Memorandum

MIAMI-DADE COUNTY

Date: March 28, 2013

To: Honorable Chairwoman Rebeca Sosa
and Members, Board of County Commissioners

From: Carlos A. Gimenez
Mayor

Subject: Response to Requests for Information Regarding Draft RFP 853 - Miami-Dade County Group Medical Insurance Program

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On February 22, 2013, a request for information was received from Commissioner Juan C. Zapata that included numerous questions related to the County's current health care program. Subsequent to his memorandum being issued, Commissioner Esteban Bovo, Jr. requested that a presentation on the status of RFP 853 – Group Medical Insurance Program, be provided at the March 12, 2013 Finance Committee. This was followed by a memorandum from Commissioner Barbara J. Jordan on March 8, 2013, which requested that a Board Workshop be held on the County's health insurance program. At the March 12, 2013 Finance Committee meeting, Commissioner Dennis C. Moss requested information regarding the savings experienced by employees and the County as a result of moving to a self-insurance model and re-tiering the dependent insurance plans in 2008. This response serves to address all of the requests and provide Board members with the current status of the Draft RFP, which is ready to be advertised.

Attachment 1 to this memorandum is the response to the questions proffered by Commissioner Juan C. Zapata. As you will see, Gallagher Benefits Services, Inc., our benefits consultant, was directed to analyze specific data from the AvMed data warehouse and compile responses for this request. This response addresses all of the questions with the exception of Questions 4 and 5, which AvMed stated is proprietary information in the insurance industry and could potentially put them at a competitive disadvantage in the upcoming RFP process. Also included within Attachment 1 are various Claim Review Summary reports and a Performance Evaluation of AvMed's Medical Plan Claims Administration, information that was requested separately by Commissioner Juan C. Zapata's Office subsequent to his initial list of questions. Please note that the onsite AvMed claims review for plan year 2012 will be conducted in May 2013. Additionally, claims reviews completed for plan years 2008, 2009 and 2011 are provided (no onsite claims review was conducted for 2010).

Attachment 2 is a copy of the Draft RFP. On February 22, 2013, as is customary for most RFPs, the draft solicitation was placed on the County's website for industry comment in preparation for formal advertisement, and remains available for review. **The overall purpose of this RFP is to attempt to procure the same level of benefits (actuarially equivalent), but at a lower cost for employees and the County.** The RFP also addresses a Collective Bargaining provision negotiated with the Police Benevolent Association during the 2012 negotiations that requires the County to engage in the RFP process with the intention of providing one or more competitive options to employees. Further, given that AvMed has been our administrator for over five years, it is simply good business practice to seek competition for this service.

Attachment 3 includes the original requests from Commissioners Juan C. Zapata and Barbara J. Jordan.

In 2008, when the County went to a self-insurance program and recalculated the charges for dependent premiums and included a new tier for employees insuring children, but not a spouse, it was estimated

that savings in health care and administrative costs would total $52.4 million and that those savings would be shared with employees by way of reduced premiums. The table below shows that when compared to an estimate of what dependent premiums would have been under a traditional insurance plan, using an annual growth factor of ten percent (industry standard was a ten to 12 percent annual growth factor), the dependent premiums under the self-insured program provided remarkable savings. As an example, for calendar years 2009-2013 an employee who had previously paid for coverage in the AvMed High Option HMO for their children would have saved more than $24,000 on health care coverage.

	Annualized Savings				
	2009	2010	2011	2012	2013
Type of Plan	AvMed HMO Low				
Single	$0.00	$0.00	$0.00	$0.00	$0.00
Ee+Spouse	($1,168.19)	($1,214.44)	($1,342.08)	($1,986.97)	($2,696.36)
Ee+Children	($3,623.85)	($3,928.44)	($4,331.84)	($5,206.58)	($6,168.79)
Family	($1,529.55)	($1,561.40)	($1,692.06)	($2,566.80)	($3,529.01)
	AvMed HMO High				
Single	$0.00	$0.00	$0.00	$0.00	$0.00
Ee+Spouse	($1,586.53)	($1,679.58)	($1,252.11)	($1,919.03)	($2,652.65)
Ee+Children	($4,052.50)	($4,404.14)	($4,333.45)	($5,235.23)	($6,227.20)
Family	($2,074.68)	($2,169.70)	($1,535.85)	($2,437.63)	($3,429.60)
	AvMed HMO POS				
Single	($25.81)	($34.76)	($32.36)	($74.34)	($120.51)
Ee+Spouse	($3,627.20)	($3,879.65)	($3,773.74)	($5,046.92)	($6,447.42)
Ee+Children	($8,762.60)	($9,547.42)	($10,092.53)	($11,845.02)	($13,772.76)
Family	($2,564.46)	($2,630.12)	($2,039.55)	($3,784.24)	($5,711.98)

The following total shows the total savings each year in health care coverage costs and the amount of savings provided to the employees.

Calendar Year Savings

	Traditional Insurance	Self-Insurance and Re-tiering	Cost Avoidance	Total Employee Savings
2009	$ 364,259,720	$ 343,646,485	$ 20,613,235	$ 40,520,217
2010	$ 379,194,369	$ 358,268,037	$ 20,926,332	$ 42,782,786
2011	$ 406,572,202	$ 334,132,879	$ 72,439,323	$ 33,889,574
2012	$ 462,638,509	$ 387,563,633	$ 75,074,876	$ 43,853,108
2013	$ 513,179,935	$ 319,336,000	$ 193,843,935	$ 50,662,318

We are ready to advertise this solicitation. Given the complexity of the solicitation, we expect to advertise for approximately four to five weeks to allow proposers time to develop their proposals; six to eight weeks to allow for the evaluation period; and ideally, full Board approval of a contract award by July 2013. The July 2013 award date is especially important given that approximately four months will be necessary to implement a new contract in an orderly manner, which includes engaging our collective bargaining partners, and preparing for an open enrollment period to have a new plan in place effective January 1, 2014. In addition, we have asked for representation from our largest union, AFSCME Local 199, to serve on the Selection Evaluation Committee.

If a Board workshop on the insurance issue is to be scheduled, we respectfully request that it be conducted within the next two weeks given the tight timeline of the RFP process.

Please do not hesitate to contact me or Deputy Mayor Edward Marquez at (305) 365-1451 if you have additional questions.

Attachments

c: Office of the Mayor Senior Staff
Lester Sola, Director, Internal Services Department
Jennifer Moon, Director, Office of Management & Budget
Arleene Cuellar, Acting Assistant Director, Internal Services Department

ATTACHMENT 1

Healthcare Analytics

A Division of Gallagher Benefit Services, Inc.

March 21, 2013

Mr. Lester Sola
Director, Internal Services Department
Miami-Dade County
111 NW 1st St.
Miami, FL 33128

Re: February 22, 2013 Request from Commissioner Zapata

Dear Lester:

Following is our response to the request from Commissioner Zapata to Mayor Gimenez. In addition to responding to the questions included in the request, we have added clarifying and/or additional information that we feel might be helpful.

1. *Could you provide the projected health care cost (budget) to actual for the past 5 fiscal years?* The actual and budget self-funded health plan expenses are summarized in the following table.

Fiscal Year	Actual/Budget	MDC	JHS	Total
2008	Budget	$243,932,400	$58,595,800	$302,528,200
	Actual	$211,808,002	$41,825,097	$253,633,099
2009	Budget	$289,702,600	$56,331,800	$346,034,400
	Actual	$280,381,049	$63,265,435	$343,646,485
2010	Budget	$284,092,300	$67,262,800	$351,355,100
	Actual	$289,301,855	$68,966,182	$358,268,037
2011	Budget	$314,127,500	$24,080,600	$338,208,100
	Actual	$301,308,399	$32,824,480	$334,132,879
2012	Budget	$337,598,600	$87,631,300	$425,229,900
	Actual	$324,881,119	$62,682,514	$387,563,633

Fiscal year 2008 is a partial year because the self-funded plan started during the year (January 1, 2008). JHS left the self-funded plan effective January 1, 2011, causing the sharp drop in JHS expenses for FY 2011 and FY 2012. JHS returned to the self-funded plan effective January 1 2012. The FY 2012 budget included the estimated costs of the PHT employees participating in the County's plan. It was anticipated that the nine-month cost for this group would be approximately $90 million.

2. *What is the expected health care cost for the current fiscal year and how are we tracking with actuals?* The following chart shows the projected Fiscal Year 2013 health plan costs split between the County and Jackson Health System. The chart shows costs in both annual dollars and on a Per Employee Per Month ("PEPM") basis.

	MDC		JHS		Total	
Average Lives	26,562		8,320		34,882	
	Annual	**PEPM**	**Annual**	**PEPM**	**Annual**	**PEPM**
Projected Annual Claims						
Medical	$257,739,143	$808.60	$73,553,121	$736.71	$331,292,264	$791.45
Pharmacy	$48,375,640	$151.77	$14,696,708	$147.20	$63,072,348	$150.68
Capitation	$3,397,513	$10.66	$1,023,158	$10.25	$4,420,671	$10.56
Subtotal	**$309,512,296**	**$971.03**	**$89,272,987**	**$894.16**	**$398,785,283**	**$952.69**
ASO Fees	**$9,740,854**	**$30.56**	**$3,051,163**	**$30.56**	**$12,792,017**	**$30.56**
PCORI Fee *	**$83,150**	**$0.26**	**$24,467**	**$0.25**	**$107,617**	**$0.26**
Total Expense	**$319,336,299**	**$1,001.85**	**$92,348,618**	**$924.97**	**$411,684,917**	**$983.51**

* Patient Centered Outcomes Research Institute fee. The fee is $1 per member per year in 2012 and $2 per member per year in 2013. Payable annually by July 31 of following year.

For the County alone, we projected total expenses of $319.3 million, based on claims of $309.5 million, administrative fees of $9.7 million, and a fee under the healthcare reform law of a little under $100,000. The budget for the fiscal year is $353 million.

3. *How important is cost transparency related to urgent and emergency services?* Transparency is important for all services, and this area is no different. The County has unusually high emergency room utilization, likely due in part to the very low copays that members pay for using an ER. During the 2013 medical plan re-design project, we looked at options that would have increased the ER copay while leaving Urgent Care copays at current levels in the hope that members would make greater use of the less expensive Urgent Care facilities, but those changes were not implemented because the County's labor unions were resistant to a change in the ER copay and all plan design changes are subject to collective bargaining. During the analysis, we were made aware that some hospitals in Miami-Dade County operate what are advertised as Urgent Care centers but have reimbursement rates that are more in line with ER rates, so steering members to those Urgent Care facilities would not save the County anything. In order to properly evaluate plan design changes, it is necessary to know how the Urgent Care facilities are paid, so cost transparency is critical.

4. *What discussions are in place, if any, to modify provider reimbursement for purposes of aligning incentives and fostering accountability of the system?* We are waiting on a response from AvMed regarding their contracting initiatives. AvMed has raised a concern about responding to this question at a time when an RFP is about to be released.

5. *What is the reported discount by carrier, HMO and PPO?* We are waiting on a response from AvMed regarding their discounts. AvMed has raised a concern about responding to this question at a time when an RFP is about to be released.

6. *Do we currently measure the rate of utilization and return on investment of wellness programs? What are the wellness programs currently in place and what is the current engagement?* Throughout the year, Benefits Administration works with the County's healthcare providers to bring a wide range of health screenings and educational information to Miami-Dade County employees. The current wellness focus consists of a **'Know Your Numbers'** campaign with various health fairs conducted throughout the County. At these health fairs, onsite health professionals perform biometric screenings, and provide lunch and learn presentations on various health and wellness topics. The County's wellness program has a very limited budget of $0.34 per employee per month and as such, return on investment is not measured, however attendance is tracked at each event offered. The objective is primarily to increase employees' awareness of their health status and encourage a healthier lifestyle.

7. *What are the Disease Management Programs currently in place and what are the outcomes? How many are participating in these programs? What is the ROI?* The County purchased Disease management ("DM") services from AvMed in 2011 but discontinued them effective January 1, 2012 because the County was not convinced that the program was paying for itself. The design of the DM program automatically enrolled all applicable members (with the option to voluntarily opt out) yet enrolled participants may not have been actively engaged in the program. The County did not feel the ROI estimates provided by AvMed could be validated.

   We have analyzed the County's data and there is certainly an opportunity for a well managed DM program to save the County money. Our data warehouse includes a health risk software package developed by 3M and known as Clinical Risk Group ("CRG"). The highest level CRG analysis simply splits County members into 4 categories, including non claimants (those with no claims in the experience period), healthy claimants (those with only routine preventive care visits but no illness or injury diagnosis), acute claimants (those with a single episode of care, either due to accident or illness, but who do not have an ongoing medical condition), and chronic claimants (those with ongoing disease conditions). Following is a summary of the County's results for the period from October 2011 through September 2012.

Clinical Category	% of Actual Claimants	Expected % of Claimants	% of Total Claims
Non Claimant	9.3%	21.9%	0.0%
Healthy Claimant	35.9%	40.1%	10.5%
Acute Claimant	6.2%	5.2%	5.3%
Chronic Claimant	**48.6%**	**32.7%**	**84.2%**
Total	100.0%	100.0%	100.0%

The table shows that the County has a much higher incidence of chronic illness than our benchmarks would suggest. Our benchmarks are based on our entire client block and are adjusted for demographics. We have drilled down further and found that within the chronic illness category, the County has high frequencies of conditions for which DM programs are available (e.g. diabetes and hypertension). This does not mean the decision to terminate the DM program was a bad one. It does suggest that if a DM program focused on the right conditions can be developed at a reasonable fee, it has the potential to save the County money.

8. *Can we measure claims and utilization rates by bargaining unit?* Participants are not currently reported by bargaining unit to the health plan. Benefits staff is currently pursuing capturing bargaining unit affiliation on eligibility files.

9. *What is the case mix adjusted cost per case by hospital system?* Case mix is a measure of severity and adjusting by case mix is a means of providing a more normalized comparison of costs between facilities. A facility with a lower cost per case mix adjusted admission would be considered more efficient than a facility with a higher cost. The following table summarizes the case mix adjusted dollars paid per inpatient admission. The table includes all claims incurred from July 1, 2011 through June 30, 2012 and paid through September 30, 2012. Medicare Diagnosis Related Group ("DRG") weights are used as the basis for case mix, and hospital systems are listed in order of decreasing total inpatient dollars paid.

