Nassau County School Board

May 31, 2011

The Nassau County School Board released an RFP for Group Health Insurance for the 2011-2012 fiscal year. The review criteria and results of the review by the Agent of Record can be found below.

The recommendation to accept the offer from Blue Cross Blue Shield was accepted by the insurance committee at their meeting on May 26, 2011. The final recommendation on this RFP and on plan designs will be made to the Nassau County School Board at their June 23rd, 2011 board meeting.

Failure to file a protest within the time prescribed in section 120.53 (5), Florida Statutes,shall constitute a waiver of proceedings under Chapter 120, Florida Statutes.

June 9, 2011 – This date an error was found in the date of the Board meeting outlined above. The date was originally posted as the 26th. This was a typographical error and the date of the Board meeting is the 23rd.

RFP# 2011-01 Group Medical Insurance
Opening Date May 9, 2011 3:00pm
1201 Atlantic Avenue
Feranandina Beach, Fl 32034

Companies Mailed an RFP	Received Response 5/9/2011
CIGNA	Received RFP
AETNA	received RFP
HUMANA	Declined to quote
United Health Care	Received RFP
AV - MED	Received RFP
Blue Cross Blue Shield of FL	Received RFP
Coventry Health Care of Florida	Declined to quote
Morrow Insurance Agency	Quoted GAP Insurance
Valery Insurance, Inc	Quoted Retiree Only Supplements

Witness To Opening	Company Representing
Susan Farmer	NCSB
LAURIE ROBERT	NCSB
Beth Thorpe	NCSB
Christina Tillman	Miller Health Grp.
Jackie Tyson	Miller Health Grp

Nassau County School Board

Point Scoring Criteria for Medical / RX Benefit Proposals
May 2011

The objectives of the RFP scoring guidelines are to:

- Ensure consistent and unbiased scoring
- Remove individual scoring subjectivity to the extent possible
- Achieve a consensus score for each proposal and items within it

RFP responses may be evaluated using points scoring criteria and scorecards. Results can then be compared within a carrier evaluation matrix. From this, the optimum carrier vendor can be chosen.

RFPs are best evaluated as a team effort, following an agreed process and framework such as below.

Undertake the following actions to review, analyze, and score the responses and then compare in a matrix. Remember, this process is a tool. It is normal that new areas will be revealed and will necessitate follow-up questions or even new criteria to introduce. Do not let the shown criteria necessarily be the limiting criteria used, meaning new ideas and areas will be identified and need further examination and questioning.

On receiving the RFP proposals:

- Date and time stamp the receipt of responses.
- Acknowledge each receipt.
- Have the responses been received on time? If not, will you accept late responses?
- Have you received all the responses you expected? Will you chase up the outstanding responses or will you ignore the carriers who have not responded?

- How complete is each response? Have you received everything you requested from each carrier?

Reviewing and analyzing the RFP responses:

- Agree upon the weighting of each criteria component. The same weighting is to be used for each carrier.
- Analyze each RFP response using a "scorecard". This is the individual carrier scoring sheet which will include the scoring criteria, the weighting, and 0-1-2-3 scores.
- Review each requirement listed in the RFP and check the answers provided by the carrier. Use the 0-1-2-3 scoring, the weighting, and then the points. The points are the mathematical product of weight times score. Enter brief comments on the "Notes" column.
- **Note:** Carriers will tell you what they are capable of and can do and will present themselves in the best light. They will not tell you what they cannot do. You have to find this out yourself, so work carefully and record the evidence as you find it.
- By carrier, as you review, keep a log of each question you come up with for follow-up. Have the team compile and review the questions for submission to the carrier if they are clearly a contender candidate.
- Repeat the process, using a new scorecard for each carrier.

Other factors to consider:

- Keenness and enthusiasm of the carrier to be involved with NCSB.
- The professionalism exhibited in all aspects by the carrier.
- Quality standards that the carrier has achieved.
- The carrier being able to meet the time scales and deadlines, including the finalist/ selection phase and also the full implementation phase.
- Whether the carrier has the resources to handle implementation.
- Cost and payment terms offered and whether they are negotiable.
- Carrier references, both current clients and recent terminations. Especially those who are also public school boards.

