

Meeting Date
March 3, 2015



AGENDA	
Section	Unfinished Business
Item No.	<i>IVA</i>

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
<i>Stockton Whitten</i>	Assistant County Manager	Gerard Visco, Insurance Director / 5-5446



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 4, 2015

MEMORANDUM

TO: Gerard Visco, Insurance Director

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

The Board of County Commissioners, in regular session on March 3, 2015, directed staff as follows:

- Draft a Request for Proposals (RFP) that has as a component a request for a fully insured proposal with a narrow network health plan design, offered by a single health plan provider, with a five-year cost guarantee. As an alternative proposal, a three-year cost guarantee can also be submitted. The Board further directed that a revised draft of this RFP be sent to potential vendors and local hospital systems for their review and input to staff in advance of the March 17, 2015 Board Meeting
- Draft an Request for Proposals (RFP) that has as a component a request for a fully insured proposal with 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. As an alternative proposal, a three-year cost guarantee can also be submitted. The Board further directed that a revised draft of this RFP be sent to potential vendors and local hospital systems for their review and input to staff in advance of the March 17, 2015 Board Meeting.

Your continued cooperation is always appreciated.

Sincerely,

BOARD OF COUNTY COMMISSIONERS
SCOTT ELLIS, CLERK

Tammy Etheridge, Deputy Clerk

/kg

cc: County Manager

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 do not return 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 do not return 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 (c.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
<p>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?</p>		
<p>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?</p>		

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.

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

Company:

Provide your response to the following issues:

Issue	Response
<p>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.</p>	
<p>2. Will your Company provide an onsite, full-time clinical coordinator as specified in the Scope of Services?</p>	
<p>3. Describe any additional staff you will dedicate to the County to assist with issues such as banking/finance, eligibility, health and wellness, etc.</p>	
<p>4. State your member call in medical customer service location and hours of operation.</p>	
<p>5. List the percent of customer service calls that result in problem resolution on the initial call.</p>	
<p>6. For 2014, indicate your medical performance results in the following categories (format indicated in parenthesis):</p> <p>a. Clean claims processed within 10 days (percentage);</p> <p>b. Clean claims processed within 30 days (percentage);</p> <p>c. Average claims turnaround time (number of days);</p> <p>d. Claims coding accuracy (percentage);</p> <p>e. Claims dollar accuracy to include over and under payments (percentage);</p> <p>f. Average speed of telephone answer (number of seconds);</p> <p>g. Average telephone call abandonment rate (percentage)</p>	<p>a</p> <p>b</p> <p>c</p> <p>d</p> <p>e</p> <p>f</p> <p>g</p>
<p>7. List the percent of medical claims received electronically and claims completely adjudicated electronically versus manually broken out by physician and facility claims.</p>	
<p>8. Indicate whether your claims processing system or patient record captures and can report on the following:</p> <p>a. Laboratory values specific to the member;</p> <p>b. Compliance with periodic physicals and preventive diagnostic services specific to the member;</p> <p>c. Plan sponsored biometric screening values specific to the member performed by a third party vendor selected by the County;</p> <p>d. Prescription medication adherence and compliance.</p>	<p>a.</p> <p>b.</p> <p>c.</p> <p>d.</p> <p>e.</p>
<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.</p>	

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>	
<p>6. If you are proposing integrated PBM services please confirm the following and/or list any deviations:</p> <ul style="list-style-type: none"> a. 100% pass-thru pricing for rebates, administrative fees and other discounts/revenue received from pharmaceutical manufacturers are guaranteed b. You will continually negotiate MAC retail pricing and pass those savings through directly to the County c. You will contractually agree to disclose all sources of revenue for administration of the pharmacy program d. You will allow auditing of all claims versus a claims sample and outline any limitations to the auditing scope and frequencies e. You will not apply "spread pricing" 	<p>a</p> <p>b</p> <p>c</p> <p>d</p> <p>e</p>
<p>7. If you are proposing integrated PBM services, regarding your Company's drug formulary list, indicate:</p> <ul style="list-style-type: none"> a. Frequency and timing of formulary changes b. Method to notify employer, including summary of member impact c. Method to notify specific members impacted d. Method to notify providers e. Availability of formulary via hard copy and on website 	<p>a</p> <p>b</p> <p>c</p> <p>d</p> <p>e</p>
<p>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.</p>	
<p>9. Will your Company identify and assist members with End Stage Renal Disease in applying for Medicare benefits?</p>	
<p>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?</p>	

Company:

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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Volusia																																																															
Indian River																																																															
<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
that expire or will be renegotiated in the 2015 or 2016 calendar years,	
11. If the County identifies a provider currently in their network not currently contracted with your Company will you agree to attempt contracting?	
12. List the contracted services where a capitation fee is applied. Will you provide encounter data for services covered under your capitation arrangement?	
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?	
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.	
15. Describe how medical services are provided for members traveling outside the United States.	
16. How do you communicate with providers on Plan design changes, Evidence based medical guidelines, Provider performance profiles?	
17. How does your Company determine provider performance and what action is taken when standards are not met?	
18. How and when will you notify the County of any pending provider terminations?	
19. If you are proposing integrated PBM services, provide the name, location, and years your Company has used the current mail order pharmacy facility.	
20. If you are proposing integrated PBM services, provide your Company's specialty pharmacy facility name, location, and years of service for your Company.	
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.	