HOSPITAL SYSTEM	# of Admits	Paid per Admit	Average Case Mix	Case Mix Adjusted Paid Per Admit
BAPTIST HEALTH SYSTEM	1,261	$16,180	1.25	$12,988
MEMORIAL HEALTH SYSTEM	590	$14,154	1.16	$12,235
UNIVERSITY OF MIAMI	313	$17,674	1.34	$13,170
AVENTURA HOSPITAL AND MEDICAL CENTER	209	$24,203	1.62	$14,975
MIAMI CHILDREN'S HOSPITAL	104	$34,508	1.48	$23,268
JACKSON HEALTH SYSTEM	373	$7,411	1.38	$5,380
MT SINAI MEDICAL CENTER	168	$16,079	1.60	$10,057
PALMETTO GENERAL HOSPITAL	116	$15,449	1.24	$12,477
KENDALL REGIONAL MEDICAL CENTER	98	$15,502	1.20	$12,908
MERCY HOSPITAL	104	$14,587	1.10	$13,226
NORTH SHORE MEDICAL CENTER	105	$13,109	0.95	$13,855
CLEVELAND CLINIC HOSP – WESTON	62	$15,529	1.52	$10,186
HIALEAH HOSPITAL	63	$15,044	1.05	$14,332
Total All Admits	**4,164**	$15,353	**1.26**	**$12,149**

Most of the systems are reasonably similar, in the $12,000 to $14,000 range. Miami Children's has a very high case mix adjusted cost per admission, but there is a strong argument that Medicare DRG weights do not do a good job for pediatric admissions. We investigated the low cost per admission at Jackson Health System and we have concluded

that they are mainly a function of lower reimbursement rates at the Jackson facilities. We see the same result on outpatient services performed at the Jackson facilities. This suggests that AvMed has negotiated lower reimbursement rates with Jackson than with other hospitals in the area, yielding a lower cost per service at Jackson than at other hospitals.

10. Provide a breakdown of utilization by hospital both on a percentage basis and cost. See Attachment A for exhibits showing total hospital utilization on an inpatient, outpatient, and combined basis. The tables are based on claims incurred from July 1, 2011 through June 30, 2012 and paid through September 30, 2012. Each exhibit lists the top 14 facilities. Baptist Health System, Memorial Health System, and the University of Miami Hospital and Clinics are the 3 most used systems for both inpatient and outpatient claims.

11. Provide numbers on the usage of Urgent Care centers and the median and average cost per visit. We sorted Urgent Care visits into 3 categories. First, there are the free standing Urgent Care centers that are not affiliated with or billed through a hospital system. These are the least costly urgent care settings. Second, there are free standing clinics operated by hospitals that are billed through the hospital. Finally, there are Emergency Room visits that are billed under a code that identifies them as urgent, rather than emergency, care. Visits for all 3 categories for the 12 months ending June 30, 2012, are summarized in the following table. The claim amounts include all charges associated with the visit, including physician and facility charges.

Setting	# of Visits	Paid by Plan	Paid/Visit
Urgent Care Center	2,535	$528,067	$208
Clinic	7,580	$4,133,686	$545
Hospital	1,532	$602,530	$393
Total	**11,647**	**$5,264,283**	**$452**

It is clear the urgent care visits that are affiliated with hospital systems have a much higher average cost than visits to independent centers. Our analysis does not include a severity measure, so we can't address the question of whether members with more serious conditions are more likely to use a hospital-affiliated center. While Urgent Care visits are much less costly than Emergency Room visits (see Question 13 below for more information on that), we are seeing some blurring of the distinctions between Urgent Care and Emergency Care with some of the major hospital systems.

12. What is the average cost per day at the top 5 facilities? The following chart summarizes the paid claims, days, and cost per day at the top 5 inpatient facilities.

Rank	Hospital Name	Claims Paid	# of Days	Paid Per Day
	BAPTIST HEALTH SYSTEM			
	BAPTIST HOSPITAL OF MIAMI, INC	$10,101,664	3,101	$3,258
	SOUTH MIAMI HOSPITAL, INC.	$5,827,869	1,270	$4,589
	WEST KENDALL BAPTIST HOSPITAL INC	$1,183,442	260	$4,552
	HOMESTEAD HOSPITAL INC	$919,123	276	$3,330
1	**SUBTOTAL**	**$18,032,097**	**4,907**	**$3,675**
	MEMORIAL HEALTH SYSTEM			
	MEMORIAL HOSPITAL-WEST	$3,613,336	1,065	$3,393
	MEMORIAL REGIONAL HOSPITAL	$3,017,734	795	$3,796
	MEMORIAL HOSPITAL MIRAMAR	$1,257,971	518	$2,429
	MEMORIAL HOSPITAL OF PEMBROKE	$461,740	212	$2,178
2	**SUBTOTAL**	**$8,350,781**	**2,590**	**$3,224**
	UNIVERSITY OF MIAMI			
	UNIVERSITY OF MIAMI HOSPITAL	$5,147,661	1,171	$4,396
	UNIVERSITY OF MIAMI HOSP & CLINICS	$384,406	219	$1,755
3	**SUBTOTAL**	**$5,532,067**	**1,390**	**$3,980**
4	**AVENTURA HOSPITAL AND MEDICAL CENTER**	**$5,058,505**	**924**	**$5,475**
5	**MIAMI CHILDREN'S HOSPITAL**	**$3,588,780**	**544**	**$6,597**

13. *What is the utilization and cost of Emergency Room versus Urgent Care?* The County's Emergency Room utilization has historically been very high. For the 12 months ending June 30, 2012, including runout claims paid through September 30, 2012, the County averaged 317 ER visits per 1000 members per year. Gallagher's benchmark for a similar population is just under 200 visits per 1000 members. The average facility cost per ER visit was $1,349, with another $262 in physician charges. By comparison, the County averaged 45 visits to Urgent Care centers, with an average cost per visit of $208, including all physician and facility charges. If we include visits to clinics and Emergency Room departments coded as Urgent Care, the utilization was 206 visits per 1000 members with an average cost of $452 per visit.

14. *What is the cost and utilization of Emergency Room by Facility?* The top ER facilities for the 12 month period from July 2011 through June 2012 (with runout claims paid through September 30, 2012) are summarized in Attachment B. The top 4 individual facilities as measured by claim dollars paid are all in the Baptist Health System.

15. *What is the healthcare cost PEPM for each of the last 3 fiscal years?* Per Employee Per Month Fiscal Year paid expenses as reported by AvMed are summarized in the following table. The table excludes PHT, but includes actives, COBRA participants, and retirees.

	PEPM Expense by Fiscal Year		
Expense	**2009/10**	**2010/11**	**2011/12**
Average Employees	27,965	27,318	27,095
Medical Claims	$670.92	$702.28	$774.36
Pharmacy Claims	$141.08	$155.82	$158.34
Capitation Claims	$8.28	$10.59	$10.43
Total Claims	**$820.29**	**$868.70**	**$943.14**
Administration	$34.40	$32.82	$30.49
Total Expense	**$854.68**	**$901.52**	**$973.63**

16. *What are the RX rebates for the past 3 fiscal years?* Under its Agreement with AvMed, pharmacy rebates are paid to the County in two stages. There are rebate credits built into the Administrative fee that serve to reduce the per employee per month fee by a specified amount that is adjusted from year to year based on plan experience. The second stage is a true up performed by AvMed that compares actual rebates earned to the PEPM credit. Depending on the results of the true up, either AvMed will owe the County a final settlement, or vice versa. Because rebates are paid by the manufacturers to AvMed's Pharmacy Benefit Manager in hindsight, the true up is conducted at the end of the year following the year to which it applies. For that reason, the most recent true up was for calendar year 2011 and at this point we do not have final data for calendar year 2012. Consequently, the following rebate amounts are actual for fiscal years 2009/10 and 2010/11 but are estimated for 2011/12. These amounts are for County employees only, although rebates are also received by the plan for PHT employees.

Fiscal Year	**Rebate Received**
2009/10	$2,845,918
2010/11	$2,704,209
2011/12 (Estimated)	$2,775,000

17. *What are the key utilization figures per fiscal year?* The following utilization measures are based on data incurred during the 12-month period from July 1, 2011 through June 30, 2012 including runout claims paid through September 30, 2012. We can update this for the most recent fiscal year when the December 2012 data feed is available in our data warehouse, likely around the end of March. We have reviewed other recent periods and found very similar results. The Gallagher benchmarks referenced below are adjusted for the County's demographics.

Inpatient Hospital: The plan averaged 73 admissions per 1,000 members, with an average length of stay of 4.7 days. This results in 345 bed days per 1000 members. The admits are close to our norms, but the average length of stay is higher than our norm of 4.1 days, and the resulting total bed days are higher than our norm of closer to 300 days.

Emergency Room: The plan averaged 317 ER encounters per 1000 members, which is very high. Our norm is closer to 200 encounters per 1000. County ER use has been at or near this level for several years.

Office Visits: The plan averaged 1,836 primary care visits per 1,000 members and 2,866 specialist visits per 1,000. The primary care use is in line with our norms, but the specialist use is very high relative to our benchmark. The increase in office visits copays implemented for 2013 is expected to result in a reduction in the frequency of office visits.

Preventive Care and Immunizations. County utilization of both preventive care visits (519 visits per 1000) and immunizations (760 per 1,000) were well above our norms (376 and 514 respectively). For these services, high utilization might be considered a positive.

Physical Therapy. The plan had almost double the number of physical therapy visits that our benchmarks would suggest. Actual utilization was 3,448 per 1,000, compared to our norm of 1,854. The increase in the specialist copay for 2013 also applies to physical therapy.

Radiology. The plan averaged 2,493 professional radiology services per 1,000, which is much higher than our benchmark of 1,606.

Pharmacy. County members average 12.5 scripts per member, which is higher than our benchmark of 10.6 scripts per member.

18. *What is expended at the top 5 facilities, showing inpatient and outpatient cost?* See Attachment A for a summary of inpatient and outpatient hospital costs by facility.

19. *What are the advantages and disadvantages to having two carriers manage our self-funded plan similar to what the state does?* It is relatively uncommon for self-funded employers to use more than one medical carrier to administer their plan. The main reasons that employers typically do not use more than one vendor are:

    - Reduced leverage in negotiating administrative fees and (where applicable) reinsurance premiums
    - Additional effort required to manage more than one vendor (multiple renewals, reviewing and merging carrier reporting, setting rates and contributions)
    - More complicated employee communications and open enrollment

- The risk of increasing cost by adding a vendor whose provider discounts are not as good

The main advantage of using more than one vendor is the additional choice that it offers employees. This is especially true for employers with multiple locations, where is it very possible that no single network provides the best mix of access and discounts in all locations. An employer like the State of Florida is a good example of this. In addition to being spread across the state, they are also large enough that they retain most of their leverage even when dealing with multiple vendors. This is less of an issue for the County, which has an overwhelming majority of employees located in a single geographic area in which most of the major carriers have a high degree of overlap in their provider networks.

20. *How much have we paid AvMed annually in administrative fees of the five year period?* AvMed's administrative fee is set on a calendar year basis. The following table summarizes the fees paid to AvMed for County employees (excluding PHT) for each year since the self-funded plan started in 2008.

		Administrative Fees	
Year	Average Employees	Annual	PEPM
2008	28,017	$10,839,249	$32.24
2009	28,246	$11,310,962	$33.37
2010	27,806	$11,591,731	$34.74
2011	27,176	$10,494,349	$32.18
2012	27,010	$9,700,912	$29.93

Note that under the pharmacy rebate process described in question 16 above, the County received significant settlements under the true up provision for years 2008 through 2010. The settlements for the MDC portion (excluding PHT), totaled approximately $900,000 for 2008, $1.6 million for 2009, and $400,000 for 2010.

21. *How do insurance programs for bargaining units that are not insured under the County's self-funded AvMed health care program compare in terms of benefits, utilization, wellness programs, costs to the County, costs to the employee, etc.?* The only County bargaining unit not covered by the County's self-funded AvMed plan is the Metro Dade Fire Fighters IAFF Local 1403. The County does not have information about benefits, utilization, or wellness programs provided under the Fire Fighters plan. That information would have to be provided directly by the Fire Fighters IAFF Local 1403.

22. *How do utilization, claims, and costs for retirees compare to active County employees?* Because healthcare costs increase with age, we expect that the cost associated with pre-Medicare eligible retirees will exceed the costs for active employees. Costs for Medicare

eligible employees are usually comparable to, or slightly below, the costs for actives because of the impact of Medicare paying primary benefits. Following is a summary of County Per Member Per Month ("PMPM") incurred costs sorted by actives, retirees, and COBRA members for the 12 months from July 2011 through June 2012, including runout claims paid through September 30, 2012. The relationship between the categories is very typical.

Category	Member Months	PMPM Claims
Actives	626,708	$471
COBRA	1,003	$1,478
Pre Medicare Retirees	44,165	$869
Medicare Retirees	6,320	$460
Total	678,196	$498

23. *Provide an analysis of the impact of PPACA (Healthcare Reform) on the County health program.* The County has already complied with several provisions of PPACA, and beginning in 2014 will have to comply with some of the major provisions of the Act as they become effective. Fortunately for the County, we do not anticipate a huge increase in costs beyond the reinsurance fee discussed in the next question.

The County has taken the following steps to comply with PPACA:

- Dependents up to age 26 are allowed to be covered, even if they are no longer full time students or dependent on the employee for financial support.
- Annual and lifetime maximums have been eliminated.
- Employee cost sharing on defined preventive services has been eliminated.
- A Summary of Benefits and Coverage has been developed for each plan and made available to employees, in a format prescribed by published regulations.
- The value of an employee's health insurance benefit is reported on the W-2 (this is a reporting issue only – the benefit is not taxable)

It is difficult to quantify the impact of the dependent age change because Florida has a state statute that requires dependents be eligible to age 30 under a different set of criteria. Therefore, if is very difficult determine which dependents who are now covered would not have been covered in the absence of PPACA. Gallagher had developed estimates of anywhere from 0.25% of claims to as much as 1.5% of claims, depending on the current dependent enrollment and how much employees have to pay to cover dependents. In the County's case, we would expect the actual cost is closer to the low end of our range.

The annual and lifetime maximums had very little effect on the County plan based on the County's existing plan provisions and the relatively small number of members affected by the limits.

The impact of eliminating cost sharing on the preventive care services was relatively small because the County had low cost sharing on these features to begin with. We estimate the impact to be approximately $300,000 per year, and we included this factor as an offset to the value of the 2013 plan design changes.

Beginning in 2014, many of the more sweeping changes included in PPACA take effect, including the existence of healthcare exchanges, the individual mandate, and a number of potential penalties for plans that fail to meet specified criteria. Because the County offers coverage that far exceeds the minimum benefit standards set out by PPACA, and at a price that meets the PPACA definition of affordability (both County HMO plans are available at no cost to the employee for single coverage), the County will not be subject to any penalties for failing to offer affordable, qualifying coverage, provided no major changes are made to the plan.

Beginning in 2018, plans whose costs exceed annual thresholds ($10,200 for employee coverage, $27,500 for family coverage) set out in PPACA will be subject to an excise tax, commonly referred to as the "Cadillac tax". The tax equals 40% of the amount by which the cost of single or family coverage exceed the threshold. The 2013 premium rates for the County's POS plans for employee, employee and spouse, and family coverage are already higher than the 2018 thresholds. If we assume no plan changes and an 8% annual plan cost increase due to medical inflation, by 2018 some of the HMO rates would also exceed the thresholds, while the POS rates would all be well above the thresholds. Under these assumptions, the current enrollment by plan and tier would trigger an excise tax of in excess of $30 million, or 6% of the projected 2018 plan cost. If no changes are made, it is likely that tax will increase each year as the plan cost is projected to grow at a faster pace than the thresholds are scheduled to increase. The County certainly has the time to take steps to reduce the impact of the Cadillac tax, but it presents an especially significant challenge to employers in South Florida, where health care costs are among the highest in the country.

