Human Resources/Insurance Committee
Blount County

July 20, 2015 5:00 PM
Agenda

1) **Roll Call**

2) **Emergency Announcement**

3) **Input on items on the Agenda**

4) **Approval of Minutes (June 16, 2015)**

5) **Discussion regarding Benefits**
   a) Monthly Revenue and Expenditures-Jenny Morgan
   b) Information from Cole Harris-CBIZ
   (Medical, Dental, County Provided Life)

6) **Discussion regarding Voluntary Worksite Benefits**
   a) Information from Cole Harris-CBIZ
   (Vision, Short Term Disability, Long Term Disability, Group Term Life, Whole Life, Critical Illness w/Cancer, Cancer, Accident, Flex Spending Account, Dependent Care Account)

7) **Input on items not on the Agenda**

8) **Adjournment**

Blount County Government
Human Resources/Insurance Committee Minutes

Tuesday, June 16, 2015 5:00 PM
Room 430 Blount County Courthouse

Members Present: Mayor Ed Mitchell, Commissioners Mike Lewis, Tom Stinnett, Mike Caylor, Grady Caskey, Gary Farmer, Sheriff James Berrong, Human Resource Insurance Committee Member David Murrell, Register of Deeds Phyllis Crisp, Highway Superintendent Bill Dunlap

Members Absent: None

Others Present: Human Resources Director Jenny Morgan, Benefits Coordinator Jodie King

Input on Items on the Agenda

None

Approval of Minutes

A motion was made by Phyllis Crisp and seconded by Grady Caskey to approve the minutes of the May 19, 2015 meeting. The motion passed on a voice vote.

Health Fund and Reporting

5. A. Information from Cole Harris with CBIZ

HR Director Jenny Morgan proceeded to tell the committee the revenue and expenditures of the Health Fund for May 2015. The May monthly revenue was 1,526,904.55; expenditure was 2,104,866.35 leaving a negative balance of -577,961.80 for the month. The YTD total revenue was 15,770,073.43; expenditure was 18,296,628.04 with a negative balance of -2,526,554.64. Jenny Morgan then recognized Cole Harris to discuss status of some informational update regarding the overview of benefits. Cole stated to the committee he will have recommendations to present at the July meeting, as CBIZ now has enough good data with cost savings measure to present. Cole mentioned the main drivers are dental, life, medical, pharmacy and stoploss. Cole also discussed the past 3 years of data to the committee; discussing the employee count for each year along with the claims data for each year. Mike Lewis asked Cole to talk about the 2015 claims data which is more and with the number of employees which is less; comparing it to the past data. Cole stated due to renewal changes, the timing of claims being paid, high claimants and pharmacy drug cost increasing daily all are a factor in the data comparison. The committee would like to have information presented via email as it comes in so they will have data prior to the meetings. Cole was still in negotiations with stoploss carriers.

Input on Items not on Agenda

None

Motion was made to adjourn at 5:49 PM

Blount County
Employee Summary Report
Reporting Period: 07/01/14 thru 06/30/15

			Membership			
			Subscriber Coverage Types			
Month	**Total**	**Members**	**EE Only**	**EE + SP**	**EE + CH**	**Family**
7/31/2014	1862	3928	947	210	194	511
8/31/2014	1905	3991	980	212	196	517
9/30/2014	1902	4005	971	213	198	520
10/31/2014	1903	4006	972	211	203	517
11/30/2014	1909	4017	974	211	210	514
12/31/2014	1906	4016	971	210	210	515
1/31/2015	1,936	4,075	979	226	214	517
2/28/2015	1,930	4,063	978	223	214	515
3/31/2015	1,911	4,033	964	219	214	514
4/30/2015	1,913	4,044	965	220	214	514
5/31/2015	1,911	4,057	960	219	213	519
6/30/2015	1,883	3,979	957	213	208	505
	22,871	**48,214**	**11,618**	**2,587**	**2,488**	**6,178**

C.C. Object	Account Title	Estimated Revenue	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Year to Date
43101	SELF-INSURANCE PREMIUMS	$ 9,300,000.00	$ 82,158.50	$ 817,450.00	$ 832,125.00	$ 767,087.07	$ 766,450.00	$ 694,075.00	$ 438,700.93	$ 723,529.60	$ 700,210.89	$ 749,087.50	$ 758,412.50		$ 7,329,286.99
43102	OTHER EMPLOYEE BENEFITS	$ 9,000,000.00	$ 654,181.74	$ 590,040.90	$ 662,747.29	$ 735,157.38	$ 666,548.38	$ 728,213.37	$ 660,509.09	$ 640,365.88	$ 705,828.99	$ 664,536.12	$ 678,077.79		$ 7,386,206.93
44110	INTEREST EARNED	$ 12,000.00	$ 1.18	$ 858.09	$ 877.36	$ 893.23	$ 626.84	$ 720.98	$ 736.23	$ 770.67	$ 563.02	$ 678.00	$ 620.02		$ 7,345.62
44160	RETIREES INSURANCE PMTS	$ 630,000.00	$ (58,871.77)	$ 14,300.00	$ 11,875.00	$ 13,700.00	$ 81,743.56	$ 93,511.00	$ 475,141.00	$ 100,462.50	$ 97,500.05	$ 101,969.50	$ 88,876.24		$ 1,020,207.08
44161	COBRA INSURANCE PAYMENTS	$ 50,000.00	$ 1,397.05	$ 3,571.90	$ 3,166.92	$ 4,154.98	$ 2,295.00	$ 2,801.96	$ 2,754.00	$ -	$ 3,672.00	$ 2,295.00	$ 918.00		$ 27,026.81
48990	OTHER-NET ASSETS UNRESTRICTED	$ 1,329,420.00	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -		$ -
	TOTAL	$ 20,321,420.00	$ 678,866.70	$ 1,426,220.89	$ 1,510,791.57	$ 1,520,992.66	$ 1,517,663.78	$ 1,519,322.31	$ 1,577,841.25	$ 1,465,128.65	$ 1,507,774.95	$ 1,518,566.12	$ 1,526,904.55		$ 15,770,073.43

	Explaination of Account Title	
43101	SELF-INSURANCE PREMIUMS	Employee Only Medical Premiums and Employer for Employee Only Medical Premiums ($25.00 and $425.00 mthly)
43102	OTHER EMPLOYEE BENEFITS	Employee Dependent Medical Premiums and Employer for Dependent Medical Premiums ($150.00; $100.00; $125.00 and $550.00 mthly)
44110	INTEREST EARNED	Interest Earned
44160	RETIREES INSURANCE PMTS	Retiree Premiums
44161	COBRA INSURANCE PAYMENTS	Cobra Premiums
48990	OTHER-NET ASSETS UNRESTRICTED	Fund Balance

C.C. Object	Account Title	Estimated Expenditures	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Year to Date
500207	EMPLOYEE INSURANCE - HEALTH	$ 605,000.00	$ 93,361.80	$ 48,682.07	$ 49,547.30	$ 52,555.53	$ -	$ 99,259.90	$ -	$ 101,346.39	$ 50,524.89	$ 50,208.75	$ 50,185.48		$ 595,672.11
500312	CONTRACTS W/PRIVATE AGCY	$ 320,000.00	$ 5,082.34	$ 27,634.34	$ 27,683.00	$ 28,702.67	$ 23,718.00	$ 27,671.67	$ 31,537.34	$ 27,218.67	$ 26,802.33	$ 28,160.00	$ 28,292.32		$ 282,502.68
500325	FISCAL AGENT CHARGES	$ 661,024.00	$ -	$ 51,839.37	$ 53,037.78	$ 105,338.07	$ -	$ 66,925.53	$ 60,540.69	$ 118,470.60	$ 41,020.18	$ 72,902.78	$ 65,703.93		$ 635,778.93
500507	MEDICAL CLAIMS	$ 18,735,396.00	$ 621,700.16	$ 1,221,723.48	$ 1,311,414.85	$ 1,594,999.05	$ 1,337,047.31	$ 1,393,951.13	$ 1,221,346.04	$ 2,256,207.81	$ 1,240,003.53	$ 2,270,622.11	$ 2,104,866.35		$ 16,573,881.82
500530	FINES, ASSESSMENTS, AND PENALTIES	$ 217,092.50	$ -	$ -	$ -	$ -	$	$ -	$ -	$ 208,792.50	$ -	$ -	$ -		$ 208,792.50
	TOTAL	$ 20,538,512.50	$ 720,144.30	$ 1,349,879.26	$ 1,441,682.93	$ 1,781,595.32	$ 1,360,765.31	$ 1,587,808.23	$ 1,313,424.07	$ 2,712,035.97	$ 1,358,350.93	$ 2,421,893.64	$ 2,249,048.08		$ 18,296,628.04

	Explaination of Account Titles	
500207	EMPLOYEE INSURANCE - HEALTH	Stoploss Carrier Premiums
500312	CONTRACTS W/PRIVATE AGCY	ETMG Clinic and CONCERN EAP (BMH)
500325	FISCAL AGENT CHARGES	HUMANA Admin Fees and Open Enrollment System
500507	MEDICAL CLAIMS	Medical Claims and Pharmacy Claims
500530	FINES, ASSESSMENTS, AND PENALTIES	ACA Fees and PCORI Fees (IRS)