Comparison matrix:

- It may be obvious from the individual scorecard results and additional factors, which carriers should be short listed as finalists. However, if it is not quite so clear, use the comparison matrix of the results of each scorecard.

- The comparison matrix forms key evidence as to which carrier should be short listed and investigated further, including for site visits. Do not just choose based on lowest price! Consider all factors before making a recommendation to the Board.
- Keep the scorecards, the matrix, and the accumulated questions and use them as the basis for a more detailed evaluation, such as when performing a site visit or attending a carrier presentation.

RFP Scoring Guidelines
May 2011

1. Plan sufficient time to review each proposal, score, resolve queries, meet carriers and achieve consensus scores.
2. RFP team members should evaluate and score proposals individually. Once completed, they should meet to discuss and compare findings. They need to agree on a consensus score for each point and for the carrier in total. However, initially, there may be wide variance in scores, comments, and queries raised by team members. These will need to be resolved and it may take further investigations and meetings before this can be achieved.
3. Only scores from team members scoring proposals may be used in calculations. No one else should be allowed input at this stage.
4. Score all relevant aspects of a carrier's proposal, not just the listed RFP criteria. Keeping systematic notes and questions, collaborating between team members, and compiling them in an organized fashion is key.
    a. All carrier requirements
    b. How informative the proposal is
    c. Implementation assistance
    d. Training
    e. Support
    f. Proposal costs
5. Do not allow costs to be the main factors in rating carriers. Always include a combination of factors, such as:
    a. Proposals
    b. Presentations and demonstrations
    c. Carrier responsiveness to questions and clarifications
    d. Keenness to be involved with NCSB
    e. As well as costs
6. Any prior experiences with the carrier should not be considered in scoring the proposals.

7. Team members should completely review and evaluate all proposals and their contents. They should all contribute to the final consensus scores for each carrier's proposal.
8. Team members should be willing to compromise as scoring develops, adjusting their own scores when there are compelling reasons.
9. Because serving the public brings with it a higher standard, meeting minutes should be recorded.
10. Team members should not be allowed to communicate directly or privately with carriers or other interested parties until the evaluation process has ended. Make sure the carriers understand this. Then, at the appropriate time but after the scoring process, the team may meet carriers to resolve queries, clarify items, and view presentations.
11. Once all queries, clarification and consensus scores have been achieved, then findings can be reviewed as a team. The team should then report these details to the Board for their input, discussion, and agreement.

Review of Group Medical Request For Proposal

Nassau County School District
1201 Atlantic Ave. Fernandina Beach, FL 32034

Jackie Tyson, Miller Health Group

5/26/2011

1. Background
    a. Performance of Blue Cross Blue Shield of Florida (BCBSFL):

BCBSFL has been the group health carrier for NCSB since 2000. During that time, they have more than adequately met the needs in a cost effective manner of NCSB both in satisfactory service and health provider choice to NCSB employees and their families; and in serving and partnering with NCSB leadership and staff. It goes without saying that BCBSFL is the apex of the group health benefit market in northeast Florida, both in the public sector market and the private sector. Both NCSB employees and staff have enjoyed the confidence of knowing that BCBSFL is the preeminent carrier in the northeast Florida market.

However, for NCSB, the caution is not allowing BCBSFL to get the upper hand in the client-vendor relationship playing too strongly upon their market dominance, nor to ignore strong and viable options that the market can bring to NCSB. On the other hand, given their depth and unparalleled provider discounts and relationships, BCBSFL is not a health carrier to be ignored and, properly managed, can be the foundation of a positive health benefit plan for NCSB.

Therefore, at the outset we can determine that BCBSFL continues to be among the top of the carrier alternatives NCSB should consider. Yet, with equal force, we can also say that the market holds viable, interesting, and effective alternatives to BCBSFL and a host of ideas and concepts for NCSB to consider.

    b. Desire for best cost/ benefit value including excellent employee and account service

As we explore the market alternatives for NCSB, only for the moment putting aside strategic ideas and directions, the immediate priorities are service and value to employees, their families, and NCSB administrative staff.