24. *Provide an estimated cost to the County of any taxes imposed on self-insured plans including the Patient Centered Outcomes Research Trust Fund and if the County has to pay the reinsurance tax, which is $5.25 per member per month starting in January of 2014 and paid in 2015.* The Patient Centered Outcomes Research Institute ("PCORI") fee started at $1 per member per year in 2012, increased to $2 per member per year in 2013, and is expected to increase with medical inflation through 2019, at which time it is scheduled to expire. The fee is payable by July 31st of the year following the year for which it accrued. For the County (excluding PHT), PCOR amounted to approximately $48,000 for **calendar year** 2012 and we project a cost of $95,000 for **calendar year**

2013, with small increases thereafter for the duration of the program. The projected 2013 **fiscal year** fee is $83,150.

The reinsurance fee is charged to carriers and plan administrators for a three year period from 2014 through 2016. The 2014 fee is projected to be $5.25 per member per month (approximately $3 million for calendar year 2014), but it is expected to decrease in 2015 and 2016 as the targeted total revenue to be raised falls.

We would be happy to provide additional detail regarding these or any related questions the County Commission or staff may have.

Sincerely,

Glen R. Volk, FSA, MAAA
Area Vice President & Consulting Actuary

Attachment A

Top Inpatient Hospital Providers By Claims Paid
Claims Incurred from July 1, 2011 through June 30, 2012 and Paid through September 30, 2012

Rank	Hospital Name	Claim $ Paid	# of Admits	$ Per Admit	%of Total Claims	% of Total Admits
	BAPTIST HEALTH SYSTEM					
	BAPTIST HOSPITAL OF MIAMI, INC	$10,101,664	681	$14,834	15.8%	16.4%
	SOUTH MIAMI HOSPITAL, INC.	$5,827,869	306	$19,045	9.1%	7.3%
	DOCTORS HOSPITAL INC	$2,371,084	112	$21,170	3.7%	2.7%
	WEST KENDALL BAPTIST HOSPITAL INC	$1,183,442	72	$16,437	1.9%	1.7%
	HOMESTEAD HOSPITAL INC	$919,123	90	$10,212	1.4%	2.2%
1	**SUBTOTAL**	**$20,403,181**	**1,261**	**$16,180**	**31.9%**	**30.3%**
	MEMORIAL HEALTH SYSTEM					
	MEMORIAL HOSPITAL-WEST	$3,613,336	236	$15,311	5.7%	5.7%
	MEMORIAL REGIONAL HOSPITAL	$3,017,734	165	$18,289	4.7%	4.0%
	MEMORIAL HOSPITAL MIRAMAR	$1,257,971	146	$8,616	2.0%	3.5%
	MEMORIAL HOSPITAL OF PEMBROKE	$461,740	43	$10,738	0.7%	1.0%
2	**SUBTOTAL**	**$8,350,781**	**590**	**$14,154**	**13.1%**	**14.2%**
	UNIVERSITY OF MIAMI					
	UNIVERSITY OF MIAMI HOSPITAL	$5,147,661	271	$18,995	8.1%	6.5%
	UNIVERSITY OF MIAMI HOSP & CLINICS	$384,406	42	$9,153	0.6%	1.0%
3	**SUBTOTAL**	**$5,532,067**	**313**	**$17,674**	**8.7%**	**7.5%**
4	**AVENTURA HOSPITAL AND MEDICAL CENTER**	**$5,058,505**	**209**	**$24,203**	**7.9%**	**5.0%**
5	**MIAMI CHILDREN'S HOSPITAL**	**$3,588,780**	**104**	**$34,508**	**5.6%**	**2.5%**
	JACKSON HEALTH SYSTEM					
	JACKSON MEMORIAL HOSPITAL	$1,965,212	210	$9,358	3.1%	5.0%
	JACKSON NORTH MEDICAL CENTER	$490,079	86	$5,699	0.8%	2.1%
	JACKSON SOUTH COMMUNITY HOSPITAL	$309,090	77	$4,014	0.5%	1.8%
6	**SUBTOTAL**	**$2,764,381**	**373**	**$7,411**	**4.3%**	**9.0%**
7	**MT SINAI MEDICAL CENTER**	**$2,701,349**	**168**	**$16,079**	**4.2%**	**4.0%**
8	**PALMETTO GENERAL HOSPITAL**	**$1,792,036**	**116**	**$15,449**	**2.8%**	**2.8%**
9	**KENDALL REGIONAL MEDICAL CENTER**	**$1,519,150**	**98**	**$15,502**	**2.4%**	**2.4%**
10	**MERCY HOSPITAL**	**$1,517,069**	**104**	**$14,587**	**2.4%**	**2.5%**
11	**NORTH SHORE MEDICAL CENTER**	**$1,376,484**	**105**	**$13,109**	**2.2%**	**2.5%**
12	**CLEVELAND CLINIC HOSP - WESTON**	**$962,770**	**62**	**$15,529**	**1.5%**	**1.5%**
13	**HIALEAH HOSPITAL**	**$947,749**	**63**	**$15,044**	**1.5%**	**1.5%**
14	**HOLY CROSS HOSPITAL INC**	**$566,281**	**27**	**$20,973**	**0.9%**	**0.6%**
Total of Top 14 Systems		**$57,080,584**	**3,593**	**$15,887**	**89.3%**	**86.3%**
Total for All Hospitals		**$63,929,688**	**4,164**	**$15,353**	**100.0%**	**100.0%**

Attachment A

Top Outpatient Hospital Providers By Claims Paid
Claims Incurred from July 1, 2011 through June 30, 2012 and Paid through September 30, 2012

Rank	Hospital Name	Claim $ Paid	# of Encounters	$ Per Enounter	% of Total Claims	% of Total Encounters
	BAPTIST HEALTH SYSTEM					
	BAPTIST HOSPITAL OF MIAMI, INC	$13,307,159	10,582	$1,258	16.1%	14.5%
	SOUTH MIAMI HOSPITAL, INC.	$7,013,210	4,363	$1,607	8.5%	6.0%
	DOCTORS HOSPITAL INC	$3,396,446	2,152	$1,578	4.1%	2.9%
	WEST KENDALL BAPTIST HOSPITAL INC	$2,962,876	1,345	$2,203	3.6%	1.8%
	HOMESTEAD HOSPITAL INC	$3,768,229	1,421	$2,652	4.6%	1.9%
1	**SUBTOTAL**	**$30,447,921**	**19,863**	**$1,533**	**36.9%**	**27.1%**
	MEMORIAL HEALTH SYSTEM					
	MEMORIAL HOSPITAL-WEST	$6,133,295	4,142	$1,481	7.4%	5.7%
	MEMORIAL REGIONAL HOSPITAL	$3,440,525	2,087	$1,649	4.2%	2.9%
	MEMORIAL HOSPITAL MIRAMAR	$1,866,980	2,389	$781	2.3%	3.3%
	MEMORIAL HOSPITAL OF PEMBROKE	$1,174,771	2,111	$556	1.4%	2.9%
2	**SUBTOTAL**	**$12,615,572**	**10,729**	**$1,176**	**15.3%**	**14.7%**
	UNIVERSITY OF MIAMII					
	UNIVERSITY OF MIAMI HOSP & CLINICS	$8,539,711	10,234	$834	10.3%	14.0%
	UNIVERSITY OF MIAMI HOSPITAL	$3,612,042	3,201	$1,128	4.4%	4.4%
3	**SUBTOTAL**	**$12,151,753**	**13,435**	**$904**	**14.7%**	**18.4%**
4	**AVENTURA HOSPITAL AND MEDICAL CENTER**	**$2,648,265**	**1,308**	**$2,025**	**3.2%**	**1.8%**
5	**MT SINAI MEDICAL CENTER**	**$2,574,528**	**1,544**	**$1,667**	**3.1%**	**2.1%**
6	**MIAMI CHILDREN'S HOSPITAL**	**$2,381,276**	**3,158**	**$754**	**2.9%**	**4.3%**
	JACKSON HEALTH SYSTEM					
	JACKSON MEMORIAL HOSPITAL	$603,127	2,323	$260	0.7%	3.2%
	JACKSON NORTH MEDICAL CENTER	$638,349	1,343	$475	0.8%	1.8%
	JACKSON SOUTH COMMUNITY HOSPITAL	$708,523	1,133	$625	0.9%	1.5%
7	**SUBTOTAL**	**$1,949,999**	**4,799**	**$406**	**2.4%**	**6.6%**
8	**ANNE BATES LEACH EYE HOSPITAL**	**$1,853,704**	**4,808**	**$386**	**2.2%**	**6.6%**
9	**NORTH SHORE MEDICAL CENTER**	**$1,644,773**	**1,112**	**$1,479**	**2.0%**	**1.5%**
10	**KENDALL REGIONAL MEDICAL CENTER**	**$1,412,679**	**573**	**$2,465**	**1.7%**	**0.8%**
11	**MERCY HOSPITAL**	**$1,388,061**	**693**	**$2,003**	**1.7%**	**0.9%**
12	**PALMETTO GENERAL HOSPITAL**	**$1,039,109**	**635**	**$1,636**	**1.3%**	**0.9%**
13	**CLEVELAND CLINIC HOSP - WESTON**	**$800,014**	**593**	**$1,349**	**1.0%**	**0.8%**
14	**H. LEE MOFFITT CANCER CENTER**	**$655,630**	**117**	**$5,604**	**0.8%**	**0.2%**
Total Top 14 Facilities		**$73,563,283**	**63,367**	**$1,161**	**89.1%**	**86.6%**
Total All Facilities		**$82,552,150**	**73,184**	**$1,128**	**100.0%**	**100.0%**

Attachment A

Top Hospital Providers By Claims Paid
Claims Incurred from July 1, 2011 through June 30, 2012 and Paid through September 30, 2012

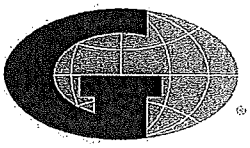
Total Hospital Facility Claim $ Paid	$146,481,838

Rank	Hospital Name	Claim $ Paid	% of Total Claims
	BAPTIST HEALTH SYSTEM		
	BAPTIST HOSPITAL OF MIAMI, INC	$23,408,823	16.0%
	SOUTH MIAMI HOSPITAL, INC.	$12,841,079	8.8%
	DOCTORS HOSPITAL INC	$5,767,530	3.9%
	WEST KENDALL BAPTIST HOSPITAL INC	$4,146,318	2.8%
	HOMESTEAD HOSPITAL INC	$4,687,352	3.2%
1	**SUBTOTAL**	**$50,851,102**	**34.7%**
	MEMORIAL HEALTH SYSTEM		
	MEMORIAL HOSPITAL-WEST	$9,746,631	6.7%
	MEMORIAL REGIONAL HOSPITAL	$6,458,259	4.4%
	MEMORIAL HOSPITAL MIRAMAR	$3,124,951	2.1%
	MEMORIAL HOSPITAL OF PEMBROKE	$1,636,511	1.1%
2	**SUBTOTAL**	**$20,966,353**	**14.3%**
	UNIVERSITY OF MIAMII		
	UNIVERSITY OF MIAMI HOSPITAL	$13,687,372	9.3%
	UNIVERSITY OF MIAMI HOSP & CLINICS	$3,996,448	2.7%
3	**SUBTOTAL**	**$17,683,820**	**12.1%**
4	**AVENTURA HOSPITAL AND MEDICAL CENTER**	**$7,706,770**	**5.3%**
5	**MIAMI CHILDREN'S HOSPITAL**	**$5,970,056**	**4.1%**
6	**MT SINAI MEDICAL CENTER**	**$5,275,877**	**3.6%**
	JACKSON HEALTH SYSTEM		
	JACKSON MEMORIAL HOSPITAL	$2,568,339	1.8%
	JACKSON NORTH MEDICAL CENTER	$1,128,428	0.8%
	JACKSON SOUTH COMMUNITY HOSPITAL	$1,017,613	0.7%
7	**SUBTOTAL**	**$4,714,379**	**3.2%**
8	**NORTH SHORE MEDICAL CENTER**	**$3,021,258**	**2.1%**
9	**KENDALL REGIONAL MEDICAL CENTER**	**$2,931,830**	**2.0%**
10	**MERCY HOSPITAL**	**$2,905,130**	**2.0%**
11	**PALMETTO GENERAL HOSPITAL**	**$2,831,145**	**1.9%**
12	**CLEVELAND CLINIC HOSP - WESTON**	**$1,762,783**	**1.2%**
13	**HIALEAH HOSPITAL**	**$1,299,366**	**0.9%**
14	**H. LEE MOFFITT CANCER CENTER**	**$1,097,894**	**0.7%**
Total of Top 14 Systems		**$138,446,521**	**94.5%**

Attachment B

Top Emergency Room Hospital Providers By Claims Paid
Claims Incurred from July 1, 2011 through June 30, 2012 and Paid through September 30, 2012

Rank	Hospital Name	Claim $ Paid	# of Encounters	$ Per Encounter
	BAPTIST HEALTH SYSTEM			
	BAPTIST HOSPITAL OF MIAMI, INC	$5,508,409	2,342	$2,352
	SOUTH MIAMI HOSPITAL, INC.	$1,560,742	597	$2,614
	DOCTORS HOSPITAL INC	$801,906	323	$2,483
	WEST KENDALL BAPTIST HOSPITAL INC	$2,355,447	1,051	$2,241
	HOMESTEAD HOSPITAL INC	$2,297,175	848	$2,709
1	**SUBTOTAL**	**$12,523,678**	**5,161**	**$2,427**
	MEMORIAL HEALTH SYSTEM			
	MEMORIAL HOSPITAL-WEST	$1,126,410	1,645	$685
	MEMORIAL REGIONAL HOSPITAL	$697,271	1,247	$559
	MEMORIAL HOSPITAL MIRAMAR	$825,731	1,244	$664
	MEMORIAL HOSPITAL OF PEMBROKE	$877,926	1,879	$467
2	**SUBTOTAL**	**$3,527,338**	**6,015**	**$586**
3	**AVENTURA HOSPITAL AND MEDICAL CENTER**	**$1,486,844**	**736**	**$2,020**
4	**KENDALL REGIONAL MEDICAL CENTER**	**$965,440**	**468**	**$2,063**
5	**MERCY HOSPITAL**	**$665,390**	**310**	**$2,146**
6	**MT SINAI MEDICAL CENTER**	**$659,587**	**496**	**$1,330**
7	**MIAMI CHILDREN'S HOSPITAL**	**$613,500**	**602**	**$1,019**
	JACKSON HEALTH SYSTEM			
	JACKSON MEMORIAL HOSPITAL	$241,393	669	$361
	JACKSON NORTH MEDICAL CENTER	$163,757	387	$423
	JACKSON SOUTH COMMUNITY HOSPITAL	$113,674	368	$309
8	**SUBTOTAL**	**$518,823**	**1,424**	**$364**
9	**UNIVERSITY OF MIAMI HOSPITAL**	**$372,254**	**296**	**$1,258**
10	**FLORIDA HOSPITAL MEDICAL CENTER**	**$157,290**	**102**	**$1,542**
11	**CLEVELAND CLINIC HOSP - WESTON**	**$152,922**	**289**	**$529**
12	**WESTSIDE REGIONAL MEDICAL CENTER**	**$127,973**	**78**	**$1,641**
13	**MARINERS HOSPITAL INC**	**$119,743**	**35**	**$3,421**
14	**PLANTATION GENERAL HOSPITAL**	**$100,525**	**61**	**$1,648**
Total of Top 14 Systems		**$21,991,304**	**16,073**	**$1,368**



Healthcare Analytics
a Division of Gallagher Benefit Services, Inc.