Blount County Carriers Quoted

ASO

Carriers Quoted:	Status
Aetna	Decline
Allegiance	Received
BCBST	Received
CIGNA	Received
HealthSmart	Received
UHC / UMR	Received

Ancillary/Dental

Carriers Quoted:	Status
Allstate	Received
Ameritas	Received
Assurant	Decline
CIGNA	Received
Companion	Not Received
Dearborn	Received
Delta	Not Received
Guardian	Not Received
Hartford	Not Received
Lincoln	Decline
Metlife	Received
Mutual of Omaha	Received
Principal	Received
Prudential	Decline
Reliance Standard	Not Received
Standard	Received
SunLife	Received
Unum	Received
USAble	Received

Stop Loss

Carriers Quoted:	Status
AIG	Decline
BCBST	Decline
CIGNA	Decline
Companion	Decline
Guardian	Decline
HCC Life	Received
HealthSmart	Decline
HM Life	Current
ING	Decline
Optum	Decline
Reliance	Decline
Sextant	Decline
Starmark	Decline
Sun Life	Decline
Symetra	Decline
UMR	Decline
Zurich	Decline

PBM

Carriers Quoted:	Status
Employers Health (Car	Received
EmpiRX	Received
Magellan Rx	Received
AmeriClear Rx	Received
BCBST	Received
Aetna	Decline
CIGNA	Received
UHC	Received
Express Scripts	Received
ProAct Rx	Received

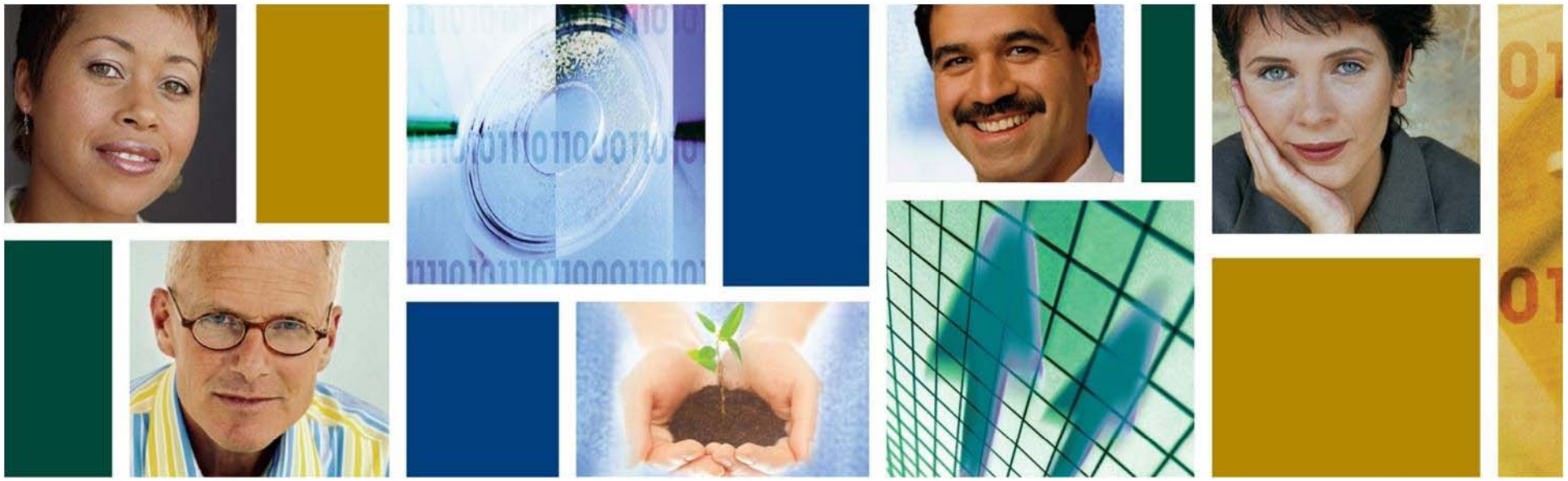
Blount County Government

Expected Savings

Origin		2014-2015	2015-2016 Renewal	2015-2016 Proposed
Stop-Loss Premium		**$615,828.00**	**$769,872.00**	**$597,986.00**
ASO Fees		**$665,264.88**	**$644,145.36**	**$648,507.00**
Run-Out ASO Fee (After Incentives)		**$0.00**	**$0.00**	**$188,435.50**
Plan Funding		**$18,080,100.00**	**$18,080,100.00**	**$20,495,664.00**
Employee/Retiree Contributions		$2,170,500.00	$2,170,500.00	$4,112,364.00
Blount County Funding		$16,383,300.00	$16,383,300.00	$16,383,300.00
	*Claims**	*$17,968,880.40*	*$19,226,702.03*	*$18,346,539.77*
	Stop-Loss	*$615,828.00*	*$769,872.00*	*$597,986.00*
	*All other Admin fees***	*$1,052,578.80*	*$1,031,481.36*	*$1,035,916.44*
	ACA (Estimates)	*$275,000.00*	*$275,000.00*	*$275,000.00*
Net Plan Funding		**($1,832,187.20)**	**($3,222,955.39)**	$51,786.29
Tobbacco Discount		$0.00	$0.00	$107,175.00
Dental Insurance (Total)		$1,027,108.68	$1,078,542.12	$977,110.32
	Dental Insurance (County Cost)	$271,963.68	$285,614.00	$256,116.00
	Dental Insurance (EE Cost)	$755,145.00	$792,928.12	$720,994.32
Life Insurance		$192,700.20	$192,700.20	$86,719.09
Budgeted County Costs		$16,847,963.88	$16,861,614.20	$16,726,135.09
Net Actual Expected County Costs		$18,680,151.08	$20,084,569.59	$16,674,348.80
Employee Costs (Inclusion of Tobacco)		$2,925,645.00	$2,963,428.12	$4,940,533.32
Expected Net Gain/Loss to plan fund		**-$1,832,187.20**	**-$3,222,955.39**	**$158,961.29**

***Assuming a 7% trend in Medical claims**

** All other Admin fees include On Site Clinic Admin, EAP, and ASO



Blount County Government HR Committee Recommendations

Presented by:

Cole Harris, RHU
Vice President of Sales & Marketing
CBIZ Benefits & Insurance Services of Tennessee, Inc.
Office: 865-251-5149; Fax: 865-251-5143

Overview

- Carriers Marketed
- Ancillary Coverages (Vision, Voluntary Life/Short-Term Disability/Long-Term Disability)
- Worksite Coverages
- Stop-Loss
- Dental
- Life
- ASO
  - References
- Pharmacy Benefit Manager (PBM)
- Plan Designs
- Wellness
- Plan Funding Levels / Contribution Recommendations

Carriers Marketed

- Stop-Loss: 17
- Ancillary (Life/Disability/Dental/Vision): 19
- PBM: 10
- ASO: 6

Voluntary Vision Insurance

($0)

- Current Carrier: Superior Insurance
- Renewal Date: January 1st, 2016
  - Two additional year rate guarantee

Voluntary Life/Disability ($0)

- Current Carrier: Humana
- Renewal Date: January 1st, 2016
  - Rate Hold
- Recommendation: Dearborn National
  - True open enrollment for products
    - New Guarantee Issue available
  - Rate hold for Short-term disability and Life
  - Reduction of 17% for Long-Term Disability
    - Salary of $38,400 for the benefit of 60% would see an estimated $5 monthly reduction in cost

Worksite Coverages

($0)

- Current Carrier: Humana
- Renewal Date: January 1st, 2016
  - Rate Hold
- Recommendation: Colonial
  - True open enrollment for products
    - New Guarantee Issue available
- Critical Illness w/o Cancer, Critical Illness with Cancer, Cancer, Accident, Whole Life, Universal Life with Long Term Care, and Individual
  - Whole and Universal Life enrollment to be uploaded to Kronos software from Colonial enrollment system

Worksite Coverages

($0)

- Enrollers will be available to assist employees in enrollment of all products offered
  - 75% of the employees will be required to be seen
    - Free F.S.A. administration with Debit Card for County if Metric achieved
    - Losses from terminated employees prior to contributions received trued up after 3rd year and covered by Ameriflex
  - Enrollment on Kronos software
  - 90% retention rate of products

Stop-Loss

($17,842)

- Carrier: HM Life
- 2014-2015 Specific Stop-Loss Limit: $250,000
- Initial July 1st Renewal: 45%
  - $277,117 Increase
- Revised Renewal: 25%
  - $154,044
- Recommended:
  - $300,000 Specific Stop Loss: 2.9% Decrease
  - $17,842 annual savings over current
- Pended reimbursements as of June 15th: $40,881.34

Dental Insurance

($17,842)

