abbate: What I said was several of those ideas we have brought forward to the Board in the past, and for example, the idea for the over 65 is something that we're moving forward on on a separate RFP, and if the Board would like to see a component that says as part of that when you bid it you bid one-on-one discussions, that could be put as part of the RFP as well. So the answer to that I believe would be yes.

Fisher: Okay, Commissioner Infantini. Were you done, sir?

Smith: Yes, I'm done.

Infantini: I believe Frank is correct. They have really done an excellent job. I know they painstakingly went through item-by-item for us to vote on, and overwhelmingly we consistently said now we want to have families included. We don't want to get rid of spouses. I know I don't want to get rid of mine, and I'm thinking many of you don't want to get rid of yours, so I don't want to take any spouses off the plan or kids or anything like that. So I believe the RFP will actually sufficiently cover and hopefully the organizations will come forward in their proposals and incorporate some of the suggestions that Monique and David have been recommending.

Abbate: I could add, Commissioners, we put forward, and the Commissioners may remember this, we put forward an opportunity to do a narrow, very narrow clinic that people could be driven to and we would share 50 percent of the cost. We took that initiative not only to individual Commissioners, but we went out into the community and spoke with each of the major hospital systems, told them that this was a potential idea they could, to look at for feedback. So we don't know if we'll get any of that, but we try to put out some additional innovative ideas that are very consistent with what you've heard, and staff has taken that initiative with the Board's current consultant and done that over the last six months. We started that particular process in November and we continued to have that dialogue right into January and February.

Fisher: Okay, with that, pleasure of the Board? I'm looking for a motion for approval of the item.

Barfield: So moved.

Fisher: Okay. Got a motion by Commissioner Barfield. Do I have a second?

Smith: Second.

Fisher: Second by Commissioner Smith. Any further discussion? All in favor say Aye.

Fisher, Barfield, Infantini, Smith, Anderson: Aye.

Fisher: All opposed? Approves 5:0. Good job staff in putting that all together.