Miami – Dade County

PERFORMANCE EVALUATION
OF
AVMED'S
MEDICAL PLAN CLAIMS ADMINISTRATION
BETWEEN
JANUARY 1, 2011 AND DECEMBER 31, 2011

CONDUCTED
MARCH 2012

May 31, 2012

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Background

Miami – Dade County (Miami – Dade) offers two self-funded HMO options (High and Low) and a self-insured POS medical plan for the benefit of its 29,000 enrolled employees, retirees, and their eligible dependents. AvMed serves as the health plan's third party claims administrator.

Miami - Dade engaged the Healthcare Analytics division of Gallagher Benefit Services, Inc. ("GBS") to conduct an independent assessment of AvMed's medical plan claims administration service rendered between January 1, 2011 and December 31, 2011 in order to determine if the quality of the administrative service was at an optimal level. This report contains the findings and recommendations of the performance evaluation.

Evaluation Overview

The performance evaluation was comprised of a claim audit of a statistically-valid sample of previously processed claims the primary goal of which was to examine individual medical claim transactions in detail to determine if each was processed following Miami - Dade's benefit provisions, industry-wide processing guidelines, and AvMed's established policies and procedures.

The audit population was comprised of all Miami - Dade claims incurred and processed by AvMed between January 1, 2011 and December 31, 2011. This included 587,917 claims with a paid total of $215,971,145. The audit sample included 225 randomly selected claims with a paid total of $9,763,738.

The evaluation was performed in March 2012 at the offices of AvMed in Miami, FL. A summary of our conclusions and recommendations follows.

Conclusions and Recommendations

- The audit sample was selected in a statistically valid manner using a stratified random selection methodology. Therefore, there is a statistical basis upon which to project the administrative and financial error rates as well as the percent of benefits paid in error from in the audit sample to the entire medical claim population.

- The audit results presented in this report are measured against industry standards of quality performance, AvMed's internal quality standards, and the performance guarantees between Miami - Dade and AvMed.

- This claim audit was unusual in that GBS did not find any "in sample" financial or administrative errors. Although a number of questions were posed, AvMed was able to provide documentation that proved that the claims were paid correctly. Typically, results such as these are due, at least partially, to a straight forward plan design, high rates of

automatic adjudication (i.e., claims processed without manual intervention), and/or a well trained and well supervised claims processing staff.

- The administrative error rate quantifies the incidence of processing errors that result in no measurable financial effect on the claim. As we recorded no administrative errors on this audit, AvMed's performance in this category is well within the industry performance standard of 5.00% and the AvMed internal performance standard of 5.00%.

- The financial error rate quantifies the incidence of processing errors that result in measurable overpayments or underpayments. The financial error rate from this audit at 0.00% is clearly better than the industry performance standard of 3.00%.

- The percent of benefit dollars paid in error is the most significant finding in any audit. It represents the measure of the number of Miami - Dade benefit dollars that were incorrectly paid by AvMed. For the purposes of this calculation, the absolute value (overpayments plus underpayments) of financial errors is used. AvMed's performance in this most important error category of 0.00% is, again, well above the industry performance standard and the AvMed internal performance standard, both of which are set at 1.00%. AvMed's performance guarantee states that Miami - Dade claims will be processed with a financial accuracy rate of 99.00%.

- As part of this audit, GBS conducted an independent analysis of the turnaround time by AvMed to process Miami - Dade's medical claims over the entire claim population. During this period, an average turnaround time of 10.5 calendar days or 7.7 business days was measured. The analysis also shows that AvMed processed 88% of all Miami - Dade claims within 14 calendar days and 87% within 10 business days. AvMed's internal analysis reflects that approximately 99.74% of Miami – Dade's claims were processed within 10 days during 2011. The variance in results comes from the fact that GBS is unable to distinguish "clean claims" from "non-clean" claims (as required by the Performance Guarantee). Also, even though weekends and standard national holidays were removed from the GBS analysis, the fact that GBS included all claims that are in the data file (e.g., adjustments) accounts for some of the additional discrepancy in the reported totals.

Claim Audit Objectives

The performance evaluation was comprised of a claims audit of a statistically-valid sample of claims the primary goal of which was to examine individual, previously processed, medical claim transactions, in detail, to determine if each was processed following Miami - Dade's benefit provisions, industry-wide processing guidelines, and AvMed's established policies and procedures. Each audited claim transaction was completely readjudicated and examined to determine processing accuracy / correctness in:

- Claimant and provider eligibility verification
- Detecting duplicate claim payments
- Evaluating the medical necessity of submitted charges
- Applying preexisting condition limitations
- Applying utilization review requirements
- Recognition of negotiated provider discounts
- Determination of prevailing fees
- Detecting other insurance coverage
- Applying coordination of benefits (COB) provisions
- Applying plan design provisions
- Calculation of benefit payment amounts
- Dispersal of HRA funds (if applicable)
- Honoring benefit payment assignments
- Completeness of file documentation and information to process claims
- Communicating to claimants about ineligible expenses
- Turnaround time
- Identification and submission of claims eligible for stop-loss coverage

The evaluation was performed in March 2012 at AvMed's offices located in Miami, FL. While on-site, the GBS audit team worked with, and referred questions to, appropriate AvMed representatives for substantiation of procedures and sign-off on all processing errors.

Claim Audit Population

The audit population was comprised of all 587,917 Miami - Dade medical claims incurred between January 1, 2011 and December 31, 2011, and processed by AvMed during the same time period. These claims had a total paid amount of $215,971,145 (see Exhibit 1).

Claim Audit Sample

GBS selected the audit sample using a statistically valid, stratified, random sampling technique. First, the population of 587,917 claims was divided into a series of groups, or strata, based upon the dollar value of each claim payment (see Exhibit 2). Using proprietary software, a random sample of claims was then selected from each stratum. The entire sample included 225 claims or *audit observations* with a total paid amount of $9,763,739 (see Exhibits 3 and 4). All claims with payments in excess of $15,000 were included. This sample includes only 0.04% of the claims in the audit population but accounts for 4.5% of the population's total payments.

For statistically valid samples such as this one, GBS guarantees the representativeness of its audit sample by measuring the difference between the mean claim amount of the entire population from which the sample was drawn and the weighted mean claim amount of our sample. If the difference between those amounts is greater than 1.00%, we re-sample the population until our criterion is met. For Miami - Dade' medical sample, our method produced an acceptable sample as follows (see Exhibit 5):

Sample Representativeness	
Population Mean Claim Amount	$367.35
Weighted Sample Mean Claim Amount	$366.33
Absolute Difference	**$1.02**
Percent Difference	**0.28%**

Claim Audit Findings

This claim audit was unusual in that GBS did not find any "in-sample" financial or administrative errors. Although a number of questions were posed, AvMed was able to provide documentation that proved that the claims were paid correctly. Typically, results such as these are due, at least partially, to a straight forward plan design, high rates of automatic adjudication (i.e., claims processed without manual intervention), and/or a well trained and well supervised claims processing staff. The normal method of calculating error rates will be described for future reference.

Given that the sample is statistically valid, GBS has projected the administrative and financial error incidence rates as well as the percent of benefits paid in error from within the audit sample to the entire audit population. Errors uncovered in the sample are weighted according to the number of claims in the stratum from which they were selected. Next, these sample error rates are extrapolated to the entire population of claims. The audit results are then measured against industry standards of quality performance as well as AvMed's internal performance standards.

In this report, audit findings are separated by error type and draw the following distinctions:

- *Financial errors* resulting in measurable overpayments or underpayments
- *Administrative errors* having no measurable financial effect on the claim – that is, errors in spelling, coding, or statistics and/or errors having a financial effect that cannot be exactly measured (e.g., failure to pursue a COB opportunity)
- *Benefits paid in error*, which measures the effect of the financial errors on the amount of benefit payments.

For each potential error uncovered during the audit, AvMed was provided with an opportunity to provide additional information upon which agreement could be reached to remove the error. Absent such information, AvMed was asked to sign off on all remaining errors. Agreement was reached on the error status of all audited claims and as noted previously, no errors were identified in this sample. The following text and tables are for illustrative purposes only.

Administrative Error Rate

The administrative error rate quantifies the incidence of processing errors that result in no measurable financial effect on the claim. As no administrative errors were identified on this audit, AvMed's performance in this category is well within the industry performance standard of 5.00% and the AvMed internal performance standard of 5.00%.

Administrative Error Rate	
Administrative Error Rate	**0.00%**
Industry Standard	5.00%
AvMed Internal Standard	5.00%

Financial Error Rate

The financial error rate quantifies the incidence of processing errors that result in measurable overpayments or underpayments. The financial error rate from this audit at 0.00% is clearly better than both the industry performance standard of 3.00% and the AvMed internal performance standard of 3.00%.

Financial Error Rate	
Financial Error Type	**Error Rate**
Overpayments	0.00%
Underpayments	0.00%
Total Financial Error Rate	**0.00%**
Industry Standard	3.00%
AvMed Internal Standard	N/A

Percent of Benefits Paid In Error

The percent of benefit dollars paid in error is the most significant finding in any audit. It represents the measure of the number of Miami - Dade benefit dollars that were incorrectly paid by AvMed. For the purposes of this calculation, the absolute value (overpayments plus underpayments) of financial errors is used. AvMed's performance in this most important error category of 0.00% is, again, well above the industry performance standard and the AvMed internal performance standard, both of which are set at 1.00%. AvMed's performance guarantee states that Miami - Dade claims will be processed with a financial accuracy rate of 99.00%.

Percent of Benefit Dollars Paid In Error		
Financial Error Type	**Error Rate**	**Projected Dollar Value**
Overpayments	0.00%	$0.00
Underpayments	0.00%	$0.00
Total Dollars Mispaid	**0.00%**	**$0.00**
Industry Standard	1.00%	$2,159,711
AvMed Internal Standard	1.00%	$2,159,711
AvMed Performance Guarantee	1.00%	$2,159,711

Turnaround Time

As part of this audit, GBS conducted an independent analysis of the turnaround time by AvMed to process Miami - Dade's medical claims over the entire claim population. During this period, an average turnaround time of 10.5 calendar days or 7.7 business days was measured. The analysis also shows that AvMed processed 88% of all Miami - Dade claims within 14 calendar days and 87% within 10 business days. AvMed's internal analysis reflects that approximately 99.74% of Miami – Dade's claims were processed within 10 days during 2011. The variance in results comes from the fact that GBS is unable to distinguish "clean claims" from "non-clean" claims (as required by the Performance Guarantee). Also, even though weekends and standard national holidays were removed from the GBS analysis, the fact that GBS included all claims that are in the data file (e.g., adjustments) accounts for some of the additional discrepancy in the reported totals.

EXHIBITS 3-1

AvMed Claim Review Summary
Claims Paid from January 2008 through December 2008

Section I: Claim Review Financials

Summary of Populations and On Site Samples	Population		On Site Samples	
Total Claims for Review Period	618,121	$191,695,494	225 claims	$4,681,878
Review Results (Net Errors)	Deloitte Consulting		Agreed Amount	
	Number	Net Amount	Number	Net Amount
Sample – On site	15 Financial, 4 Processing	$15,279.98	14 Financial, 4 Processing	$15,269.98

Performance Summary	Results of On Site Sample	Miami-Dade County Performance Standards	Carrier Action to Address Review Issue	Closure Date
Claims Financial Accuracy	99.26%	99%		
Payment Accuracy*	93.78%	95%	This standard is not consistent with the performance guarantees in the Miami-Dade County contract #559. It is not clear what the basis for this performance standard is, since this was not addressed in the RFP or the performance guarantee schedule. *Sample # 17*: This item is included in the computation of payment accuracy. AvMed disagrees with the classification of this as an error. It is AvMed policy not to deduct co-payment from the facility claims and only to apply this rule to the physician claims. In other claims included in the audit, both physician and facility claims were received and the co-payments were appropriately deducted from the physician claim. In this particular case, no physician claim was received, and therefore no opportunity to deduct a co-payment existed. We believe there can be disagreement in construction of the procedure, but the procedure was followed as intended and therefore cannot constitute an error.	
Claim Coding Accuracy	98.22%	95%		

* Measurement not part of the performance guarantee agreed upon in Contract #559. Measurement is based on industry standard and is displayed for illustrative purposes.

AvMed Claim Review Summary
Claims Paid from January 2008 through December 2008

Performance Summary	Results of On Site Sample	Miami-Dade County Performance Standards	Carrier Action to Address Review Issue	Closure Date
Claims Turnaround Time:				
• Average for Processing	1.41 Days	No Industry Benchmark		
• % Within 10 business days (14 calendar days)	99.56%	90%		
• % Within 22 business days (30 calendar days)*	100.00%	98%		
• Average for Payment*	24.04 Days	No Industry Benchmark	This standard is not consistent with the performance guarantees in the Miami-Dade County contract #559. The elapsed time from claims received to claims payment is affected by numerous factors, some within AvMed's control and some not. For non clean claims, the plan relies on the provider or member to respond to requests for additional information to facilitate the ultimate disposition of the claim. The time limits of such responses are at the discretion of the provider or member. The statistic presented here includes both non clean claims as well as clean claims and it is not clear what the meaning or relevance of this computed statistic is. As noted by the auditor, there is no industry benchmark offered, therefore, this further puts in question the relevance of this statistic.	
• % Within 10 business days (14 calendar days)*	57.78%	90%	This standard is not consistent with the performance guarantees in the Miami-Dade County contract #559. The benchmark presented for this line item was developed to evaluate the turnaround for clean claims (see above). As presented here, the turnaround time statistic (which includes non clean claims) is not meaningful.	

* Measurement not part of the performance guarantee agreed upon in Contract #559. Measurement is based on industry standard and is displayed for illustrative purposes.

AvMed Claim Review Summary
Claims Paid from January 2008 through December 2008

Performance Summary	Results of On Site Sample	Miami-Dade County Performance Standards	Carrier Action to Address Review Issue	Closure Date
• % Within 22 business days (30 calendar days)*	76.00%	98%	This standard is not consistent with the performance guarantees in the Miami-Dade County contract #559. The benchmark presented for this line item was developed to evaluate the turnaround for clean claims (see above). As presented here, the turnaround time statistic (which includes non clean claims) is not meaningful.	
Turnaround Time for Payment was significantly below industry standards; however, it is important to note that our calculation takes into account any adjustments made after initial payment. This turnaround time benefits the County and as long as the providers are not complaining about payment, we do not see this as a problem.			As stated earlier by the auditors, there are no industry benchmarks for turnaround time Average for Payment. In addition, there is no contractual performance guarantee for this measure between MDC and AvMed Health Plans.	

Definitions:

A **financial** error occurs when an incorrect amount is paid, is paid to the wrong party, or is paid under the incorrect claimant's file.