- Current Carrier: BlueCross BlueShield of TN
- Renewal Date: January 1st, 2016
  - Initial increase scheduled for July 1st of 5%
    - Negotiated a rate hold
  - 6% increase for January 1st, 2016: $16,317.82 increase to County
    - Revised to 5%: $13,650 Increase to County
      - 2 year rate guarantee with a cap of 5% for third year
  - Met Life offered a Rate Hold
    - Average increases of 7+% annually
    - Smaller Network of Providers

Dental Insurance

($67,840.36)

- Recommended Carrier: Delta Dental
  - Benefit Match
  - Largest National Network
    - Premier Network: 89% of TN dentists participate
    - PPO Network: 63% of TN dentists participate
    - Out-of-Network: 80th percentile of Usual and Customary
  - Blount County Data: 94% of claims paid in-network compared to 78% with Current
  - 2 year Rate Guarantee
    - 5% Cap on 3rd year
  - $4,167 reduction in monthly premium
    - $49,998.36 annual reduction

Dental Insurance

($67,840.36)

Current

Count	County	Employee
Employee Only	$23.51	$0
Family	$0	$49.24

Proposed

Count	County	Employee
Employee Only	$22.14	$0
Family	$0	$47.32

Renewal

Count	County	Employee
Employee Only	$24.69	$0
Family	$0	$51.70

Life Insurance (County Provided) ($173,825.36)

- Current Carrier: Humana
  - $192,700.20 Annual ($11 PEPM)
- Renewal Date: January 1st, 2016
  - Rate Hold
- Recommendation: Dearborn National
  - Owned by a few of the BlueCross BlueShield Plans
  - Rated A+ by AM Best and S&P
  - $86,715.09 Annual ($4.95 PEPM)
- Savings: $105,985

Administrative Services

($173,825.36)

- Current Carrier: Humana
  - $665,264.88
- Renewal Date: January 1st, 2016
  - $644,145.36 (3.2% reduction)
- Issues
  - Customer Service
  - Incorrect documents/data/billing
  - Lack of flexibility with claims payments
  - Lag time on Reporting
  - Cumbersome administration

Administrative Services ($71,174.64)

- Run-Out Administration:
  - Claims incurred during the plan year with Humana, but paid after moving vendors
    - Example: John Doe has a $1,000 claim on December 3rd. Claim is submitted by provider on January 3rd. Claim is paid by Humana due to date of Service and use of Humana network
  - Will administer claims for 18 months after departure
  - Cost to administer is equal to 8% of two months worth of claims
    - Estimated at $245,000

Administrative Services

($54,416.76)

- Recommendation: Allegiance
  - Owned by CIGNA Corporation
    - CIGNA Wrap network
  - Boutique TPA specializing in Government/Hospital entities
  - Flexibility/Customization
  - Consolidated Billing
  - $648,507.00
- Savings: $16,757.88

Administrative Services ($2,147.74)

- Performance Guarantees:
  - See Performance Guarantee Document
  - $77,820 at risk
- Incentives
  - First month administration fee is discounted 50% (not including the National Network Access Fee): ~$21,043
  - Second month administration fee is discounted at 25%: ~$10,521.50
  - One-time $25,000 implementation subsidy
  - Total Incentives: $56,564.50

Administrative Services

($2,147.74)

- Network Discount Guarantees:
  - Knoxville – 59.5%
  - Nashville – 60.3%
  - Tri-Cities – 56.1%
  - Chattanooga – 50.4%
  - A reduction of greater than a weighted 3% variance will occur in a percentage of Administrative fees returned to the County dependent on the severity of the change
    - At risk: $93,360

Administrative Services

($294,202.97)

- Network Re-price:
  - All prior year claims ran through CIGNA's network
- Gross Medical Claims
  - $29,600,183
  - Humana After Discounts: $13,194,775
    - Average discount: 55.42%
  - CIGNA Network After Discounts: $12,015,076
    - Average discount: 59.41%
    - 3% Variance: $12,902,719.77
  - Estimated Savings on Claims: $1,179,699
    - 3% variance: $292,055.23

Administrative Services

($294,202.97)

- References:
  - Collier County (2,000 employees)
    - 4 years with Allegiance
    - Weekly claims calls / Quarterly in-person claims review
    - Private network with CIGNA Wrap
    - Incredibly Flexible for their needs
  - School Board of Collier County
    - Around 5,000 employees
    - Started in January of 2013
    - Utilizes local network with the CIGNA wrap
    - Meets quarterly in-person to discuss claims/trends
    - Incredibly happy with service

Administrative Services

($294,202.97)

- References:
  - Montana Association of Counties (1,400 employees)
    - 10 years with Allegiance
      - 1st and only ASO for the Association
    - Incredible support and reporting
    - Use Caremark for the PBM since 2007 and very happy
    - Consolidated billing without issues

PBM Services

($1,106,562.97)

- Current: Humana
  - Net Claim Costs: $5,409,000
  - Estimated Rebates: $223,000
  - Total Estimated Pharmacy Cost: $5,186,000
- Caremark (Through Employers Health)
  - 1 year contract
  - Net Claim Costs: $4,994,000 / 3% Variance: $5,143,820
  - Estimated Rebates: $794,000 / $770,180
  - Total Estimated Pharmacy Costs: $4,200,000 / $4,373,640
- Total Estimated Savings: $986,000
  - 3% Variance: $812,360
  - $10 per member at risk in Performance Guarantees

PBM Services

($1,106,562.97)

- Current: Humana
  - Net Claim Costs: $5,409,000
  - Estimated Rebates: $223,000
  - Total Estimated Pharmacy Cost: $5,186,000
- Caremark (Through Employers Health)
  - 1 year contract
  - Net Claim Costs: $4,994,000 / 3% Variance: $5,143,820
  - Estimated Rebates: $794,000 / $770,180
  - Total Estimated Pharmacy Costs: $4,200,000 / $4,373,640
- Total Estimated Savings: $986,000
  - 3% Variance: $812,360
  - $10 per member at risk in Performance Guarantees

2016 Claims

($728,903.60)

- 2015 Gross Medical Claims
  - $29,600,183
- 2016: 7% Trend
  - Medical: $31,672,195.81
    - Average discount: 59.41%
    - Trended Number: $12,902,719.77
    - Additional Stop-Loss Claims: $150,000
  - Pharmacy Claims Trended: $5,143,820
  - Total Expected 2016 Claims : $18,346,539.77
- Total Increase in Expected Claims: $377,659.37

Plan Design Offerings

($728,903.60)

- Current: 1 plan design
- Proposed: 3 plan designs
  - Plan 1: Same coverage as current
  - Plan 2: Slightly higher deductible and inclusion of copays
  - Plan 3: High deductible high Copay plan
- See Spreadsheet for details

Wellness

($836,078.60)

- Offer tobacco-free discount of $25 less than tobacco user for Employee Only / $50 per month for spouse
  - Would need to offer a reasonable alternative for those who wish to quit smoking
    - American Lung Association provides a self-paced online program for $40 per participant
  - Anticipated 25% of population utilizes tobacco
    - 25% of tobacco population expected to not receive discount
  - Expected generated excess deductions of $107,175
  - Per the American Lung Association:
    - Claims costs for tobacco exceed $2,200 per year
    - Loss productivity exceed $2,200 per year per tobacco user
- CBIZ will bid programs in 2016 for a 2017 effective date

Plan Funding

($836,078.60)

- Current Average Monthly Funding
  - $1,546,150
- No Plan/Carrier Changes Recommended Factors (January 2016)
  - $1,800,479
- Claims have been tracking at 7% medical trend year-over-year
- Expected Monthly plan funding with carrier/plan changes
  - $1,707,972

Retirees

($836,078.60)

- Grandfather existing retirees
- Change the Plan funding/Contribution strategy for new retirees beginning 2017
  - Charge the difference in actuarial value between Active and Retiree

Plan Funding Levels (Active/Retirees)

- Current Levels (Blount County Contribution + Employee)

	Plan 1	Plan 2	Plan 3
Employee Only	$450	N/A	N/A
Employee Spouse	$1,125	N/A	N/A
Employee Child	$1,100	N/A	N/A
Family	$1,150	N/A	N/A

Plan Funding Levels (Active/Retirees)

- Proposed Levels (Blount County Contribution + Employee)

	Plan 1	Plan 2	Plan 3
Employee Only	$516.05	$474.76	$450
Employee Spouse	$1,290.12	$1,186.91	$1,125
Employee Child	$1,261.45	$1,160.53	$1,100
Family	$1,318.79	$1,213.28	$1,150

Employee Contributions (Active)

- Option 1:
  - Change to a percentage of premium for base plan from flat amount
    - Based on funding levels
  - Buy-up the difference to the alternate plans
- Option 2:
  - Traditional Flat-Premium

Employee Contributions (Active)

Monthly

	Plan 1	Plan 2	Plan 3
Employee Only	$91.05	$49.76	$25 (5.683%)
Employee Spouse	$315.12	$211.91	$150 (13.637%)
Employee Child	$286.45	$185.53	$125 (11.623%)
Family	$343.79	$238.28	$175 (15.564%)

* Tobacco Users add the $25 / $50 fee

Summary

($836,078.60)