For cost considerations alone, we reviewed the entire spectrum of funding options: from fully insured prospective rating through to full self-funding. The major spectrum of funding arrangements appears as:

- Fully insured, prospectively rated
- Fully insured, surplus/ deficit accounting
- Fully insured, retrospective premium arrangement
- Fully insured, minimum premium plan arrangement (“MPP”)
- Self-funded, with health Plan reinsurance (“stop-loss”)
    - Through an insurance carrier: “ASO”, “Administrative Services Only”
    - Through a “TPA”, “Third Party Administrator”
- Self-funded, no stop-loss

Currently, NCSB is fully insured with an “Annual Accounting and Retention Agreement”, also referred to by BCBSFL as a “Pro-Share Agreement”. This is very close to the second option above. The Pro-Share Agreement represents a beneficial approach offering the Board the stability of a fully insured contract

under the oversight of the State Insurance Commissioner (versus the less regulated and less protected ERISA-only oversight); gives the oversight and stringent review necessary to ensure that the expense and other components are competitive; and, allows the Board to share in any "underwriting profit" (i.e.- returned unused premium after taking out claim charges and expenses).

In soliciting proposals from the market, we put the heaviest weight on optimal funding terms. Through the RFP solicitation and follow-up, we guided the market to offer fully insured arrangements at least as attractive as the current BCBSFL Pro-Share arrangement. Some complied initially, some complied through follow-up, and some would not offer such funding at all.

On the funding approach spectrum above, month-to-month funding levels vary with claims volume. This, plus recognizing the additional administrative burden placed on the current Board staff with any of the self-funded approaches, even including the Minimum Premium arrangement, the entire funding focus of the RFP was fully insured with surplus/ deficit accounting. This assures the Board of the most advantageous net cost without the additional administrative and cash management burdens of self-funding.

c. Market and regulatory backdrop

The overwhelming regulatory influence on the health benefit climate today is the Patient Protection and Affordable Care Act ("PPACA") signed into law on March 23 2010 along with the Senate corrections law ("Health Care and education Reconciliation Act of 2010"), which comprise Health Care Reform. For the purposes of the NCSB consideration of alternate carrier vendors, the impact of PPACA is neutral as it impacts all players similarly. Even while the rollout and challenges to PPACA continue and looms over all employers and health plans, it is not a central theme to this evaluation and selection process.

PPACA's impact has begun to be felt by the carrier and TPA market. Other than employers and plans that have been able to secure federal exemptions; or, employers that have retained their "grandfather status" (unlike the majority of employers), benefit plan designs offered for all employer plans have been impacted. Depending on the size and type of plan, carriers have added 1% to as high as 9% to premiums to cover the risk and claims from the new PPACA plan provisions. In addition, looking ahead, insurance carriers are either already altering or preparing to drastically alter plan designs offered to the market.

The greatest shift appears to be the uncertainty as to whether some carriers or other participants will be leaving the market. For fully insured plans, PPACA limits the amount of premium carriers can designate to cover expenses and profit. Last year, one significant health insurance carrier left the market because of PPACA. It is expected that lower overhead regional/ local boutique carriers will emerge plus a proliferation of specialty "wellness oriented" self-funded programs through TPAs with stop-loss coverage.

For NCSB, it is of the utmost importance to choose the most stable carrier with proven programs that will unquestionably remain as a strong participant and not place NCSB in the role of beta site or "guinea pig" for new programs. This ensures proper depth of services, health provider contracting, and

competitive pricing; plus, the confidence of moving forward with demonstrated concepts. The proponents under consideration for NCSB meet these guidelines.

d. Perspective

As we enter into the consideration of new vendors and programs, the prevailing question is:

"Is there enough of an advantage in any new plan or concept under consideration to merit moving from BCBSFL versus what we now have from BCBSFL or what we can expect to get from BCBSFL? Is a change worth the disruption to employees, families, and staff?"

While we do not want to limit open-mindedness in considerations, this practical point must never be far from the forefront of the considerations. Admittedly, this gives BCBSFL an incumbency advantage. However, this is consistent with the fact that this RFP Bid process was undertaken because of a desire for market knowledge and leverage with the possibility of changing for significant improvements, not because of any dissatisfaction with BCBSFL.