A **processing** error occurs when the correct amount is paid to the correct party under the correct claimant's file, but the claims administrator's own claim processing guidelines are not followed; for example, a diagnosis code is mis-keyed, potential other insurance coverage is not investigated, etc. A processing error recorded for a claim will not result in a measurable financial amount. It is possible, however, that a processing error may result in one or more future financial errors.

Financial accuracy rate is calculated by dividing the absolute value of overpayments and underpayments by the total dollars paid for the sample and then subtracting the resulting number from one to develop a percentage accuracy measure.

Payment accuracy rate is calculated by dividing the total number of claims paid correctly by the total number of claims reviewed.

Procedural accuracy rate is calculated by dividing the total number of procedurally correct claims by the total number of claims reviewed.

* Measurement not part of the performance guarantee agreed upon in Contract #559. Measurement is based on industry standard and is displayed for illustrative purposes.

AvMed Claim Review Summary
Claims Paid from January 2008 through December 2008

Section 2: Details of Findings

	Carrier Action to Address Review Issue	Closure Date
On-site Review *Plan Design* **Issues** • Sample #11: Finding – There is an inconsistent application of HMO and POS copayments with respect to diagnostic testing. POS does not apply copayments to diagnostic testing and/or radiology in the office setting; however, the HMO plan does. AvMed administered the plan according to the plan summaries. • Sample #17: Claim is for a clinic visit (facility bill) and no copay was taken. AvMed's procedure is to apply the copay to the physician bill. However, a copay should be taken on the facility bill if there no physician bill is received. Claim overpaid $10.00. AvMed disagrees to this error as their standard is to only take copay on the physician bill regardless. • Sample #23: Claim is a coordinated claim with other active commercial coverage, with AvMed as the secondary payer. A $10 copay was applied in error. Claim underpaid $10.00. **Recommendations** • MDC should review the plan design and consider consistency of copayments for diagnostic testing, radiology, and clinic visits. • AvMed should review claims paid as secondary to determine if there is a systemic error that automatically deducts copayments.	• This request needs to be evaluated by Miami-Dade County. • AvMed has reviewed the circumstances surrounding this error and has determined that it does not represent a systemic issue related to the payment of secondary claims.	
Pricing and Contract Issues **Issue** • Sample #70 – Claim is for a provider in the BeechStreet network; however, the claim was priced through Viant rather than BeechStreet. Processing error only as BeechStreet confirmed that pricing would be unaffected. Processing Error only. • Sample #72: Claim is for a provider in the BeechStreet network; however, there is no BeechStreet savings as the billed amount is less than the allowed amount. Claim should have been paid based on billed amount. Claim was priced incorrectly resulting in a $24.80 underpayment. • Sample #92: Claim is for services rendered by an out-of-network provider and should be paid at 90th percentile of HIAA rates. Claim paid at 81st percentile of HIAA instead, resulting in a $22.50 underpayment.		

AvMed Claim Review Summary
Claims Paid from January 2008 through December 2008

	Carrier Action to Address Review Issue	Closure Date
• Sample #102: Claim calculated using MCMF fee schedule. It appears there is a systematic issue with MCMF resulting $.01 - $.02 overpayments per line. Claim overpaid by $0.05. • Sample #116: Claim calculated using MCMF fee schedule, which resulted in a $0.08 overpayment. Additionally, this claim was adjusted and no copay was due. Copayment should have been refunded to the member, not the provider. Net underpayment of $9.92. • Sample #117: Claim is for a provider in the BeechStreet network. Claim was priced incorrectly resulting in a $40.00 underpayment. • Sample #147: Claim paid incorrectly and not in accordance with the provider contract, resulting in an overpayment of $349.27. • Sample #164: Based on the contract and fee schedule provided, several claim lines were underpaid resulting in a total net underpayment of $12.75. • Sample #214: Claim was priced incorrectly and not in accordance with the provider contract, resulting in a $9,024.57 overpayment. • Sample #225: Claim is for a provider in the BeechStreet network. BeechStreet originally priced the claim at 100%. Claim was then repriced correctly by BeechStreet; however, AvMed requested the incorrect refund amount from the provider. Claim overpaid $50.02. **Recommendation** • Claims for the providers in Samples #72 and #117 should be reviewed to determine if other claim payments have been affected. • AvMed should review all out-of-network claims paid at HIAA to ensure that all claims were paid at the 90th percentile. • AvMed should review the MCMF fee schedule to determine if overpayments are a systemic issue. *Miscellaneous* **Issue** • Sample #2 – Finding – Supplies are paid without request for details, when charges determined to not be "excessive." There are no specific guidelines in place to determine what constitutes "excessive" charges. • Sample #56 – Claim is for a member who was retro-terminated. Claim was not reversed after retro-termination information was received and no follow-up letter was sent to the provider. Claim is overpaid $85.49. • Sample #97 – Patient Account number was entered into the system as the Tax ID. Processing Error.	• AvMed will run a report for both providers to ensure that all claims have been paid correctly. • AvMed concurs. • AvMed has reviewed this finding and has determined that this is does not represent a systemic issue.	

AvMed Claim Review Summary
Claims Paid from January 2008 through December 2008

	Carrier Action to Address Review Issue	Closure Date
• Sample #130 – Claim was adjusted after the claim sample was provided. Per Deloitte guidelines, claims adjusted after the claim sample has been received by the claims administrator are considered an error. At the time of the on-site claim review the claim was pending and the final overpayment cannot be calculated until claim is finalized. Estimated overpayment of $25.59. • Sample #150 - Patient Account number was entered incorrectly: the last digit was left off in error. Processing error. • Sample #193 – Claim originally processed and paid correctly, but was adjusted incorrectly resulting in an overpayment of $5,952.00. • Sample #195 - Claim priced by percent of billed charges. However, personal convenience items, which are not a covered expense, were included in the calculation. Claim overpaid $3.00. • Sample #217 - One claim line was appropriately denied, but was not removed from the system. Overall claim payment was not affected, processing error only. **Recommendation** • AvMed should consider establishing a guideline to determine what constitutes "excessive" charges (a dollar amount) for paying supplies. • AvMed should continue to follow-up for payment recovery for the claim in Sample #56.	• AvMed will review current guidelines for high dollar supplies. • Letter was sent to ensure follow up continues.	
<u>Observations from the Questionnaire and On-Site Review</u> Deloitte reviewed AvMed's responses to the questionnaire and interviewed AvMed personnel to obtain clarification on responses. Observations include: • Dual contracts – Providers can be both an AvMed contracted provider and a Beech Street contracted provided and thereby having more than one TIN loaded on the systems. There is the possibility that the incorrect TIN, which aligns with the reimbursement amount, could be selected and possibly impact the payment. While AvMed maintains a thorough internal audit process, no specific audit exists that targets dual contracted providers. • The quality review manager has a direct report to the Claims Director, Helen Creech. While this is not uncommon in the industry, however, there usually is an "internal audit" department, in addition to the quality review position, that is not part of the Claims department and conducts regular claims audits.	• To clarify, AvMed does not select the TIN, but selects the provider based on the TIN billed on the claim. A specific internal audit currently exists for this process. • It should be noted that there are 2 corporate audit-related functions that do not report to Claims Operations. The Internal Audit Department is led by our Chief Audit Executive, who reports directly to the CEO. The other is the Audit Services and Investigation unit, which reports to AvMed's General Counsel.	

AvMed Claim Review Summary
Claims Paid from January 2008 through December 2008

	Carrier Action to Address Review Issue	Closure Date
• AvMed utilizes multiple levels of control and oversight to ensure claims are accurately paid. For example, hospital audits are conducted on most hospital claims and the diligence of the review team has had a positive impact on the application of contract provisions often resulting in additional savings for the County through reduced claim payments. • We did note that several processes rely on manual review and while seemingly effective, manual processes create a risk of human error. Additionally, the quality of services could be comprised if staffing is reduced or the staff experience level is not maintained.		

AvMed Claim Review Summary
Claims Paid from January 2008 through December 2008

Section III: Next Steps

	Carrier Action to Address Review Issue	Closure Date
Financial Recovery Agreed Upon Overpayments: AvMed agreed to the following net payment errors in the claim samples reviewed: • Random Sample Review $15,269.98 Details supporting these findings are included in a supplemental exhibit to this report. • AvMed should review and comment on the recommendations in the report.	• It should be noted more clearly in the report that AvMed met and exceeded all Claims performance guarantees.	

AvMed Claim Review Summary
Claims Paid from January 2009 through December 2009

Section I: Claim Review Financials

Summary of Populations and On Site Samples	Population		On Site Samples	
Total Claims for Review Period	827,248	$264,240,354	225 claims	$7,374,414
Review Results (Net Errors)	Deloitte Consulting		Agreed Amount	
	Number	Net Amount	Number	Net Amount
Sample – On site	7 Financial, 0 Processing	$5,540.06	5 Financial, 0 Processing	$595.46

Performance Summary	Results of On Site Sample	Miami-Dade County Performance Standards	Carrier Action to Address Review Issue	Closure Date
Claims Financial Accuracy	99.38%	99%	It appears that the results shown of 99.38% are calculated using claims that AvMed contends are paid correctly. When calculating the Claims Financial Accuracy using the same strata calculations as the auditors used and only with the errors agreed to by AvMed, the Financial Accuracy is 99.77%. When calculating the Claims Financial Accuracy using the calculations as stated in this document under Definitions, and only with the errors agreed to by AvMed, the Financial Accuracy is 99.99%.	
Payment Accuracy*	96.89%	95%	This standard is not consistent with the performance guarantees in the Miami Dade County contract #559. It is not clear what the basis for this performance standard is, since this was not addressed in the RFP or the performance guarantee schedule. Also, it appears that the results shown of 96.89% are calculated claims that AvMed contends are paid correctly.	
Claim Coding Accuracy	100%	95%	Agree.	

AvMed Claim Review Summary
Claims Paid from January 2009 through December 2009

Performance Summary	Results of On Site Sample	Miami-Dade County Performance Standards	Carrier Action to Address Review Issue	Closure Date
Claims Turnaround Time:				
• Average for Processing*	9.39 Days	No Industry Benchmark	This standard is not consistent with the performance guarantees in the Miami Dade County contract #559. It is not clear what the basis for this performance standard is, since this was not addressed in the RFP or the performance guarantee schedule. The statistic presented here includes both non- clean claims as well as clean claims and it is not clear what the meaning or relevance of this computed statistic is. As noted by the auditor, there is no industry benchmark offered, therefore, this further puts in question the relevance of this statistic.	
• % Within 10 business days (14 calendar days)	83.11% for all claims; contractual performance guarantee is based on clean claims only. As such, results should not be used for comparison to contractual performance guarantees.	90%	This standard is not consistent with the performance guarantees in the Miami Dade County contract #559. The benchmark presented for this line item was developed to evaluate the turnaround for clean claims from date received to date processed. As presented here, the turnaround time (TAT) statistics (which include non clean claims) is not meaningful. The elapsed time from claims received to claims payment is affected by numerous factors, some within AvMed's control and some not. For non clean claims, the plan relies on the provider to respond to requests for additional information to facilitate the ultimate disposition of the claim. The time limits of such responses are at the discretion of the provider. AvMed would like to point out that claims pulled for this audit (225 claims) should not represent turnaround time for the purpose of making comparisons to Performance Guarantees. Such comparisons might be misleading. For TAT, AvMed reports on the entire population of clean claims only. Consistent with the Performance Guarantee which states that turnaround time is calculated using the **time from the date a claim is received to the date it is processed (i.e., paid, pended or denied) excluding weekends and holidays (clean claims only)** and consistent with quarterly reporting , the Claims Turnaround time % Within 10 business days (14 calendar days) is 99.85% for 2009.	

AvMed Claim Review Summary
Claims Paid from January 2009 through December 2009

Performance Summary	Results of On Site Sample	Miami-Dade County Performance Standards	Carrier Action to Address Review Issue	Closure Date
• % Within 22 business days (30 calendar days)	92.89% for all claims; contractual performance guarantee is based on clean claims only. As such, results should not be used for comparison to contractual performance guarantees.	98%	This standard is not consistent with the performance guarantees in the Miami Dade County contract #559. The benchmark presented for this line item was developed to evaluate the turnaround for clean claims from date received to date processed. As presented here, the turnaround time statistics (which include non clean claims) is not meaningful. The elapsed time from claims received to claims payment is affected by numerous factors, some within AvMed's control and some not. For non clean claims, the plan relies on the provider to respond to requests for additional information to facilitate the ultimate disposition of the claim. The time limits of such responses are at the discretion of the provider. AvMed would like to point out claims pulled for this audit (225 claims) should not represent turnaround time for the purpose of making comparisons to Performance Guarantees. Such comparisons might be misleading. For TAT, AvMed reports on the entire population of clean claims only. Consistent with the Performance Guarantee which states that turnaround time is calculated using the **time from the date a claim is received to the date it is processed (i.e., paid, pended or denied) excluding weekends and holidays (clean claims only)** and consistent with quarterly reporting , the Claims Turnaround time % Within 22 business days (30 calendar days) is 99.97% for 2009.	
• Average for Payment*	25.04 Days	No Industry Benchmark	This standard is not consistent with the performance guarantees in the Miami Dade County contract #559. It is not clear what the basis for this performance standard is, since this was not addressed in the RFP or the performance guarantee schedule. The statistic presented here includes both non- clean claims as well as clean claims and it is not clear what the meaning or relevance of this computed statistic is. As noted by the auditor, there is no industry benchmark offered, therefore, this further puts in question the relevance of this statistic.	

AvMed Claim Review Summary
Claims Paid from January 2009 through December 2009

Performance Summary	Results of On Site Sample	Miami-Dade County Performance Standards	Carrier Action to Address Review Issue	Closure Date
• % Within 10 business days (14 calendar days)*	60.89%	90%	This standard is not consistent with the performance guarantees in the Miami Dade County contract #559. It is not clear what the basis for this performance standard is, since this was not addressed in the RFP or the performance guarantee schedule. As presented here, the turnaround time statistics (which include non clean claims and calculates adjustments made after the initial payment) is not meaningful.	
• % Within 22 business days (30 calendar days)*	81.78%	98%	This standard is not consistent with the performance guarantees in the Miami Dade County contract #559. It is not clear what the basis for this performance standard is, since this was not addressed in the RFP or the performance guarantee schedule. As presented here, the turnaround time statistics (which include non clean claims and calculates adjustments made after the initial payment) is not meaningful.	
Claims Turnaround Time: Avmed commented that the response time limit is at the discretion of the provider. However, Deloitte would contend that the time responses should not be at the discretion of the provider. Time limit should be included in the provider contracts and AvMed should be determining a specific turnaround time for additional information that is in line with industry standards. Turnaround Time for Payment was significantly below industry standards; however, it is important to note that our calculation takes into account any adjustments made after initial payment. This turnaround time benefits the County and as long as the providers are not complaining about payment, we do not see this as a problem. Deloitte agrees that the contractual performance guarantees for Turnaround Time are based on clean claims and as such, the results of the claim review should not be utilized in assessing this contractual performance guarantee. Deloitte will work with AvMed to determine if there is way in which we can distinguish clean claims in our onsite sample review for the purpose of measuring the contractual performance guarantees related to Turnaround Time. While AvMed may not deem performance measures that are not specifically outlined in the contractual performance guarantees or the RFP as "meaningful", Deloitte strongly disagrees. These measures are import in assessing the claim and payment processing of the claims administrator to identify potential issues that may impact members or providers.			For TAT, AvMed reports on the entire population of clean claims only. Consistent with the Performance Guarantees which state that turnaround time is calculated from using the **time from the date a claim is received to the date it is processed (i.e., paid, pended or denied) excluding weekends and holidays (clean claims only)** and consistent with quarterly reporting,, the Claims Turnaround time % Within 10 business days (14 calendar days) is 99.85% for 2009, and the Claims Turnaround time % Within 22 business days (30 calendar days) is 99.97% for 2009. AvMed met the performance guarantees for Turnaround Time as stated in the Miami Dade County Contract #559.	