- Refer to the expected savings sheet for analysis
- Expected savings of $836,078.60 over current plan projection
  - Funding Health Deficit expected currently negative:
    - $1,832,187.20
  - 2015-2016 Expected Health Funding Deficit as-is:
    - $3,222,955.39
  - 2015-2016 Expected surplus of Health Funding:
    - $51,786.29
- Contribution and Plan Changes increase to overall fund:
  - $158,961.29

Blount County Government (BCG)
Medical & Pharmacy Financial Adequacy Forecast (Aggressive)
Forecasted Increase at 1/1/2016
Executive Summary

INTRODUCTION

The following partially self insured medical and prescription drug funding rate projection was developed for Blount County for a January 1, 2016 effective date for 12 months. In forecasting the prospective funding rates, applicable actuarial standards of practice were followed, in particular Actuarial Standard of Practice 5, "Incurred Health and Disability Claims". In the forecast, there are many factors and assumptions used to derive the estimated funding rates. Such factors and assumptions include but are not limited to:

- Historical monthly paid claims, and individual large claims were reviewed & trended to estimate the prospective claims for the period January 1, 2016 through December 31, 2016
- Renewal Administration fees from Selected Vendor
- Individual stop loss fees from the Selected Vendor
- Plan changes and associated decrements regarding the plan changes
- Used current enrollment figures

CBIZ Actuarial has relied on Humana and Blount County on the accuracy and integrity of the information requested and received.

The conclusions drawn in this report are based on the assumptions outlined. It should be noted that there is no guarantee that Blount County will experience the assumptions and hence, deviations are anticipated.

SUMMARY OF RESULTS

1. **Enrollment Snap Shot**

	Base Plan	Active	Retired
Employee Only = E	916	716	200
Employee & Spouse = ES	276	214	62
Employee & Child/ren = EC	206	205	1
Family = F	519	513	6
Total	1917	1648	269

2. **Current Active & Retiree Premium Equivalent Rates January 1, 2015 (Next change anticipated at January 1, 2016)**

	Base Plan	Ee Share	Er Share
E	$450.00	$25.00	$425.00
ES	$1,125.00	$150.00	$975.00
EC	$1,100.00	$125.00	$975.00
F	$1,150.00	$175.00	$975.00
Monthly:	$1,546,150	$180,875	$1,365,275

3. **Expected Costs From 1/1/2016 through 12/31/2016**

The following premium equivalent rates are set at a 1/1/2016 effective date and are good for the calendar year. The rates account for the following claims and expenses:

- ⇒ Paid claims less stop loss reimbursements from January 1, 2016 through December 31, 2016
- ⇒ Administration expenses and Stop Loss Premium
- ⇒ No contribution to surplus. The premium equivalent rates are anticipated to cover all claims and expenses with nothing left over, e.g., inflow = outgo.

Expected Claims, Administration Expenses, and Stop Loss Premiums From 1/1/2016 through 12/31/2016

Section 2 is the detail supporting the expected costs. Section 2 is broken down into Combined Retiree & Active, Active Only, and Retiree Only. The expected claims and expenses from January, 2016 through December, 2016 are calculated on a Per Employee, Employee and Spouse, Employee and Child/ren, and Family monthly basis. They would represent the premium equivalent rates at 1/1/2016.

Premium Rates No Plan Changes

	Base Plan	Active	Retiree
E	$512.38	$512.38	$512.38
ES	$1,280.95	$1,280.95	$1,280.95
EC	$1,252.48	$1,252.48	$1,252.48
F	$1,309.41	$1,309.41	$1,309.41
Monthly:	$1,760,479	$1,569,475	$191,004
		$1,760,479	Difference from Total is due to rounding (not material)
Increase:	13.86%		

Premium Rates With Plan Adjustments (Offering 2 Plans along side Current)

Premium Development:

	Current (Plan 1)	Plan 2	Plan 3	
Actuarial Values:	0.842	0.797	0.725	(See Section 2A for plan details)
	1.000	0.947	0.861	

Target Premiums:

	Current (Plan 1)	Plan 2	Plan 3
EE	$512.38	$485.00	$441.18
ES	$1,280.95	$1,212.49	$1,102.95
EC	$1,252.48	$1,185.54	$1,078.44
F	$1,309.41	$1,239.43	$1,127.46

Estimated Enrollment:

	Current (Plan 1)	Plan 2	Plan 3	Total:
EE	550	275	91	916
ES	166	83	27	276
EC	124	62	20	206
F	311	156	52	519
Total:	1151	576	190	1917
Migration:	60%	30%	10%	100%

Target Premium Needed:

Current (Plan 1)	Plan 2	Plan 3	Total:
$1,056,982	$500,866	$150,124	$1,707,972

Adverse Selection Adjusted Decrements:

Current (Plan 1)	Plan 2	Plan 3
1	0.92	0.872009

Adverse Selection Adjusted Premiums:

	Current (Plan 1)	Plan 2	Plan 3
EE	$516.05	$474.76	$450.00
ES	$1,290.12	$1,188.91	$1,125.00
EC	$1,261.45	$1,160.33	$1,100.00
F	$1,318.79	$1,213.28	$1,149.99

Increase in Premium Relative to Current Premiums

Current (Plan 1)	Plan 2	Plan 3			
14.7%	5.5%	0.0%	$25.00	$49.76	$91.05
14.7%	5.5%	0.0%	$150.00	$211.91	$313.12
14.7%	5.5%	0.0%	$125.00	$185.53	$286.45
14.7%	5.5%	0.0%	$174.99	$238.28	$343.79

Adjusted Premium Collection:

Current (Plan 1)	Plan 2	Plan 3	Total:
$1,064,549	$490,299	$153,124	$1,707,972

4. Forecasted Expense Rates from 1/1/2016 through 12/31/2016 (Increase in Item 3 Above times Current Funding Rates)

A. No Changes For 2016 other than Stop Loss Renewal

Expected

	Base Plan
E	$512.38
ES	$1,280.95
EC	$1,252.48
F	$1,309.41
Monthly:	$1,760,479
PEPM:	$918.35

5. Fixed Costs as a % of Expected Funding Rates

Administration	4.81%
Stop Loss	2.77%
PPACA (RTF & PCORI)	0.36%
Other	0.00%
Total:	8.24%

Under Traditional Program

Administration & Stop Loss Range is between 15.9% to 24.9% (Includes Health Insurance fee)

Blount County Government
Medical Plan Analysis
January 1st, 2016

	Plan 1					
	Humana					
	Current Traditional			Renewal Traditional		
Benefits *(Members Pay)*	Blount County	NPOS	Out (Separate)	Blount County	NPOS	Out (Separate)
Network	Blount County Not Applicable			Blount County Not Applicable		
Deductible						
Individual	$500	$500	$1,000	$500	$500	$500
Family	$1,000	$1,000	$1,000	$1,000	$1,000	$1,000
Coinsurance	90%	80%	50%	90%	80%	50%
Medical Out-of-Pocket						
Individual	$1,500	$1,500	$5,000	$1,500	$1,500	$5,000
Family	Per Covered Person	Per Covered Person	Per Covered Person	Per Covered Person	Per Covered Person	Per Covered Person
Lifetime Maximum	unlimited			unlimited		
Hospital Services						
Inpatient Hospital	10% after deductible	20% after deductible	50% after deductible	10% after deductible	20% after deductible	50% after deductible
Outpatient Hospital	10% after deductible	20% after deductible	50% after deductible	10% after deductible	20% after deductible	50% after deductible
Emergency Room	Deductible / Coinsurance			Deductible / Coinsurance		
Routine Services						
Primary Care Office Visit	10% after deductible	20% after deductible	50% after deductible	10% after deductible	20% after deductible	50% after deductible
Specialist Office Visit	10% after deductible	20% after deductible	50% after deductible	10% after deductible	20% after deductible	50% after deductible
Urgent Care	$50 Copay	$50 Copay	$50 Copay	$50 Copay	$50 Copay	$50 Copay
Wellcare Exam	100% covered	100% covered	Not Covered	100% covered	100% covered	Not Covered
	Humana					
Prescription Drugs						
Mail Order		2 times Copay			2 times Copay	
Tier 1 Drugs	$10 Copay	$10 Copay		$10 Copay	$10 Copay	
Tier 2 Drugs	30% max of $60	30% max of $60		30% max of $60	30% max of $60	
Tier 3 Drugs	30% max of $60	30% max of $60		30% max of $60	30% max of $60	
Tier 4 Drugs	30% max of $60	30% max of $60		30% max of $60	30% max of $60	
Preventive Drugs						
Combined Out-of-pocket						
Individual	$6,350			$6,350		
Family	$12,700			$12,700		

Plan 1

Allegiance

Traditional

Blount County	CIGNA	Out (Separate)
Blount County		
Not Applicable		
$500 $1,000 90%	$500 $1,000 80%	$1,000 $1,000 50%
$1,500 Per Covered Person	$1,500 Per Covered Person	$5,000 Per Covered Person
unlimited		
10% after deductible	20% after deductible	50% after deductible
10% after deductible	20% after deductible	50% after deductible
Deductible / Coinsurance		
10% after deductible	20% after deductible	50% after deductible
10% after deductible	20% after deductible	50% after deductible
$50 Copay	$50 Copay	$50 Copay
100% covered	100% covered	Not Covered