2. Review goals of RFP (as taken from RFP)

a. CARRIER QUALIFICATIONS

At a minimum, Proposers shall meet the following qualifications:

- 5 years' experience in providing group medical care administration in the state of Florida.
- Be a licensed insurance carrier per Florida Department of Insurance regulations.
- Be free from legal and regulatory matters, which might prevent the Proposer from fulfilling the obligations of the Agreement.
- Exhibit financial stability and company viability sufficient to fulfill the obligations of the Agreement.
- Have a dedicated account manager to function as the primary contract for all services.

b. CARRIER REQUIREMENTS

At a minimum, Proposer shall provide:

- A group health insurance plan for all active and retired employees and their eligible dependents.
- Assistance to the School Board with the communication of the plan to employees, including conducting enrollment meetings.
- Manage and control costs for members and the School Board through proven methodologies such as negotiated discounted fees for services, reimbursement to providers based on per diem or the number of days that a given patient is provided access to a prescribed therapy, or capitation where providers are paid at a set dollar amount determined by a per member per month calculation.
- Timely and accurate claims processing.

c. CARRIER CRITERIA

- **Provider Access and Discount**:

Carrier must have excellent provider access and discounts.

- **Customer Service:**

Demonstrable superior customer and **account service and support**, preferably with strong local & accessible points of contact as team leaders. This will include participant level and support staff. We desire a responsive, experienced, and mature Account Representative(s) with ready access to high level decision making when called upon.

The Account Representative(s) must be willing to attend client meetings; both account level and employee meetings, as reasonably called upon. After complete and successful implementation, account level meetings should be no less than quarterly; including review of claims, charges, and wellness indicator/ disease state management measures.

- **Renewal Underwriting Logic**:

It is particularly important that this information is clear and easily understood and communicated. This includes but is not limited to discussion and satisfactory explanations of trend, expected claims, claim margin, capitation charges, pooling charges, reserves, and reserve changes.

- **Comprehensive Availability of Reports:**

This includes reports on demand with access to both client and broker, including RX reporting. NCSB expects good faith compliance by the claims payer in the area of HIPAA PHI with proper restrictions, but not to extent of unnecessarily or arbitrarily limiting data availability to NCSB's Privacy Officer and other key designated team members.

- **Cooperation with Outside Vendors and Resources**:

In the future we may desire to have an outside vendor assist us in containing health care costs. An example is a Health Coach or an Onsite Health Clinic or Medical Home Provider. It is assumed there may be some duplicate services. A requirement of any carrier shall be that they willingly agree to work with any of our outside vendors, including the sharing of claims information on participants, if applicable and HIPAA compliant.

- **Timely Presentation of Renewal:**

It is imperative that the School Board is given no less than a 120-day renewal time frame in advance of anniversary.

- **Minimum of "Add-on Fees":**

This includes normally undisclosed fees.

- **Simplification of Administration:**

It is important that all proposing carriers have a system in place whereby they can simplify the daily administration of benefits for the school district staff.

- **Meaningful Cost Control Initiatives:**

This includes, but is not limited to, chronic disease management with utilization report capability and availability.

- **Aggressive Wellness Initiatives and Resources:**

It is desirable that a proposing carrier provides an annual health fair that includes health risk assessments and biometric screenings without additional cost to NCSB. Any other wellness initiatives are a plus.

- **Meaningful Performance Guarantees:**

This includes addressing many of the above criteria.

- **Stable Contractual Relationships with Healthcare Providers and Hospitals:**

The proposing carrier must have stable hospital and large physician group contracts. Please refer to questions in Appendix A.

- **Additional Criteria:**

This includes communications/ support (written/ hard copy/ electronic; staff support; employee meetings) and pro-active compliance guidance.

3. Brief review of RFP process

Using the above criteria and the NCSB purchasing standards, and then supplementing it with key data and documents, a very extensive Request for Proposal ("RFP") was prepared, posted by NCSB, and submitted to the market. Five carriers submitted proposals and two declined to offer proposals:

- Aetna
- AvMed
- Blue Cross Blue Shield of Florida (incumbent)
- CIGNA
- United Health Care
- Coventry declined to quote
- Humana declined to quote

All proposals were received before the RFP deadline. The form and format of all proposals were acceptable with some of a very complete and excellent quality.