**Measurement not part of the performance guarantee agreed upon in Contract #559. Measurement is based on industry standard and is displayed for illustrative purposes.*

AvMed Claim Review Summary
Claims Paid from January 2009 through December 2009

Definitions:

A **financial** error occurs when an incorrect amount is paid, is paid to the wrong party, or is paid under the incorrect claimant's file.

A **processing** error occurs when the correct amount is paid to the correct party under the correct claimant's file, but the claims administrator's own claim processing guidelines are not followed; for example, a diagnosis code is mis-keyed, potential other insurance coverage is not investigated, etc. A processing error recorded for a claim will not result in a measurable financial amount. It is possible, however, that a processing error may result in one or more future financial errors.

Financial accuracy rate is calculated by dividing the absolute value of overpayments and underpayments by the total dollars paid for the sample and then subtracting the resulting number from one to develop a percentage accuracy measure.

Payment accuracy rate is calculated by dividing the total number of claims paid correctly by the total number of claims reviewed.

Procedural accuracy rate is calculated by dividing the total number of procedurally correct claims by the total number of claims reviewed.

AvMed Claim Review Summary
Claims Paid from January 2009 through December 2009

Section 2: Details of Findings

	Carrier Action to Address Review Issue	Closure Date

On-site Review
Plan Design
Issues
• Sample # 94: This was for an emergency room visit under the POS plan. A $50 copayment should apply. Both a $25 and $50 copayment were applied, resulting in an underpayment of $25, agreed to by AvMed.
• The plan summary for the HMO High Plan is misleading in terms of benefit coverage.
  ○ Finding - Sample #72: This claim was for diagnostic services received by a primary care physician under the HMO High Plan. The HMO High Plan does not apply copayments to diagnostic testing and/or radiology in the office setting. The claim paid correctly, not applying a copayment. However, the benefit summary is misleading, stating that diagnostic services in an office setting require a $10 copayment. AvMed did not administer the benefit according to the plan summary, but rather based on MDC's intent.
  ○ Finding - Sample # 112: This claim was for minor surgery in a physician's office. The HMO High Plan does not apply copayments to minor surgery performed in the office setting. The claim paid correctly, not applying a copayment. However, the benefit summary is misleading, stating that minor surgery in an office setting requires a $10 copayment. AvMed did not administer the benefit according to the plan summary, but rather based on MDC's intent.
Recommendations
• MDC should review the plan design and consider consistency of copayments for diagnostic testing and surgery performed in an office visit setting.
	This request needs to be evaluated by Miami Dade County.	

Pricing and Contract Issues **Issue** • Sample #21: This claim was for post-surgical care. The patient had surgery by the same physician for a CPT code (58150) with a 90-day global period. This claim paid incorrectly as it was within the surgical global period and the services were after care. AvMed agreed to an overpayment of $34.21. There also appears to be an out of sample overpayment of $56.70 relating to		

AvMed Claim Review Summary
Claims Paid from January 2009 through December 2009

	Carrier Action to Address Review Issue	Closure Date

the same surgical global fee.
• Sample #121: The multiple surgery guideline was applied to this case; however, the claim was repriced incorrectly by Viant. AvMed agreed to an overpayment of $518.00.
• Finding – Some claims were paid without applying "lesser than" language.
  o Sample #124
  o Sample #130		

• Sample #129: Claim was not priced by Beech Street and it appears that the provider was not actually participating in the Beech Street network. As such, the claim should not have been covered as the provider is out of network. Price negotiation attempted by Viant, but no discount was agreed to by the provider. The sample was overpaid by $2,334.00, AvMed disagreed with this error.	AvMed disagrees--Member is under the Away from home program and as such has access to the Beech Primary network out of the service area. Provider status with Beech Primary network verified through the Beech website. Called phone # on the claim form and confirmed physical address which matches the website. The claim was sent to Viant on 06/17/09 and came back 06/20/09 without a discount.	
• Sample #158 and #165: AvMed uncovered a discrepancy in contract rates themselves and had initiated a correction and settlement process with the facility prior to receipt of the claim sample for the County review. The discrepancy was due to the hospital having the wrong charge master calculation and thus it was loaded incorrectly. AvMed agreed to an overpayment of $7.36 for Sample #158 and $10.89 for Sample #165.		
• Sample #195: This is a contract interpretation issue. The contract language states that the conversion factor rate should be paid ($7,600), and then $5,500 per diem over the DRG threshold days. This results in an underpayment of $2,610.60 disagreed to by AvMed. Deloitte Consulting believes the contract language is open for interpretation. However, AvMed notes that the interpretation has been made between AvMed and the facility, and that the contract is not unique to this particular facility. The process for these types of contracts is for DRG pricing to be based on a fixed conversion factor that is multiplied by the DRG weight (even though the contract language references a different process).	AvMed disagrees--While some of AvMed's contracts are complex, the favorable terms of these contracts offset the possible risk involved in the manual process required to adjudicate. The language that may be considered open to interpretation is clarified and documented, when necessary, with AvMed and the provider.	
• Finding - Sample #212: This is a contract interpretation concern in which clarification is necessary outside of the contract language for processing. This is a contract interpretation issue. The payment is not consistent with the contract language. • Finding – Sample #214 and 217: Contract included outlier and carveout language in same paragraph. AvMed states that the outlier doesn't apply to the trauma case rate, but also seems to be applying the carveout clause from the same paragraph. • Finding - There are numerous samples where the contract states a certain		

	Carrier Action to Address Review Issue	Closure Date
percentage of the Medicare allowable fee schedule; however, the pricing provided did not match the paid amount. AvMed notes that providers are aware that the Medicare allowable fee schedule is modified from time to time, and that rate changes are not made retroactively. o Sample #19 o Sample #47 o Sample #101 o Sample #102: Medicare 2009 fee schedule published on 10/31/2008. Retroactive changes are not reimbursed, but the lengthy delay in updating the rates in the system caused an overpayment of $5. **Recommendation**		
• AvMed should ensure that "lesser than" language is included in all provider contracts.	"Lesser than" language is AvMed's preferred language when it can be negotiated into the contract.	
• AvMed should review contracts as many are difficult to understand, open to interpretation, and may lead to confusion. AvMed is diligent in following up with discrepancies, but payment and pricing in system should match contract wording and there should be no inconsistencies and minimal need for additional clarification with provider relations or the facility.	While some of AvMed's contracts are complex, the favorable terms of these contracts offset the possible risk involved in the manual process required to adjudicate. The language that may be considered open to interpretation is clarified and documented, when necessary, with AvMed and the provider.	
• AvMed should make sure Medicare fee schedules are updated on a timely basis in the system.	AvMed's contracts with provider's state clearly that AvMed decides when to update the Medicare fee schedules. Fee schedules are loaded timely, as they are received, and the effective date will match if it is a future date. However, quite often, the Medicare fee schedule is received with a retro effective date. Clearly, it is not cost effective to adjust claims back to Medicare's effective date.	
Miscellaneous **Issue**		
• Finding - There are numerous samples where the diagnosis pointer indicates more than one diagnosis; however, the claim has the primary diagnosis only. AvMed notes that this is a system functionality based on Amisys logic and a display issue. All of the diagnosis codes are captured but stored at the claim level. o Sample #2 o Sample #35 o Sample #42 o Sample #44		

	Carrier Action to Address Review Issue	Closure Date
○ Sample #59 ○ Sample #68 ○ Sample #133 ○ Sample #142 ○ Sample #180 ○ Sample #193 ○ Sample #203 ○ Sample #209 ○ Sample #210 ○ Sample #221 ○ Sample #223 • Finding – Sample #218: There is a display issue pertaining to the secondary diagnosis in box A on the electronically transmitted claims. The secondary diagnosis in box A is skipped, going right to box C. AvMed notes that this is a low priority bug as it does not create an adjudication issue, and all diagnoses are captured in the database. • Finding - Sample #133: There is a departmental issue (JM coding) with how the provider name and contract name are loaded. The billing provider was listed as Jackson Children's Hospital while the contract provided was for Jackson Memorial Hospital. These hospitals bill under the same tax ID number (TIN), however, the contract fees are different. • Finding – Sample #190: This claim was for a member who was retroactively terminated. The claim processed correctly at the time of adjudication based on the available eligibility information. AvMed should follow-up to make sure refunds are captured as there are several claims that were paid after the retroactive termination. • Finding: Sample #215: This claim was adjusted as a result of a hospital audit conducted by AvMed. The claim originally processed correctly based on the contract; however, charges were later decreased. AvMed should follow-up to make sure refunds are captured as over six months have passed since this was approved. • Finding - Sample #210: This claim was for a motor vehicle accident. At the time of the review, the case was still open for subrogation investigation. **Recommendation** • AvMed should work to fix the display issue for the additional diagnosis codes. • AvMed should continue to follow-up for payment recovery for the claim in	As noted, this is a low priority as the display of the additional diagnosis codes is not an adjudication issue and the information is stored at the claim level rather than the line level.	

AvMed Claim Review Summary
Claims Paid from January 2009 through December 2009

	Carrier Action to Address Review Issue	Closure Date
Sample #190, Sample #210, and Sample #215.	AvMed has reviewed the overpaid claims. Sample #215 has been recovered. AvMed has reviewed the circumstances surrounding the error identified in Sample 190 and has determined that it does not represent a systemic issue related to the recovery of claims paid for retroactively terminated members. AvMed will follow up for payment recovery in this case. Sample 210 remains open for subrogation pending settlement.	
Observations from the On-Site Review Observations include: • AvMed utilizes multiple levels of control and oversight to ensure claims are accurately paid. For example, hospital audits are conducted on most hospital claims and the diligence of the review team has had a positive impact on the application of contract provisions often resulting in additional savings for the County through reduced claim payments.	AvMed concurs.	
• We did note that several processes rely on manual review and while seemingly effective, manual processes create a risk of human error. Additionally, the quality of services could be comprised if staffing is reduced or the staff experience level is not maintained.	While some of AvMed's contracts are complex, the favorable terms of these contracts offset the possible risk involved in the manual process required to adjudicate. The staff is well trained and audited. In addition, contracts are reviewed routinely to determine if there is any opportunity for programming that will allow automation. The consistently high results in Financial, Payment, and Coding accuracy reflect very effective, accurate claims adjudication.	
• Student eligibility is only verified once per year by member processing. The standard is for health plans to verify student eligibility more than once per year.	The County and AvMed have collectively agreed to verify over aged dependents eligibility at the beginning of the plan year. This is clearly stipulated in the "Summary Plan Description" section III. - Eligibility. In addition, recent trends indicate that more plans have adopted an annual (instead of semi-annual) verification process.	

AvMed Claim Review Summary
Claims Paid from January 2009 through December 2009

Section III: Next Steps

	Carrier Action to Address Review Issue	Closure Date
Financial Recovery Agreed Upon Overpayments: AvMed agreed to the following net payment errors in the claim samples reviewed: • Random Sample Review: $595.46 Details supporting these findings are included in a supplemental exhibit to this report. • AvMed should review and comment on the recommendations in the report. Overall Assessment AvMed met or exceeded the contractual performance guarantees. It is important to note that note all of the performance measures included in this report are contractual performance guarantees. As previously noted, Turnaround Time is measured on clean claims only as part of the contractual performance guarantees while the claim review results reflect all claims. Deloitte will work with AvMed to determine if clean claims only can be identified and utilized in the Turnaround Time calculation. Overall, AvMed's claim s and payment processing results from this claim review were positive. While Deloitte did identify a few areas in which AvMed could improve their processes, there were no major concerns discovered through our claim review.	It should be noted more clearly in the report that AvMed met and exceeded all Claims performance guarantees.	

This document is a draft of a future solicitation and is subject to change without notice. This is not an advertisement.

Miami-Dade County, Florida *RFP No. 853*

Group Medical Insurance Program
SCOPE OF SERVICES

2.1 Background

Miami-Dade County, hereinafter referred to as the County, as represented by the County's Internal Services Department (ISD), is soliciting proposals from interested parties to offer the following Group Medical Insurance Program (Program) Plans. The Proposer shall offer an Actuarially Equivalent Plan as defined below.

For purposes of this solicitation an Actuarially Equivalent Plan is a plan that is the Actuarially equivalent to the plans currently offered by Miami-Dade County or Jackson Health System (JHS) to employees, dependents, and retirees. To determine Actuarially equivalence, the Proposer must consider existing plan designs, network/utilized providers and formulary compositions. The existing plan designs, include a Point-of-Service (POS) plan, and two Health Maintenance Organization (HMO) options: High and Low, as defined by the plan designs (see Attachment E, Plan Designs). Additionally, there are three separate plans offered to Medicare-eligible retirees, including a low option, a high option with pharmacy coverage, and a high option with no pharmacy coverage. For informational purposes only, there is a piloted Limited Network Plan (only offered to Jackson Health System (JHS) employees). This piloted Limited Network Plan, which offers the same benefits as the High HMO Plan, is not part of the existing plan option required to be included in the Actuarially Equivalent Plan Option in this Solicitation. However, JHS intends to continue offering this piloted Limited Network Plan to its employees. In offering an Actuarially Equivalent Plan, Proposers may propose on either a Self-Funded Plan or a Fully Insured Plan, or both.

The County does not currently purchase specific or aggregate reinsurance and does not anticipate purchasing reinsurance if the plan remains Self-funded. Consequently, reinsurance proposals are not included in the scope of this Solicitation.

County and JHS employees, dependents, and retirees will be eligible for these plans. A list of covered groups is below.

Covered groups include:

- Miami-Dade County Staff
- Jackson Health System (JHS)
- County and JHS Retirees under age 65
- Retirees 65 and older
- County Judges (approximately 50 individuals)
- Housing Finance Authority (approximately 5 individuals)
- Industrial Development Authority (approximately 3 individuals)
- Town of Miami Lakes (approximately 48 individuals)

Note: The International Association of Firefighters Local 1403 ("IAFF"), offers a plan to its members. Employees will be offered the opportunity to participate in any of the County plans, or the Union plan, if eligible. The actual number of individuals participating in the County plans can be found in **Attachment A, Census.**

2.2 Qualification Requirements

1. **Minimum Qualification Requirement:**
   Proposer shall be licensed by the State of Florida, Office of Insurance Regulation, Office of Insurance Regulation , to provide the plan services for which the proposal is being submitted for, as of the proposal due date.

