DEPARTMENTAL INPUT
CONTRACT/PROJECT MEASURE ANALYSIS AND RECOMMENDATION

Rev 1

✓ New contract	OTR	CO	SS	BW	Emergency	Previous Contract/Project No. RFP559

Re-Bid Other

LIVING WAGE APPLIES: __YES ✓NO

Requisition/Project No: RFP 853

TERM OF CONTRACT: 2 year with unlimited options-to-renew

Requisition/Project Title:- RQID1300083 / Group Medical Insurance Program

Description: Miami-Dade County, is soliciting proposals from interested parties to offer Group Medical Insurance Program (Program).

User Department(s): Internal Services Department (ISD)

Issuing Department: ISD Contact Person: Annie Perez Phone: 305-375-1620

Estimated Cost: $100 million Funding Source: General Funds REVENUE GENERATING:___

ANALYSIS

Commodity/Service No: 94842 and 95348 SIC:

Trade/Commodity/Service Opportunities

Contract/Project History of Previous Purchases For Previous Three (3) Years
Check Here___if this is a New Contract/Purchase with no Previous History

	EXISTING	2ND YEAR	3RD YEAR
Contractor:	AvMed		
Small Business Enterprise:			
Contract Value:	$15 million/year for Administrative fee		
Comments:			

Continued on another page (s): _____Yes _____No

RECOMMENDATIONS

SBE	Set-Aside	Sub-Contractor Goal	Bid Preference	Selection Factor
		%		
		%		
		%		
		%		

Basis of Recommendation:

Signed: Annie Perez Date to SBD: 3/4/13

Date Returned to DPM: _____

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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.