Caremark

	2 times Copay	
$10 Copay	$10 Copay	
30% max of $60	30% max of $60	
30% max of $60	30% max of $60	
30% max of $60	30% max of $60	

$6,350
$12,700

Plan 2

Allegiance

Traditional

Blount County	CIGNA	Out (Separate)
Blount County		
Not Applicable		
$1,000 $2,000 90%	$1,000 $2,000 70%	$2,000 $4,000 50%
$2,500 $7,500	$2,500 $7,500	$5,000 $10,000
unlimited		
10% after deductible	30% after deductible	50% after deductible
10% after deductible	30% after deductible	50% after deductible
$500 Copay		
$30 Copay	$30 Copay	50% after deductible
$50 Copay	$50 Copay	50% after deductible
$100 Copay	$100 Copay	50% after deductible
100% covered	100% covered	Not Covered

Caremark

	2 times Copay	
$10 Copay	$10 Copay	
$40 Copay	$40 Copay	
$70 Copay	$70 Copay	
$140 Copay	$140 Copay	

$6,350
$12,700

Plan 3

Allegiance

Blount County	CIGNA	Out (Separate)
Blount County		
$2,500 $5,000 90%	$2,500 $5,000 70%	$5,000 $10,000 50%
$4,000 $12,000	$4,000 $12,000	$10,000 $30,000
unlimited		
10% after deductible	30% after deductible	50% after deductible
10% after deductible	30% after deductible	50% after deductible
$750 Copay		
$40 Copay	$40 Copay	50% after deductible
$60 Copay	$60 Copay	50% after deductible
$125 Copay	$125 Copay	50% after deductible
0% after deductible	0% after deductible	0% after deductible

Caremark

$10 Copay	$10 Copay	
$40 Copay	$40 Copay	
$100 Copay	$100 Copay	
$200 Copay	$200 Copay	

$6,350
$12,700

Blount County Government
Effective Date: 1/1/2016 - 12/31/2016

OAP Discount Guarantee Proposal

- One discount will be guaranteed per site, encompassing all categories of utilization (IP, OP, physician, etc.).
- Applies to In-Network Fee-For-Service charges only.
- Guarantee does not apply to:
  - Charges that are not fee-for-service charges (e.g. capitation payments)
  - Charges for services/supplies that are not Covered Services (such as COB, plan exclusions, UM denials, pending or duplicate charges, etc.)
  - Charges made by providers that are not Participating Providers in a Service Area
  - Charges that involve payment of in-network benefits to out-of-network providers
  - Claims of Participating Providers whose reimbursement rates are regulated by a state and not, therefore, negotiable by Cigna
  - Services provided under an agreement with providers where all billed charges equal negotiated discounted charges (such as Gentiva, NIA, etc.)
  - Charges made by any Cigna HealthCare company (e.g. including but not limited to Tel-Drug, Inc., Tel-Drug of Pennsylvania, Inc., Cigna Behavioral Health and Cigna HealthCare of Arizona, Inc.'s staff model)
  - Claims for members over age 65.
- Claims in excess of $100,000 will be removed in their entirety from the discount guarantee calculation.
- Guarantee presumes that the normal charges made by network providers (i.e. hospital's charge masters and billed charges for other providers) remain flat or increase. In the event that the normal charges of participating providers decrease, the discount target will be reduced accordingly.
- Guarantee presumes there will be no substantial changes (i.e. including but not limited to the addition of a new participating hospital, termination of a participating hospital) in Cigna HealthCare's network in the Service Area that could potentially affect the discount in place.
- If the actual number of employees enrolled on the Effective Date differs by 15% or more from the projected enrollment Cigna HealthCare may revise the Performance Guarantees to account for such difference.
- Guarantee will be reconciled after the close of the policy period by comparing a ***weighted average*** of actual discounts achieved to a ***weighted average*** of the guaranteed discounts. The weighting used to determine the weighted average will be the proportion of In-Network considered charges generated in each site as a percentage of the total.
- Guarantee assumes an industry standard Covered Charges trend from a third party. If the increase in Covered Charges from the third party is greater than the actual increase in Covered Charges by more than 1%, Cigna HealthCare may revise the discount guarantee percentage.
- Maximum Pay-out is equal to $4.00 PEPM of the Access Fee for the sites that are included in this guarantee.

Performance Guarantees
Blount County Government
Effective Start Date: January 1, 2016

Allegiance™
a Cigna Company

IMPLEMENTATION

	Amount At Risk
Identification Card Delivery Implementation ID Card Timeliness. 98% of the ID cards will be mailed by the agreed upon commitment date in the Implementation Calendar. Results measured at Account Level.	1%
Claim Readiness Implementation Claim Readiness. Benefit Profile and eligibility information loaded on claims processing system as of the Commitment Date set forth in the approved Implementation Calendar. Results measured at Account Level.	1%

SERVICE

	Amount At Risk
Claim Time-to-Process Medical Time to Process. Measured for the Term of the Agreement, results will meet or exceed: 90% of Claims processed w/in 14 Calendar Days. Results measured at Account Level.	2%
Financial Accuracy Medical Financial Accuracy. Measured for the Term of the Agreement, results will meet or exceed: 99% of total audited claim dollars are correctly paid. Results measured at Office Level.	2%
Payment Accuracy Medical Payment Accuracy. Measured for the Term of the Agreement, results will meet or exceed: 97% of total audited claims are correctly paid. Results measured at Office Level.	2%
Average Speed of Answer Medical ASA. Measured for the Term of the Agreement, 75% of all calls aswered within 55 seconds or less. Results measured at Special Account Queue.	1%
Call Abandonment Rate Medical Call Abandonment Rate. Measured for the Term of the Agreement, results will not exceed: 3% of calls received by Call Center(s) terminated. Results measured at Special Account Queue.	1%
Automated Maintenance Eligibility Processing Auto Eligibility Processing. Measured for the Term of the Agreement, results will meet or exceed: 99% files processed in 2 Business Days after the receipt of clean eligibility. Results measured at Account Level.	1%
Account Management Account Management. Composite Score (all categories) of 3.0 or better on the Account Management Report Card based on four (4) quarterly scorecards. Results measured at Account Level.	1%

Fees are based on the base medical admin fee only. Implementation performance guarantee is based on first month's administration fees. Fees will be paid at end of first month if not met. Regular Service performance guarantees will be based and paid on annual review of performance metrics. Client will receive quarterly performance standards for review.

Client References

Collier County Government
Contact: Alice Toppe
239-252-8966/239-252-8983
alicetoppe@colliergov.net

The District School Board of Collier County
Contact: Jane Knoble-Manalich
239-377-0355/239-377-0376
knoblj@collierschools.com

Douglas County School District
Contact: Rosa Reynolds
720-433-1252
Rosa.reynolds@dcsdk12.org

Montana Association of Counties
Contact: Alyce Bailey
406-443-8102
abailey@mtcounties.org

Montana Municipal Interlocal Authority
Contact: Amanda Clark
406-443-0907

Allegiance – *References for Blount County Government*

(1) Collier County

- 4 Years with Allegiance
- Meritane
    - They were acquired – Felt like little fish in big pond
    - Didn't like the lack of flexibility on Reporting
- Liked that Allegiance was a smaller TPA
    - Still have a weekly call for issues
    - Fly in every quarter
- CIGNA
    - Use their network
    - Uses Collier Private network as well
    - Don't have issues with CIGNA blaming Allegiance or vice versa
        - They have setup where uncertain claims come back to the group
- Claims payments
    - Use it and it's wonderful!
    - Turning it over in 3 days
- Moved to self-insured Dental from Fully-Insured
    - Saved a lot of money and claims processing is now very smooth

(2) District School Board of Collier County

Cole is going to receive a call back. She spoke highly of Allegiance in the minute call.