(Note: This is a continuing requirement throughout contract award and term of the agreement.)

2. **Preferred Qualification Requirements:**
   The Proposer should:

   1. Have a minimum "A- Rating" from A.M. Best and a Financial Classification of "VII" or higher as of the most recent rating.

   2. Have been licensed to transact the appropriate insurance and administrative products for at least five (5) years in the State of Florida. This preferred qualification is also applicable to the selected Proposer's subcontractors.

   3. Have significant experience administering claims and providing similar services to those listed herein in this Solicitation, for governmental groups of 5,000 employees or more.

   4. Have sufficient provider networks in areas in which County employees and retirees reside (primarily in South Florida). Retirees and out-of-area dependents shall have sufficient access to providers and should be covered based on the same plan designs as in-area participants. The network for the proposed plan should include a national network of providers while maximizing discounts to the plan.

Note: For the Actuarially Equivalent Plan (Self-funded and/or Fully Insured) the provider network match is based on utilized providers with at least a 92% provider match.

2.3 General Information

1. Members of the local IAFF Union 1403 may be eligible for coverage in their Union-sponsored plans. To identify participants in the Union-sponsored health plan, refer to the census data provided in **Attachment A, Census.**

2. The selected Proposer's proposed Administrative Services Only (ASO) fees for the Self-funded Plan (See Form B-1, Self-Funded Price Proposal) shall include the cost of runout claims upon plan termination (for 12 months after expiration of any contract or renewal period issued as a result of this Solicitation).

3. The selected Proposer shall retain all fiduciary responsibilities, including, but not limited to responsibility for all internal and external appeals.

4. Currently, the County contributes 97% of the single employee cost for the POS plan, 100% of the single employee cost for the HMO plan options, and approximately 35% of the cost of dependent coverage in the form of a subsidy. The employees' contributions to the cost are offered on a pre-tax basis. The County subsidizes a portion of the cost of retiree coverage; the County's retiree subsidy varies by plan and dependent tier. The County reserves the right to change its contribution strategy at any time. The selected Proposer's fees and rates shall remain effective regardless of the contribution strategy.

5. The County contribution levels are subject to collective bargaining agreements.

6. Effective January 1, 2014, any full-time County employee who has completed 60 days of employment is eligible for coverage. Any part-time employee who consistently works at least 60 hours bi-weekly and has completed 60 continuous days of employment is eligible for coverage. Executives, as identified by the County, are eligible for coverage on their first day of employment. If an election is made, coverage is effective the first day of the month following completion of the eligibility period without any actively-at-work exclusion.

   Dependent eligibility is defined as follows:

   a) Spouse or Domestic Partner (unless and eligible County employee).

   b) Married or unmarried natural children (whether or not they live with the employee), children of a domestic partner, adopted children, stepchildren or a child for whom the employee has been appointed a legal guardian pursuant to a valid court order to the end of the calendar year in which the child turns 26 (providing not offered coverage at work). The Contractor will require proof of eligibility if the child's last name differs from the employee's. Coverage may be extended to the end of the calendar year in which the child turns 30 if unmarried and the child satisfies the criteria in Florida Statute 627.6562.

c) Coverage for an unmarried dependent child may be continued beyond age 26 if the child is mentally or physically disabled. Proof of disability may be required.

d) Unmarried dependent children and dependent children of Domestic Partner from age 26 to age 30 (end of calendar year) are eligible for coverage as stipulated by Florida Statute FSS 627.6562.

7. Employees under age 65, who retire from County service, may continue POS or HMO plan membership for themselves and their dependents until age 65 with remittance of the required premium to the County. Currently, the dependents of deceased retirees or of retirees attaining Medicare eligibility may continue coverage through the retiree group by remitting the appropriate premiums. The County reserves the right to make modifications such as offering COBRA as an alternative.

8. Retired employees who have attained age 65 may choose a Medicare Supplement plan offered by the County or a Medicare Advantage plan offered by the selected Proposer with required premium remittance. The Medicare Advantage plan premium (if any) will be collected directly by the selected Proposer.

9. Retiring employees shall be provided an opportunity at the time of retirement (no later than 30 days from the retirement date) to change their medical insurance plan election in order to allow participation in the option which best meets their retirement needs. The selected Proposer shall allow an annual open enrollment period for retirees, if requested by the County.

10. All retirees under and over the age of 65 shall have access to national networks at least equivalent to the networks offered to active employees. For any Actuarially Equivalent Plan Options, the provider network match is based on utilized providers with at least a 92% provider match.

11. The selected Proposer must provide current plan participants continued coverage on a no-loss, no-gain basis (meaning no employee should lose nor gain a benefit due to a change in the selected Proposer).

12. All underwriting requirements shall conform to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), where applicable. The Proposer shall review the HIPAA Business Associate Agreement included in the County's Form of Agreement herein (**Appendix C**). The selected Proposer is required to execute this agreement as part of any award issued as a result of this Solicitation.

(a) New employees and their eligible dependents are eligible for coverage without proof of insurability and are not subject to pre-existing condition exclusions.

(b) Employees who do not enroll within their initial benefits eligibility period, and do not satisfy a HIPAA special enrollment qualifying event, may not enroll until the following annual open enrollment period with a January 1 effective date.

(c) All employees and dependents enrolled as of December 31, 2013 are eligible for coverage with no actively at work exclusion.

13. The following rules apply for adding dependents:

(a) New Dependents - A dependent of an insured may be added to the Program by submitting an application within 45 days (60 days for newborns) of acquiring the dependent status. The employee must enroll the dependent within 45 days after the marriage, registration of Domestic Partnership or birth/adoption of a child (60 days for newborns). Coverage for a new spouse or Domestic Partner is effective the first day of the month following receipt of the application. Coverage for a newborn, child placed for adoption, or adopted is effective as of the date of birth or the earlier of 1) placement for adoption, or 2) adoption date. The change in premium, if applicable, is effective the first day of the month following the birth or the earlier of 1) placement for adoption or, 2) adoption date.

(b) If eligible employees have declined coverage for themselves or their dependents because of other insurance coverage and the other coverage ends, they may request enrollment within 45 days after the other coverage ends.

(c) Change of Family Status - A dependent may be added to or deleted from the Program at anytime during the year under HIPAA or IRS section 125 provisions. Proof of the change in family status must be submitted at the time of request of change. Refer to section 13(a) above for information on adding a new dependent. Payroll changes to add a newborn are processed in accordance with Florida Statute 641.31(9). If the Change in Status (CIS) form is received by the County within the first 31 days from birth, the premium is waived for the first 31 days. If the CIS Form is received after the first 31 days, but within 60 days of the birth, the new premium will be charged retroactive to the date of birth. The same applies when adding an adopted child or child placed for adoption. The premium is waived if the CIS Form is received by the County within the first 31 days from the earlier of: a) adoption, or b) placement for adoption. If the CIS Form is received after the first 31 days, but within 45 days of the event, the new premium will be charged retroactive to the earlier of: a) adoption or b) placement for adoption. Payroll changes to delete a dependent, other than those events

specified in this paragraph, become effective the first day of the pay period following receipt by the County.

14. Employee membership terminates on the last day of the pay period for which applicable payroll deductions are made after the date the employee ceases active work for any reason other than an approved leave of absence or retirement.

15. The selected Proposer shall notify the County of any change in its financial ratings by the A.M. Best rating service, the Standard and Poors rating service, or any other industry rating service by which it is rated. Notification of such change shall be delivered by certified mail to the County no later than three (3) business days after the selected Proposer has been apprised of such change.

16. The selected Proposer shall adhere to generally accepted standards (as suggested by the National Committee for Quality Assurance "NCQA") for the consideration and credentialing of physicians in its networks.

17. The selected Proposer shall perform a GeoAccess analysis on an annual basis and make reasonable efforts to contract with additional physicians and hospital providers where minimum access standards are not met. The minimum access standards are one (1) provider/facility within 5 miles or two (2) providers/facility within 10 miles.

2.4 Enrollment/Communications Provisions

The selected Proposer shall:

1. Provide enrollment materials at a minimum of thirty (30) days prior to the start of the County's annual open enrollment period. Enrollment materials shall be provided in printed format (for approximately 7,000 employees), in an adequate amount, at the County's discretion. An electronic version and a customized benefits website shall be made available for all eligible employees/retirees during initial enrollment and to new enrollees. Materials include, but are not limited to, the Summary of Benefits and Coverage and other materials as needed.

2. Draft materials including, but not limited to, the Summary Plan Descriptions (SPD) at least 30 days prior to the Plan Year effective date, January 1st. The selected Proposer shall print and mail the SPD directly to Member homes at no additional cost to the County, with additional supplies as required by the County.

3. Utilize County-specific forms and materials, as necessary.

4. Provide identification (ID) cards to each enrolled Member. Additionally, ID cards will be generated and distributed within five (5) business days and/or a website that Members can access to print temporary ID cards, when any of the following events occur:

   a) Change in coverage option;
   b) Change in coverage tier; and/or
   c) A replacement/duplicate card is requested.

5. Ensure that the Actuarially Equivalent Plan shall identify members by Social Security number ***and/or*** employer ID number, as required by the County. The selected Proposer shall ensure that Social Security numbers are maintained for all Members enrolled in the County plans.

6. Distribute all communication materials to the various County locations no later than two (2) weeks prior to the start of the County's open enrollment period. The County shall approve in writing all booklets and any/all other employee communications prior to printing. Additionally, the County retains the right to prohibit distribution of any materials that make false or misleading statements, make reference to any plan other than the selected Proposer's plan, or any other materials or "giveaways" which the County deems to be inappropriate.

7. Review the plan-specific information in the County's Employee Benefits Handbook (see **Attachment B, 2013 Benefits Handbook**) for accuracy and provide any updates to the County annually no later than September 1 for the upcoming plan year. The County will finalize and publish the Benefits Handbook. The County shall retain final approval authority over all communication material.

8. Accept the use of the current Miami-Dade County Enrollment Form and/or use of County's on-line enrollment process. (Refer to **Attachment C, Enrollment Form**). The County uses web enrollment for the annual open enrollment and anticipates continued use of web enrollment for ongoing enrollments.

9. Have access to County employees on County premises as determined by the County.

10. Provide sufficient personnel to attend all initial enrollment period meetings and subsequent open enrollment period meetings (approximately 45) on a schedule set by the County and JHS. The selected Proposer shall provide personnel to attend meetings scheduled by the County between such annual periods, assuming reasonable notice is given.

11. Adhere to an implementation schedule for a January 1, 2014 plan effective date, with enrollment scheduled for October/November of 2013.

12. Accept eligibility data, in an electronic format, in the file layout used by the County.

13. Update eligibility data within one (1) business day from the receipt of data. The selected Proposer shall notify the County of any issues within one (1) business day from the time of the data upload.

14. Provide a single point of contact with regard to eligibility and enrollment information and coordinate any internal distribution of such information, as well as facilitate any necessary transfer of data to third party administrators.

2.5 **Benefits Provisions**

The selected Proposer shall:

1. Ensure that the Actuarially Equivalent Plan complies with federal guidelines for Cafeteria Plans pursuant to Internal Revenue Code Section 125, the Patient Protection and Affordable Care Act (PPACA), the Age Discrimination in Employment Act (ADEA), American Disabilities Act (ADA), Medicare Secondary Payor, HIPAA, and COBRA, as well as any other applicable federal requirements and all Florida mandated benefits.

2. Have full service provider contracts in place with the University of Miami School of Medicine (UMSM) and with Jackson Health Systems (JHS). Both of these providers are subject to the Actuarially Equivalent Plan and any Alternative Plan Option approved by the County, standard credentialing methods. The selected Proposer shall allow enrollees in the selected Proposer's plan to use all health care services (primary, secondary and tertiary services) offered by UMSM and JHS. Such provider contracts shall a) become effective no later than December 1, 2013, b) remain in force for the duration of the selected Proposer's contract with the County, and any renewals or extensions thereof, and c) not contain any provision restricting or limiting an enrollee's use of these providers in any way that is not imposed on other physician or hospital providers in the selected Proposer's network. The selected Proposer shall provide proof of an existing contract or a properly executed letter of intent with UMSM and JHS, which shall be negotiated by the selected Proposer with these facilities no later than October 1, 2013; or the selected Proposer must demonstrate to the County's satisfaction, at its sole discretion, that the inability to contract with these facilities was out of the selected Proposer's direct control or not its decision. **There are no exceptions allowed for this requirement.**

3. Accept the County's Employee Support Services Program (ESS) full authority to refer Members to the health plan network for mental

health/substance abuse services. The ESS shall bill and be reimbursed by the selected Proposer according to negotiated fees. **There are no exceptions allowed for this requirement.**

4. Provide wellness benefits within the Actuarially Equivalent Plan. The selected Proposer shall cooperate with the County in readily providing health screenings to employees and families at locations throughout the County. In addition, selected Proposer shall readily provide various wellness activities including, but not limited to, health risk assessments, health fairs, flu shots and educational workshops.

5. Notify the County on a timely basis, of any issues/discussions surrounding its network of physicians and hospitals which would have an impact on County employees and retirees.

6. Provide the criteria for approval of organ transplants in the Actuarially Equivalent Plan. This criteria shall be defined and incorporated by reference into any agreement issued as a result of this Solicitation, including the criteria for approval and the definition of Experimental Procedures that will not be covered by the Actuarially Equivalent Plan. The Selected Proposer shall provide all explanations in layperson's terms.

7. Provide the criteria and process for determining a Medical Necessity in the Actuarially Equivalent Plan. This criteria and process shall be defined and incorporated by reference into any agreement issued as a result of this Solicitation.

8. Accept pregnant employees/dependents, who are beyond the first trimester, to continue with their current attending OB/GYN, through the time of delivery, and such coverage shall be considered at the in-network level of benefits.

9. Provide an in-network level of care and benefits to a designated employee, and or retiree, in special catastrophic cases, as determined by the County, even if the provider utilized is not part of the selected Proposer's network.

10. Allow for any deductible satisfied, and credited by the Selected Proposer for covered medical expenses in the last three months of a calendar year (every plan year) to be carried over to satisfy the participant's next year's deductible.

11. Offer the Actuarially Equivalent POS and High Option HMO plans on an open access basis (no Gatekeeper). The Low Option HMO currently has a Gatekeeper.

12. Provide full transparency on the pharmacy rebates earned based on the County's prescription drug utilization. The selected Proposer shall provide credit for such rebates on a quarterly basis and all earned rebates will be provided even if the contract is terminated. The County reserves the right to audit the pharmacy rebate program on an annual basis.

13. Notify the County within 60 days of changes in the preferred drug list prior to the change, with explanation of how it will directly affect the County's Members. Include the number of Members affected and what other drug options the Member will have going forward.

2.6 Data and Reporting Provisions

The selected Proposer shall:

1. Provide the following reports (which shall include the information as stated below):

   (a) **Monthly Paid Claims Activity Reports**
   Monthly report of claims due to the County by the 15th of the following month, segregated by bargaining unit, active employees, Medicare and Non-Medicare eligible retirees, and further categorized with dependents and COBRA beneficiaries identified separately (active and retirees).