Company:

Issue	Response
<p>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?</p>	
<p>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?</p>	
<p>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.</p>	
<p>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.</p>	

Section 4 - Health Management (0-10 points)

Issue/Service	Response
<p>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.</p>	
<p>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?</p>	
<p>3. Describe your Company's ability to increase preventive care utilization and provide your results over the last 5 years.</p>	
<p>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.</p>	

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> <ol style="list-style-type: none"> Participation results for the past year (% engaged); Demonstrated return on investment; 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 HIP AA 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:

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

- 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.

	Subscribers	Administrative Services Only (ASO) Fees				
		2016	2017	2018	2019	2020
Fee Per Subscriber Per Month	4,289	\$	\$	\$	\$	\$
Total ASO Monthly Cost		\$	\$	\$	\$	\$
Total ASO Annual Cost		\$	\$	\$	\$	\$

- 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)	2017 %	2018 %	2019 %	2020 %	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								
2014								
2015 Anticipated								
2016 Anticipated								

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				
30 Days	2016	2017	2018	2019	2020
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				
Over 84 Days	2016	2017	2018	2019	2020
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				
Over 84 Days	2016	2017	2018	2019	2020
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	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.	
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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.

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

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			

Company:

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		

Company:

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

Category	2016 Estimated Cost Per Category
Incurred medical claims	\$
Incurred 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:

John Lynch

From: Lewis, Sally A <Sally.Lewis@brevardcounty.us>
Sent: Monday, March 02, 2015 12:14 PM
To: CGroup; Christine Mulligan; Donna Scott; John Lynch; Kelly Fulton; Tammy Etheridge
Subject: FW: Comments on FB re insurance
Attachments: Comments on FB re insurance

Please attach this Public Comment to

Item V.A

Thank you

-----Original Message-----

From: sluba2@cfl.rr.com [mailto:sluba2@cfl.rr.com]

Sent: Sunday, March 01, 2015 8:38 PM

To: Carrie Cotter; Karon Dillon; Joan Madden; Tom Jenkins; Lewis, Sally A; Ron Pritchard; Monte Zelazny; Conrad White; Ed Washburn

Subject: Comments on FB re insurance

Posts from Face Book retirees

Carlton Hibbard....Thank you Sharon. I wrote to my congressmen not to touch the FRS system a few years ago and how the drop program was wonderful incentive. I was working them and not retired but thought of those being employed or retiring.

Sharon Del Vecchio Luba answering Carlton First, yes there was always implied expectations at our orientation meetings and the BOCC always supported actives AND retirees, but in the past few years, amnesia has set in.

Kay Elliott Burk

2/24, 9:55pm

Kay Elliott Burk

Thank you, Sharon

Judy Lewellen

2/25, 8:14am

Judy Lewellen

Thank you Sharon ...Judy Lewellen

Rose Ormsbee Lyons left the conversation.

Pam Hipwell Shoemaker

Nothing's safe or sacred anymore. Thanks for all you're doing Sharon.

Jan McLarty

About three or so years ago when the county offered a one year option with United Healthcare Medicare Complete, I tried it out. The price was good, all I pay is my quarterly Medicare fee to the government, and I have had no problems

with the health care. One of my doctors is not affiliated, but my fee to him is so small that I don't even bother getting it re-cooped. So, I stayed with United Healthcare and pay much less than the County's options.

Henry Minneboo
2/26, 9:41am

Sharon Del Vecchio Luba
2/28, 8:56am

Sharon Del Vecchio Luba

BEFORE I POST MY REVIEW LATER THIS AFTERNOON FOR TUESDAY'S MEETING, HERE IS THE STATUTE RE GROUP INSURANCE FOR YOU TO BE MINDFUL OF.....

112.0801 Group insurance; participation by retired employees left off the rest since you e-mailers got it too.

Tina Anderson

Thank you Sharon, this is good news to hear.

2/28, 10:36am

Billy Osborne

So, Sharon, from reading this, (statute) it would appear that our retiree rates have been extremely high the last five years and we should not have had those 7, 8 and 10 percent increases over the last 5 years (paragraph 2 of the statute).

Maybe I'm reading it wrong .

2/28, 7:18pm

Sharon Del Vecchio Luba to Billy O.

Billy Osborne: It's not a question of whose rates went up and by how much. The Statute does not require that a certain funding mechanism be used or that retirees be subsidized by the employer (see para 3 & 4). What that section of the statute requires is that the County calculate what an un-subsidized premium would be by combining active employees with retirees and capping retiree premiums at that amount. What we get from that are called "vested rates" (remember that phrase from last year that we all had a problem with but couldn't do anything about) The statute's requirements are met as long as no retiree premium is greater than the vested rate that is published. In 2015 there are a couple of premiums that equal vested rates...i.e., the single retiree rates in both the HRA and PPO.

2/28, 7:24pm

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Thank you for clarifying Sharon . I had a feeling that I may have interpreted it wrong .

2/28, 7:44pm

Sharon Del Vecchio Luba

Medicare-eligible and Non-eligible Medicare RETIREES Update (you e-mailers got it too)

March 1 6:28am

Gary T. Ridenour

Sounds like purposeful organized chaos to me. Sad. These people (Commission) need to start thinking Golden Rule by contemplating how they want to be treated when they retire. Why should any current employee show any loyalty to the county if this level of disloyalty is what they have to look forward to upon retirement?! My health insurance under the current county setup is already in excess of \$900 a month. Where do they think we retirees are getting the funds for more increases since we're all on fixed incomes?! Disgusting unappreciative bunch.

Sharon Del Vecchio Luba

11:08am

Sharon Del Vecchio Luba

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