- ~5000 Employees
- ~6000 Members
- 2013 went with Allegiance
    - 3 year contract with option to renew
    - Service to HR and to Employees second to none
- Prior to Allegiance they were with First Service Administrators
    - Bought out by MedSafe out of Ohio
    - Moved after acquisition due to service and claims payment
    - Used Previous administrator for claims run-out
- Local network thru Community Health Partners
    - Wrap network thru CIGNA
    - No issues with the parent company and allegiance
- They assumed a private Oncology network previously negotiated without issue
    - Private Oncology network is going out of business
    - Allegiance has created an alternative solution
- Quarterly in-person claims analysis

- Contracts separate RX vendor without issue
- Very flexible and open to whatever needs arise
- Have lived up to all of the promises in the sales process
- Will be happy to share any information needed including contractsAro

(3) **Douglas County School District** – Rosa Reynolds
- 7/15/15 – Karl left voicemail

(4) **Montana Association of Counties** – Alyce Bailey
- 10 years with Allegiance
    - Created a self-funded plan in 2005 to create coverage for all Montana County employees
    - Selected Allegiance at that time and been with them ever since
    - Board of Trustees doesn't even entertain other proposals when asked from other carriers (ex: BlueCross BlueShield) – they won't even allow them to quote
    - Excellent and support
- CIGNA network is for out of state providers – has worked great for their employees while travelling
    - Allegiance has a direct network in the state of Montana
    - Even though the CIGNA network is used as a "wrap," the client really has no interaction with CIGNA. Everything they do is handled through Allegiance.
    - Never encountered an issue where there is a lack of communication between Allegiance and CIGNA.
- Quarterly reporting provided, or anytime they request them
- Verisk* - the group has access to this and loves everything it has to offer and how user-friendly it is!
- 1400 employees- around 2500 lives
- Currently use Caremark as their PBM
    - Went with ExpressScripts in 2005, but experienced a lot of problems
    - Moved to Caremark in 2007 and been very happy with them.
- All enrollment is done on paper- so they have no feedback on EDI feed to Allegiance. However, there are never any type of enrollment issues, either during open enrollment or new hires.
- Self-Funded Dental and Vision – Allegiance processes these claims.
- Life insurance is with outside vendor. They can enter this in the Allegiance system, and Allegiance does the consolidated billing for them.

(5) **Montana Municipal Interlocal Authority** – Amanda Clark
- 7/15/15 – Karl left voicemail

EMPLOYERS HEALTH

EMPLOYERS HEALTH PERFORMANCE GUARANTEES

Definitions and Limitations Applicable to the Performance Standards

The proposed performance standards are subject to the definitions and limitations set forth in the Definitions and Limitations descriptions below.

Definitions:

For purposes of the performance standards herein:

- Business Day will mean CVS/caremark's Normal Business Hours on any day other than a Saturday or Sunday or a day on which CVS/caremark is closed for general business purposes.

Limitations:

CVS/caremark will diligently attempt to maintain its performance at the levels represented herein, provided that failure to achieve or maintain those levels does not constitute a default for purposes of the termination provisions set forth in the Agreement. The proposed performance standards will be adjusted equitably by the parties to the extent that CVS/caremark has suffered a Force Majeure Event during the applicable measurement period.

CVS/caremark will not be liable to Participating Group for any failure to satisfy a performance standard during any time that no agreement existed between CVS/caremark and EHPC, even if a subsequent written agreement between the parties provides that the effective date of the Agreement is prior to the time at which the written agreement actually was executed by the parties.

The maximum penalty that CVS/caremark will have at risk for any Plan year will be as stated below for EHPC for that calendar year. The total amount at risk will be calculated and allocated as set forth below. Unless otherwise specified, all performance guarantees are to be paid to EHPC. EHPC will distribute monies equitably (based on covered lives) among all Participating Groups.

- Penalty Amount for Ongoing Guarantees – EHPC's annual performance pool will be equal to the total number of Plan Participants among the EHPC Participating Groups, as determined below, multiplied by $10.00. The total penalty amount for each Participating Group toward applicable performance guarantees will equal the number of Plan Participants within the Participating Group multiplied by $10.00.

- Penalty Amount for Implementation Guarantees – EHPC's annual performance pool will be equal to the total number of Plan Participants among the EHPC Participating Groups, as determined below, multiplied by $10.00. The total penalty amount for each Participating Group toward applicable performance guarantees will equal the number of Plan Participants within the Participating Group multiplied by $10.00.

- Penalty Amount for Medicare Part D Subsidy Guarantees – EHPC's annual performance pool will be equal to the total number of Plan Participants among the EHPC Participating Groups, as determined below, multiplied by $2.00. The total penalty amount for each Participating Group toward applicable performance guarantees will equal the number of Plan Participants within the Participating Group multiplied by $2.00.

- Determining Number of Plan Participants – For penalty calculation purposes, the number of covered lives will be based on the actual number of Plan Participants within the Participating Group as of the effective date or the first day of the anniversary being measured (Example: for the period 1/1/08 – 12/31/08, total penalty amount available will be $10.00 multiplied by the actual number of covered lives on 1/1/08).

CVSHealth

- Effective Date – Performance guarantees will be based on a calendar year for Participating Groups with January 1 effective dates when CVS/caremark begins providing services. For those Participating Groups whose effective date is other than January 1 when CVS/caremark begins providing services, Performance guarantees will be prorated for the first calendar year and based on a calendar year for any subsequent years.

If CVS/caremark fails to satisfy a performance standard that is measured for all CVS/caremark customers utilizing the same process platform, CVS/caremark will have satisfied a performance standard regarding EHPC if it satisfies that standard with respect to EHPC only.

CVS/caremark's obligations to meet the performance standards described herein are subject to the terms and conditions set forth in the Agreement. In the event of any conflict between the terms herein and the terms of the Agreement, the terms of the Agreement will control and govern the obligations of the parties regarding such matters.

If CVS/caremark fails to meet the proposed standards, the penalties described herein will be the sole and exclusive remedy available to EHPC for such failure. To the extent permitted by law, any statutory remedies that are inconsistent with the provisions hereof are waived.

If any period covered by the Agreement is less than the period covered by the proposed performance standard, and CVS/caremark has not met such performance standard for such period, the penalty associated with such failure will be prorated to reflect the actual period during which the Agreement was in effect.

Unless otherwise indicated with respect to a specific performance standard, CVS/caremark's satisfaction of the proposed performance standards will be:

(i) Monitored internally by CVS/caremark on a quarterly basis for those Participating Groups who have 5,000 or more card holders and on an annual basis for the remaining Participating Groups.
(ii) Measured by CVS/caremark on a calendar-year basis for all CVS/caremark customers utilizing the same process platform.

Service Performance Standards	Guarantee	Measurement Basis	Measurement	Amount at Risk
Percent of available pharmacies in largest network nationally. This guarantee assumes a pharmacy universe of active retail stores, and that pharmacies remain in business, are not involved in fraudulent activities, or perform any actions that warrant removal from the network. This guarantee does not apply to pharmacy changes due to EHPC or Participating Groups' request for removal of pharmacies from the network.	98%	Quarterly within sixty (60) days after the end of the quarter.	Quarterly	Should CVS/caremark fail to meet this guarantee, CVS/caremark shall credit EHPC 3% of the total amount at risk for each Participating Group.
Network Pharmacy POS Compliance				
Percent of time internal on-line system are available. Percent of time CVS/caremark's online claims processing system will be available for access by CVS/caremark's contracted pharmacies, excluding normal scheduled maintenance, as measured on a contract year basis. This standard will not apply when CVS/caremark does not have total control over the environment or communication links that impact the claims adjudication process due to third-party involvement. Scheduled maintenance will not be performed during routine pharmacy business hours.	99.90%	Quarterly within sixty (60) days after the end of the quarter as measured on a CVS/caremark book of business basis for clients utilizing the same process platform.	Quarterly	Should CVS/caremark fail to meet this guarantee, CVS/caremark shall credit EHPC 3% of the total amount at risk for each Participating Group.

Network Pharmacy Management				
Percent of EHPC network pharmacies that submit 500 or more Claims a year to CVS/caremark audited on-site each year.	**2%**	Annually within sixty (60) days after the end of the year.	Annual	Should CVS/caremark fail to meet this guarantee, CVS/caremark shall credit EHPC 3% of the total amount at risk for each Participating Group.
Subject to the availability of any active retail pharmacy within the specific area, CVS/caremark shall include a pharmacy within five (5) miles of the residence of Plan Participants when Plan Participants have an active retail pharmacy within five (5) miles of their residences.	**95% of Plan Participants**	Annually within sixty (60) days before the end of the calendar year on an EHPC book of business basis.	Annual	Should CVS/caremark fail to meet this guarantee, CVS/caremark shall credit EHPC 3% of the total amount at risk for each Participating Group
Enrollment Eligibility Updating				
Percent of ongoing eligibility updates processed within two (2) business days of receipt of a clean and complete eligibility file in an agreed upon format.	**99%**	It is measured as a percentage of all eligibility and dependent data transmitted to CVS/caremark on a quarterly basis. This will be measured on a Participating Group basis.	Quarterly	Should CVS/caremark fail to meet this guarantee, CVS/caremark shall credit EHPC 3% of the total amount at risk for each Participating Group.

Retail Paper Claims Processing Time				
Percent commercial paper claims submitted by Plan Participants, not requiring clarification processed within a weighted average of ten (10) business days. Business days are calculated from the date the Claim is received to the date the Claim is processed.	90%	Quarterly within sixty (60) days after the end of the quarter. This is measured on a Participating Group basis.	Quarterly	Should CVS/caremark fail to meet this guarantee, CVS/caremark shall credit EHPC 3% of the total amount at risk for each Participating Group.
On average, the number of business days within which CVS/caremark shall process 100% of commercial paper claims submitted by members not requiring intervention. Business days are calculated from the date the Claim is received to the date the Claim is processed.	Fifteen (15) business days	Quarterly within sixty (60) days after the end of the quarter. This is measured on a Participating Group basis.	Quarterly	Should CVS/caremark fail to meet this guarantee, CVS/caremark shall credit EHPC 3% of the total amount at risk for each Participating Group.
Mail Order Claims Processing Time				
On average the number of business days within which CVS/caremark shall dispense and ship at least 100% of all clean (not requiring intervention) mail service pharmacy Prescriptions, as measured on a contract year basis. The average calculation is determined by taking the total number of prescriptions shipped (as recorded by CVS/caremark's systems) multiplied by the number of days these prescriptions to ship divided by the total number of shipped prescriptions.	Two (2) business days	Quarterly within sixty (60) days after the end of the quarter. This is measured on an EHPC book of business basis.	Quarterly	Should CVS/caremark fail to meet this guarantee, CVS/caremark shall credit EHPC 5% of the total amount at risk for each Participating Group.