   (b) **Annual Utilization Data Reports**
   Annual report due to the County within 90 days of the close of the Plan Year, showing inpatient utilization by hospital, outpatient utilization and physician by type of service.

   (c) **Annual Care Management/Disease Management Reports**
   Annual report due to the County within 90 days of the close of the Plan Year, showing utilization by program.

   (d) **Annual Prescription Drug Management Reports**
   Annual report due to the County within 90 days of the close of the Plan Year, providing cost indicators including brand and generic drug utilization, Formulary and non-Formulary utilization with separate specialty drug cost indicators.

   (e) **Quarterly Data Feeds**
   Quarterly report due to the County within 90 days of the close of the quarter, showing quarterly data feeds including all medical and pharmacy claims and covered membership.

2. Provide on-line access to eligibility, census data and individual claim information to the onsite customer service representatives for the County.

3. Maintain utilization statistics based on the resultant desired County plan structure.

4. Provide the County (and its designated consultant, if any) with on-line access to the selected Proposer's reporting system in order to retrieve standard and ad hoc claims and utilization reports.

Note: Selected Proposer shall provide all reports in an electronic format by plan and employee group (as applicable).

2.7 Administrative and Related Services

The selected Proposer shall:

1. Accept the County's self-billing process as all benefit plans shall be administered on a self-billing fee/premium rate remittance basis.

2. Accept bi-weekly bank wire-transfers of fee/premium payments, which will be remitted for the prior pay period. The selected Proposer shall grant a 30 day grace period for active and paid leave status employees.

3. Establish, if the County is self-funded, a benefit plan account ("ASO Account") with a Qualified Public Depository bank agreed upon between County and the selected Proposer. The account shall be in the name of the County and the selected Proposer shall have signature authority for the exclusive use of the County's plan. The County shall establish a benefit plan funding account ("Funding Account") with a Qualified Public Depository bank agreed upon between County and selected Proposer. The account shall be in the name of the County for the exclusive use of the County's plan. The Funding Account will be connected to the ASO Account, for the sole purpose of funding the Account as payments are presented. Fund transfers between the Funding Account and the ASO Account will occur via an automated process that is administered by the bank. An imprest balance in the amount of seven million dollars ($7,000,000) will be maintained in the Funding Account. Should it become necessary to increase the imprest amount, the County will agree to do so based on satisfactory evidence from the selected Proposer of insufficient funds. The Funding Account shall be funded weekly by the County based on electronic reports provided by the selected Proposer of payments to be issued on behalf of the County. The selected Proposer shall provide a monthly reconciliation of the ASO Account. Any interest earned in the ASO Account shall be accrued to the County and any banking fees will be charged to the ASO Account.

4. Pursue Coordination of Benefits (COB) before payment of claims. The selected Proposer shall administer potential subrogation on a "pay, then pursue" basis. Subrogation action shall not be pursued against the County for Workers' Compensation claims that have been denied by the County.

5. Coordinate directly with Medicare, on behalf of retirees, in processing Medicare supplement plan claims.

6. Administer appropriate procedures to carefully monitor the status of over-age unmarried dependent children and dependent children of Domestic Partner (26 years and over) to ensure satisfactory proof of eligibility is obtained and that coverage complies with Federal and State regulations, including COBRA status. Dependent children and dependent children of Domestic Partner losing group coverage due to age or loss of dependent status must be notified of their COBRA rights. The selected Proposer shall notify the County within 60 days after the open enrollment effective date (January 1st of each year) of any discrepancies in eligibility including employee name, dependent to be deleted and any change in coverage level.

7. Provide all COBRA administration, including mailing of initial COBRA notification after receiving notification of a qualifying event from the County. The services required also include billing of beneficiaries and collection of appropriate premiums.

8. Provide HIPAA certificates of coverage within 30 days of coverage termination.

9. Issue HIPAA Notices of Privacy Practices to new enrollees.

10. Verify dependent eligibility at initial enrollment and overage dependents and dependents with different last names at subsequent open enrollments, and notify the County within 60 days of any discrepancies in eligibility. The selected Proposer shall verify eligibility for new hires and new enrollees within 30 days and notify the County of any discrepancies in eligibility.

11. Perform a bi-weekly reconciliation of accounts based on bi-weekly eligibility tapes provided by the County. The selected Proposer shall notify the County in writing within 10 business days of any discrepancies, to include subscriber name, subscriber identification number, name of ineligible dependent and change in coverage level, if any.

12. Provide a local account representative (who shall be physically located in the Tri-County area, and be approved by the County) with full account management capabilities. The account representative shall assist the County in the administration of the Actuarially Equivalent Plan approved by the County, in providing all necessary and related services for employees, in obtaining the appropriate resolution of issues including claims problems, and in any other ways requested, related to the Services stated herein.

13. Selected Proposer's Account Manager and account management team shall:

- Devote the necessary time to manage the account and be responsive to County needs pertaining to this Scope of Services (this includes being available for frequent telephone calls and On-site consultations with the County staff located in Miami, FL.);
- Provide the County with mobile phone numbers and email addresses of all key account management personnel;
- Be thoroughly familiar with all of the proposing company's functions that relate to the County's account; and,
- Act on behalf of the County to effectively advance County action items through the selected Proposer's corporate approval structure.

14. Provide up to four (4) On-site customer service representatives to be housed at the County administration building and/or other County designated locations. The selected Proposer shall provide computer terminals, printers and fax machines for its representatives that have on-line access capabilities of employees' eligibility and claims information, provide customer service related functions, and assist in plan administration. The customer service representatives shall adhere to regular business days/hours pursuant to the County's business schedule. If a customer service representative is on vacation, or otherwise absent for an extended period, a replacement representative shall be provided. Further, the County may request replacement of the On-site representative if he/she is not performing in a satisfactory manner. The County will advise the selected Proposer of any performance concerns and allow adequate time to resolve before requesting such replacement.

15. Comply with the Performance Standards Provisions (See **Attachment D, Sample Performance Standards)**. Compliance of Performance Standards shall be measured annually at the end of each Plan Year and any non-compliance shall be assessed as liquidated damages. The Performance Standards shall remain in effect for the duration of any contract issued, and renewal options exercised, as a result of this Solicitation.

16. Ensure that the claims processing system is fully integrated with the eligibility system.

17. Allow the County, or its representative in addition to the rights contained herein, the right to perform an annual audit of all claims, utilization management files, financial data and other information relevant to the County's account. The results of this independent audit will determine liquidated damages, in addition to recoveries, for failure to meet Performance Standards. The selected Proposer shall maintain appropriate internal audit procedures for claims and customer service administration. Additional audit programs such as pre-disbursement audits, audits of selected providers, and audits of specific services are also desirable. Fraud

prevention and detection procedures shall be maintained by the selected Proposer, including appropriate reporting to authorities.

18. Allow the County or its representative access to physician, hospital, and pharmaceutical provider contracts for the purposes of conducting the audit.

19. Allow the County or its representative to perform an audit up to 24 months after plan termination.

20. Provide all necessary data, reporting and reconciliation support as needed for the County's participation in the Retiree Drug Subsidy ("RDS") program under Medicare Part D. Such support will not include the preparation or submission of the actuarial attestation required for participation in the RDS program. Selected Proposer shall provide at no additional cost to the County, Medicare Part D prescription subsidy filing.

21. Provide all necessary data, reporting and reconciliation support as needed for the County to comply with the Patient Protection and Affordable Care Act, at no cost to the County.

2.8 **Customer/Member Services**

The selected Proposer shall:

1. Communicate any significant changes in Member Services (e.g. phone messages or prompts and personnel) to the County in advance. The selected Proposer must receive the County's approval prior to implementing major changes (e.g. unit structure and service center).

2. Provide the County with a dedicated Member Service Team. This team shall receive training on the specifics of the County's program. There shall also be a dedicated phone number for County employees to access 24/7 365 days a year.

3. Agree to the County's or Benefits Consultant's developed and administered customer satisfaction tools specific to the County's Actuarially Equivalent Plan. The County and the selected Proposer will work together to develop the survey. The survey shall be conducted annually at the County's discretion. All customer satisfaction tools must be approved by the County prior to execution. Results of the survey shall be provided to the County with appropriate analysis and response by the selected Proposer.

4. Provide to all plan Members its standard grievance procedure (included in the SPD) for Member's claim disputes when services are denied. Every new Member shall receive notification of a detailed explanation of grievance procedures within 30 days of the effective date of coverage.

5. Provide all claims data, as requested by the County; and in the instance that the County competitively solicits its Group Medical Insurance Program, the selected Proposer shall comply with any such claims data request within 10 business days of such written request. Such claims data shall include, but is not limited to: paid claims data by month, incurred claims data by month; such disruption and network data as requested, prescription drug and behavioral health care claims data as requested, large claims data and utilization data as requested.

2.9 Alternative Plan Option

As the County evolves its health benefits strategy, the selected Proposer should be able to adapt to any future changes to the Group Medical Insurance Plan that will achieve cost savings to the County, such as Alternative Plan Option(s). Proposers are highly encouraged to submit information for Alternative Plan Option(s) as part of their proposal(s). The Alternative Plan Option(s) should target cost savings of $50 million for both the County and its employees through a creative approach of Alternative Plan designs and a cafeteria type of plan election (such as high deductible plans, limited network options, etc.) in which Proposers may use its standard networks and formulary composition. The County may, at its sole discretion, consider Alternative Plan Option(s) at a future date. Proposers providing information for an Alternative Plan Option(s) should consider the following criteria:

1. The plan designs should be outlined including plan summary and details for each benefit level. All state-mandated benefits must be covered and all exclusion, limitations and not covered items should be fully outlined.

2. The network for any Alternative Plan Option should have sufficient provider networks including all specialty levels and all facilities.

3. The Formulary for the Alternative Plan Option and how it compares to the County's current formulary.

4. The County's targeted cost savings for the alternative plans is $50 million. Proposers should describe how the cost savings will be achieved within these plan alternatives, including assumed enrollment within each plan offering.

5. All other terms and conditions outlined within the scope of services should also be considered when designing these plan alternatives.

ATTACHMENT 3

MEMORANDUM
BOARD OF COUNTY COMMISSIONERS
Commissioner Juan C. Zapata, District 11

DATE: February 22, 2013

TO: Mayor Carlos A. Gimenez

FROM: Commissioner Juan C. Zapata

RE: Miami-Dade County Health Insurance Program

In 2007, the Board of County Commissioners approved a contract award to AvMed, Inc. to provide a self-funded health care program for Miami Dade County, which included a Point-of-Service (POS) plan and a high and low Health Maintenance Organization (HMO) plan. Five years have elapsed since the County entered into this contract, which provides ample information to assess the program. I want to request a detailed report to help us formulate better policy for the County's health insurance programs. I would like the report to include responses to the following questions and any other relevant information, which may assist the Board in a thorough analysis of our current health care policy with respect to health insurance.

1) Could you provide the projected health care cost (budget) to actuals for the past 5 fiscal years?

2) What is the expected health care cost for the current fiscal year and how are we tracking with actuals?

3) How important is cost transparency related to urgent and emergency services?

4) What discussions are in place, if any, to modify provider reimbursement for purposes of aligning incentives and fostering accountability of the system?

5) What is reported discount by carrier, HMO and PPO?

6) Do we currently measure rate of utilization and return on investment on wellness programs? What are the wellness programs currently in place and what is the current engagement?

7) What are the current Disease Management Programs currently in place and what are the outcomes? How many are participating in these programs? What is the ROI?

8) Can we measure claims and utilization rates by bargaining unit?

9) What is the case mix adjusted cost per case by hospital system?

10) A breakdown of utilization by Hospital both on a percentage basis and cost.

11) Numbers on usage of Urgent care centers and the median and average cost per visit.

12) What is the average cost per day at the top 5 facilities?

13) What is the utilization/cost of Emergency Room versus Urgent Care?

14) What is the cost and utilization of Emergency Room by facility?

15) What is health care cost PEPM for each of the last 3 fiscal years?

16) What are the RX rebates for the past 3 fiscal years?

17) What are the key utilization figures per fiscal year? Bed days per 1000, admissions per 1000, Average Level of Service

18) What is expended at the top 5 facilities, showing cost inpatient vs. outpatient?

19) What are the advantages and disadvantages to having two carriers manage our self- insured plan similar to what the state does?

20) How much have we paid AvMed annually in administrative services fees over the five year period?

21) How do insurance programs for bargaining units that are not insured under the County's self-funded AvMed health care program compare in terms benefits, utilization, wellness programs, costs to County, costs to employee, etc.?

22) How does utilization, claims and costs for retirees compare to active County employees?

23) An analysis on the impact of PPACA (Healthcare Reform) on the County's health program.

24) Provide an estimated cost to the County of any taxes imposed on self-insured plans including the Patient-Centered Outcomes Research Trust Fund and if the County has to pay the reinsurance tax which is $5.25 per member per month starting in January of 2014 paid in 2015.

cc: Chairwoman Rebeca Sosa
Members Board of County Commissioners
Deputy Mayor Edward Marquez
Jennifer Moon, Budget Director
Lester Sola, Director of Internal Services Department
Daniel Cullen, Risk Management Director

MEMORANDUM

TO: Honorable Carlos A. Gimenez, Mayor

FROM: Barbara J. Jordan, Commissioner
District 1

DATE: March 8, 2013

RE: Miami-Dade County Employee Health Insurance Program

I want to commend my colleague, Commissioner Zapata, for his recent inquiry regarding the County Employee Health Insurance Program. Your response to his February 22 Memorandum should provide an excellent framework for a Board Workshop about our health insurance program. In the wake of the Supreme Court decision upholding the Patient Protection and Affordable Care Act (PPACA), I am sure the entire Board of County Commissioners will want to know the impact of this federal legislation on our county healthcare program.

In addition to providing a detailed analysis of the impact of the PPACA, it would be helpful if you prepare a presentation to clarify the health insurance provisions within the Collective Bargaining Agreement with the Police Benevolent Association (PBA). On November 8, 2012, the Board of County Commissioners ratified your commitments to cap premium rates and to provide "actuarially equivalent" plan options for the PBA and all county employees.

Health insurance for our organization is a personal concern for every one of our employees. The Charter of Miami-Dade County expressly provides that "the Board of County Commissioners shall provide and place into effect a practical group insurance plan for all county employees" (Section 5.05 F.). This is an issue that requires complete transparency.

I am aware that a Special Presentation has been set for the Finance Committee on Tuesday, March 12, 2013 for "The RFP on Medical." Before an RFP is presented to the Board of County Commissioners for review, there needs to be a full discussion regarding the impact of the federal PPACA, a review of your responses to Commissioner Zapata's Memorandum, and a thorough explanation of the effects of the bargaining agreement you negotiated with the PBA.

March 8, 2013

I thank you in advance for your commitment to transparency and your cooperation in providing a thorough presentation on the County Employee Health Insurance Program, *before* an RFP is submitted to the Board of County Commissioners for approval. I trust the Chairwoman of the County Commission will provide you an opportunity to address these important matters before the full board at your earliest convenience.

c: Honorable Rebeca Sosa, Chairwoman
And Members, Board of County Commissioners
Honorable Harvey Ruvin, Clerk of the Circuit and County Courts
Robert A. Cuevas, County Attorney