Mail Order Claims Processing Time				
On average the number of business days within which CVS/caremark shall dispense and ship at least 100% of all non-clean (requiring intervention or clarification) mail service pharmacy Prescriptions. The average calculation is determined by taking the total number of prescriptions shipped (as recorded by CVS/caremark's systems) multiplied by the number of days these prescriptions took to ship divided by the total number of shipped prescriptions.	Five (5) business days	Quarterly within sixty (60) days after the end of the quarter. This is measured on an EHPC book of business basis.	Quarterly	Should CVS/caremark fail to meet this guarantee, CVS/caremark shall credit EHPC 5% of the total amount at risk for each Participating Group
Retail Claims Processing Accuracy				
CVS/caremark guarantees electronic Claims processing accuracy for retail pharmacies will be at least 99.5% in any Contract Year for which EHPC conducts a Claims audit as provided in the audit rights section of this Agreement. Upon a final and conclusive determination of any discrepancies discovered by such a Claims audit, the electronic Claims processing accuracy rate shall be calculated based upon the following formula: ((total number of electronic retail paid Claims processed in sample) - (number of electronic retail paid Claims processed incorrectly in sample)) / (total number of electronic retail paid Claims processed in sample).	99.5%	Quarterly within sixty (60) days after the end of the quarter. This is measured on an EHPC specific basis. A report will be provided for each Participating Group upon request.	Quarterly	Should CVS/caremark fail to meet this guarantee, CVS/caremark shall credit EHPC 3% of the total amount at risk for each Participating Group.

Mail Order Claims Processing Accuracy				
CVS/caremark's accuracy in dispensing Prescriptions from its mail service pharmacy (correct drug, correct strength, correct dosage form and correct participant).	99.995%	Quarterly within sixty (60) days after the end of the quarter. This is measured on an EHPC book of business basis.	Quarterly	Should CVS/caremark fail to meet this guarantee, CVS/caremark shall credit EHPC 3% of the total amount at risk for each Participating Group.
Customer Service				
Average time in seconds that inbound calls to CVS/caremark's toll-free customer service lines shall be answered. Measurement excludes calls routed to an IVR.	30 seconds	Quarterly within sixty (60) days after the end of the quarter This is measured on an EHPC book of business basis.	Quarterly	Should CVS/caremark fail to meet this guarantee, CVS/caremark shall credit EHPC 6% of the total amount at risk for each Participating Group.
Minimum percentage of inbound calls to CVS/caremark's toll-free customer service lines that are abandoned. Measurement excludes calls routed to an IVR and excludes calls abandoned by the participant within the first thirty (30) seconds.	<3%	Quarterly within sixty (60) days after the end of the quarter. This is measured on an EHPC book of business basis.	Quarterly	Should CVS/caremark fail to meet this guarantee, CVS/caremark shall credit EHPC 3% of the total amount at risk for each Participating Group.

Minimum percentage of inbound calls to CVS/caremark's toll free customer service lines that will be blocked.	1%	Quarterly within sixty (60) days after the end of the quarter. This is measured on an EHPC book of business basis.	Quarterly	Should CVS/caremark fail to meet this guarantee, CVS/caremark shall credit EHPC 3% of the total amount at risk for each Participating Group.
Percent of written inquiries received by CVS/caremark's Customer Care Department from all members will be responded to within 10 business days following the business day on which such inquiry was received.	96%	Quarterly within sixty (60) days after the end of the quarter. This is measured on an EHPC book of business basis.	Quarterly	Should CVS/caremark fail to meet this guarantee, CVS/caremark shall credit EHPC 3% of the total amount at risk for each Participating Group.
Customer Service				
Percent of issues CVS/caremark will resolve at the first point of contact. First call resolution is the number of inquiries completely resolved at the time of initial contact divided by the total inquiries.	90%	Quarterly within sixty (60) days after the end of the quarter. This is measured on an EHPC book of business basis.	Quarterly	Should CVS/caremark fail to meet this guarantee, CVS/caremark shall credit EHPC 3% of the total amount at risk for each Participating Group.
Percent of issues CVS/caremark will resolve within 5 business days.	95%	Quarterly within sixty (60) days after the end of the quarter. This is measured on an EHPC book of business basis.	Quarterly	Should CVS/caremark fail to meet this guarantee, CVS/caremark shall credit EHPC 3% of the total amount at risk for each Participating Group

Member Satisfaction Survey				
Retail Pharmacy Member Satisfaction Survey **Satisfaction surveys shall be conducted during the plan year among CVS/caremark's base of prescription drug benefit members. Survey respondents shall be selected at random from members who have recent experiences with one or more of the following CVS/caremark services: 1) Retail Pharmacy benefits; 2) Mail Service Pharmacy benefits; 3) Customer Care.** **Based upon a statistically valid sample, overall satisfaction ratings of at least 90% shall be guaranteed for Retail Pharmacy benefits. For the purposes of this guarantee, satisfaction shall be defined as Satisfied or better on the following 5-point scale; Completely Satisfied, Very Satisfied, Satisfied, Dissatisfied, Very Dissatisfied. CVS/caremark shall be responsible for survey design, data collection, analysis and all costs associated with conducting the surveys.**	90%	Quarterly within sixty (60) days after the end of the quarter. This is measured on an EHPC book of business basis. Results for each Participating Group will be provided at least annually	Quarterly	Should CVS/caremark fail to meet this guarantee, CVS/caremark shall credit EHPC 6% of the total amount at risk for each Participating Group.

Member Satisfaction Survey				
Mail Pharmacy Member Satisfaction Survey **Satisfaction surveys shall be conducted during the plan year among CVS/caremark's base of prescription drug benefit members. Survey respondents shall be selected at random from members who have recent experiences with one or more of the following CVS/caremark services: 1) Retail Pharmacy benefits; 2) Mail Service Pharmacy benefits; 3) Customer Care.** **Based upon a statistically valid sample, overall satisfaction ratings of at least 90% shall be guaranteed for Mail Service Pharmacy Benefits. For the purposes of this guarantee, satisfaction shall be defined as Satisfied or better on the following 5-point scale; Completely Satisfied, Very Satisfied, Satisfied, Dissatisfied, Very Dissatisfied. CVS/caremark shall be responsible for survey design, data collection, analysis and all costs associated with conducting the surveys.**	90%	Quarterly within sixty (60) days after the end of the quarter. This is measured on an EHPC book of business basis. Results for each Participating Group will be provided at least annually.	Quarterly	Should CVS/caremark fail to meet this guarantee, CVS/caremark shall credit EHPC 6% of the total amount at risk for each Participating Group thereafter for each consecutive quarter of below standard results.

Account Service				
Percent of calls returned by account service representative within one (1) business day of receipt.	95%	Quarterly within sixty (60) days after the end of the quarter This is measured on an EHPC book of business basis. Results for each Participating Group will be provided at least annually.	Quarterly	Should CVS/caremark fail to meet this guarantee, CVS/caremark shall credit EHPC 3% of the total amount at risk for each Participating Group.

CVS/caremark guarantees that if any issue cannot be resolved within 2 business days, CVS/caremark will, within 1 business day of receipt by the account manager, provide an estimated time of resolution via electronic or verbal communication to requestor.	90%	Quarterly within sixty (60) days after the end of the quarter. This is measured on an EHPC book of business basis. Results for each Participating Group will be provided at least annually.	Quarterly	Should CVS/caremark fail to meet this guarantee, CVS/caremark shall credit EHPC 3% of the total amount at risk for each Participating Group.
Number of days for a response to a written inquiry.	Three (3) business days	Quarterly within sixty (60) days after the end of the quarter. This is measured on an EHPC book of business basis. Results for each Participating Group will be provided at least annually.	Quarterly	Should CVS/caremark fail to meet this guarantee, CVS/caremark shall credit EHPC 3% of the total amount at risk for each Participating Group.
CVS/caremark guarantees that based on receipt of a clean, accurate and complete electronic eligibility file no later than the 5th day of the month that is prior to the effective date of the Agreement or mutually agreed upon re-issue date, that 99% of enrollees to CVS/caremark will be mailed ID cards and/or Welcome Booklets five (5) days prior to the effective date or re-issue date.	99%	Quarterly within sixty (60) days after the end of the quarter on a Participating Group basis.	Quarterly	Should CVS/caremark fail to meet this guarantee, CVS/caremark shall credit EHPC 3% of the total amount at risk for each Participating Group.
Account Service				
CVS/caremark guarantees that 99% of new members will be mailed ID cards and/or Welcome Booklets within five (5) business days of receipt of a clean, accurate and complete electronic file for ongoing eligibility updates. Implementation and re-issues are not considered part of this guarantee.	99% within five (5) business days	Quarterly within sixty (60) days after the end of the quarter on a Participating Group basis.	Quarterly	Should CVS/caremark fail to meet this guarantee, CVS/caremark shall credit EHPC 3% of the total amount at risk for each Participating Group.

Reporting Guarantee				
All monthly, quarterly, and annual reports will reflect accurate data, based upon data contained in CVS/caremark's data systems at the time the reports are produced. CVS/caremark is exempt from this standard if incomplete or inaccurate data were received on the claim or externally processed files, and/or were due to circumstances beyond CVS/caremark's control as will all updates to the on-line reporting tool provided to the division.	100%	Quarterly within sixty (60) days after the end of the quarter on a Participating Group basis.	Quarterly	Should CVS/caremark fail to meet this guarantee, CVS/caremark shall credit EHPC 3% of the total amount at risk for each Participating Group.
Generic Substitution				
CVS/caremark guarantees at least 95% of total mail service prescriptions with qualifying generics shall be dispensed with a generic product, where substitution is permitted by applicable law, the Plan Participant consents, and CVS/caremark is unrestricted in its ability to promote the dispensing of generic drugs as measured on a Contract Year.	95%	Measured on an EHPC book of business basis.	Annual	Should CVS/caremark fail to meet this guarantee, CVS/caremark shall credit EHPC 3% of the total amount at risk for each Participating Group.
Generic Utilization				
Guaranteed percentage increase in generic utilization on a Plan year basis.	1% annual increase in generic utilization	Measured on a Participating Group basis.	Annual	Should CVS/caremark fail to meet this guarantee, CVS/caremark shall credit EHPC 3% of the total amount at risk for each Participating Group.

Management Report Timeliness				
Quarterly standard management reports for Participating Groups on the QL processing platform shall be available within thirty (30) days after the end of each calendar quarter. Quarterly standard management reports for all other Participating Groups shall be available within forty-five (45) days after the end of each calendar quarter.	100%	Quarterly within sixty (60) days after the end of the quarter on a Participating Group basis.	Quarterly	Should CVS/caremark fail to meet this guarantee, CVS/caremark shall credit EHPC 3% of the total amount at risk for each Participating Group.
Account Management				
CVS/caremark guarantees a satisfaction rating of at least 4.0 on a 5 point scale. For the purposes of this guarantee, satisfaction shall be defined as Satisfied or better on the following 5-point scale; Completely Satisfied, Very Satisfied, Satisfied, Dissatisfied, Very Dissatisfied.	4.0 satisfaction rating	Guarantee will be measured during the fourth quarter every year on an EHPC book of business basis. Survey results for Participating Groups will be made available upon request.	Annual	Should CVS/caremark fail to meet this guarantee, CVS/caremark shall credit EHPC 3% of the total amount at risk for each Participating Group

Medicare RDS Support				
RDS Subsidy reporting shall be in compliance with all MMA Part D requirements	100%	Quarterly within sixty (60) days after the end of the calendar quarter on a Participating Group basis.	Quarterly	Should CVS/caremark fail to meet this guarantee, CVS/caremark shall credit EHPC 25% of the total amount at risk for each Participating Group.
CVS/caremark shall retain all RDS claims information for the required time frame	100%	Quarterly within sixty (60) days after the end of the calendar quarter on a Participating Group basis.	Quarterly	Should CVS/caremark fail to meet this guarantee, CVS/caremark shall credit EHPC 25% of the total amount at risk for each Participating Group.

CVS/caremark shall identify all Medicare Part B prescriptions and provide to EHPC entities concurrent with each RDS Subsidy submission.	95%	Quarterly within sixty (60) days after the end of the calendar quarter on a Participating Group basis.	Quarterly	Should CVS/caremark fail to meet this guarantee, CVS/caremark shall credit EHPC 25% of the total amount at risk for each Participating Group.
RDS Subsidy submission reports will be accurate 99.99% in all areas. CVS/caremark is exempt from this standard if incomplete or inaccurate data is received on the claim or eligibility files received by CVS/caremark.	99.99%	Quarterly within sixty (60) days after the end of the calendar quarter on a Participating Group basis.	Quarterly	Should CVS/caremark fail to meet this guarantee, CVS/caremark shall credit EHPC 25% of the total amount at risk for each Participating Group.

Implementation (For New Participating Groups)			
Group Structure, Benefit Plan Design	**Plan Administration Turnaround Time.** With written Participating Group sign-off of the accuracy of Participating Group Plan design and/or requested changes and testing, CVS/caremark guarantees that Participating Group's standard Plan design changes will be implemented within 10 days. Plan design changes during November, December and January, as well as complex Plan design changes, will be implemented by a mutually agreed upon date. Participating Group will be responsible for reporting any failure to meet the above stated guarantee to CVS/caremark on an annual basis. This is measured on a Participating Group specific basis	Within 60 days after the effective date of the Participating Group being implemented	Should CVS/caremark fail to meet this guarantee, CVS/caremark shall credit EHPC 11% of the total amount at risk for each Participating Group.
Eligibility Load	Plan Participant eligibility will be loaded within 15 days of receipt of a clean and complete eligibility file in an agreed upon format.	Within 60 days after the effective date of the Participating Group being implemented	Should CVS/caremark fail to meet this guarantee, CVS/caremark shall credit EHPC 11% of the total amount at risk for each Participating Group.
Initial ID Cards	**ID Card Implementation or Re-Issue.** CVS/caremark guarantees that, based on receipt of a clean, accurate and complete electronic eligibility file no later than the 5th day of the month that is prior to the effective date of the Agreement or mutually agreed upon re-issue date, CVS/caremark will mail ID cards and/or welcome booklets to99% of Plan Participants ten (10) days prior to the effective date or re-issue date.	Within 60 days after the effective date of the Participating Group being implemented	Should CVS/caremark fail to meet this guarantee, CVS/caremark shall credit EHPC 11% of the total amount at risk for each Participating Group.
Toll Free Telephone Number (Availability)	A single integrated and dedicated toll-free telephone number for both retail and mail service assistance will be established and maintained by the date indicated in the implementation work plan for each Participating Group.	Within 60 days after the effective date of the Participating Group being implemented	Should CVS/caremark fail to meet this guarantee, CVS/caremark shall credit EHPC 11% of the total amount at risk for each Participating Group.

Implementation (For New Participating Groups)				
Communications	The CVS/caremark Implementation Project Manager will provide regular weekly updates to EHPC entities tracking the status of the implementation.		Within 60 days after the effective date of the Participating Group being implemented	Should CVS/caremark fail to meet this guarantee, CVS/caremark shall credit EHPC 11% of the total amount at risk for each Participating Group.
Post Implementation Review Meeting	The CVS/caremark Implementation Project Manager will conduct a post-implementation review meeting with EHPC entities within thirty (30) days after the effective date.		Within 60 days after the effective date of the Participating Group being implemented	Should CVS/caremark fail to meet this guarantee, CVS/caremark shall credit EHPC 11% of the total amount at risk for each Participating Group
Turnaround Time on Resolution of Implementation Issues	CVS/caremark guarantees a turnaround time of five (5) business days for resolution of implementation issues, to be measured and based on a mutually developed Implementation Plan.		Within 60 days after the effective date of the Participating Group being implemented	Should CVS/caremark fail to meet this guarantee, CVS/caremark shall credit EHPC 11% of the total amount at risk for each Participating Group
Client's Overall Satisfaction With Implementation Process	All timeline deadlines are met, cards are distributed to the correct addresses on time, communication materials are created and distributed as indicated and agreed, the benefit is set-up to adjudicate claims according to the documentation provided and agreed upon by the EHPC, and Claims adjudicate correctly based on Plan design, accepted or rejected clinical and utilization management programs, pricing and cost sharing parameters. All reporting and group, and account structure set-up are as agreed upon by the EHPC.		Within 60 days after the effective date of the Participating Group being implemented	Should CVS/caremark fail to meet this guarantee, CVS/caremark shall credit EHPC 11% of the total amount at risk for each Participating Group

Implementation (For New Participating Groups)				
Timing of EHPC's Receipt of Comments on Contract Draft by CVS/caremark Legal Department.	CVS/caremark guarantees the timing of EHPC's receipt comments to the contract draft within five (5) business days of receipt of contract comments from EHPC. For the purpose of this requirement, the business day following CVS/caremark's receipt of the EHPC's requests/comments relating to the contract shall be the first day in measuring the five (5) business day turnaround time.	Guarantee measured from delivery of each contract draft to CVS/caremark. This is measured on an EHPC basis.	Assessed after each occurrence.	Should CVS/caremark fail to meet this guarantee, CVS/caremark shall credit EHPC 12% of the total amount at risk for each Participating Group