Briefly, a two-pass proposal review process was used for the consideration of the submitted proposals. With the above criteria as a guide along with the premium rates, the broker review team undertook the first pass high-level review of each proposal. Two were eliminated, as key requirement provisions were not successfully met. It is noteworthy that based on simple premium rates alone, those eliminated were the highest and lowest priced proposals. They were not eliminated because of removal of the high and low bidders, but because of specific concerns, including:

- Inability or unwillingness to offer surplus/deficit participating funding
- No wellness financial grant funding for NCSB
- Network concerns regarding discount percentages and missing certain key health providers
- Unwillingness or inability to offer performance guarantees
- First year reporting concerns
- Unwillingness to offer references unless considered as a finalist
- Financial ratings were less than "A" quality

These concerns were of enough concern to eliminate contenders in the first pass and not approach them with follow-up questions or requests. This left three finalists for a second-pass review: Aetna, Blue Cross, and CIGNA.

The second-pass was far more intensive. Following the format design as conveyed in the RFP which each carrier followed, a page-by-page review of the remaining three proposals was begun. The last items within each proposal to be reviewed were the actual contracts and plan documents. Priority was first given to the premium rate and retention/expense pricing, underwriting and, cost components; network access, stability, and discounts; wellness initiatives and wellness grants; meaningful and accessible reporting; and, customer service, account service, and performance guarantees.

A separate two-part document was designed for this process laying out the procedures: "Point Scoring Criteria for Medical/ RX Benefit Proposals, May 2011" and "RFP Scoring Guidelines, May 2011". A 13-page scoring inventory was developed specifically for NCSB and captured the main parameters as outlined. An onsite questionnaire was also prepared for site visits as needed. These documents are available separately from this report.

These documents were designed to make the evaluation orderly and to bring forth a process eliminating as much bias as possible and to be complete.

4. Summary of RFP responses and evaluation
    a. Spreadsheet and discussion of premium rates

Key to evaluating the cost behind group health proposals is to resist the urge to jump to the lowest premium rates and instead keep in mind that premium rates are simply one part of the cost equation. A summary of the main cost components and how they work:

- Premium and premium rates: Rates per unit per month generate premium that is the top line revenue to the carrier.
- Claims:
    - Paid claims: Payments to health care providers including monthly capitation fees for certain provider contracts.
        - Of chief importance is the level of discounts that the carriers are able to negotiate with the health care providers. The deeper the discounts, the lower the claims that are charged back to the policyholder. <u>This is a critical differentiation factor among carriers.</u>
    - Incurred claim reserves: Accrued reserves carriers hold to cover their contractual obligation to pay claims that emerge after cancellation. These reserves are adjusted every year based on inflation, plan design changes, and changes in the covered population.
    - Pooled claims: These actually reduce the amount of claims charged against the premium. These are large claims that exceed a certain pre-determined dollar amount. For NCSB, this amount is $150,000. This prevents a run of particularly expensive large claims from overly negatively impacting the setting of future premium rates and from reducing and potential surplus accounting for NCSB. To "forgive" these large claims, a pooling charge is assessed, per below.
- Expenses: Often referred to as "retention" as this is the component "retained" by the carrier to cover their costs of doing business including their obligation to pay state premium taxes. It does include a component for company profits (or for non-profit companies, a "contribution to surplus").
- Pooling charges and other "risk charges": The charge for forgiving the large claims described above. Risk charges may possibly be applied for certain contingencies by some carriers and generally are not major charges.
- Surplus/ deficit: All of the above charges are netted out from the collected premium. The balance is either a positive ("surplus") or negative ("deficit"). Participating contracts allow the client to collect a portion of the surplus. The other side of this risk/ reward proposition is that a deficit may be carried by the carrier, which would be made up in future premiums.

The surplus/ deficit calculation is the true cost of the group health benefit program. If a carrier does not allow this calculation, then the true cost ids simply the premium paid. However, for a group of the size of NCSB, by far industry norms are for some kind of costing where the client participates in true net costing, such as what NCSB now enjoys or in one of the variations of self-funding. This rests on the accepted maxim: "over the long run, each employer pays their own way". Net costing approaches ensure that each component can be evaluated and compared to the market. Such a comparison has been done for NCSB.

For the purposes of summary, below is a table showing the gross premium offered by each quoting carrier plus the other factors that were brought about through the RFP process:

	Employee Count	Monthly	Annual		Guaranteed Surplus Payment	Wellness Grant	Total	
BCBSFL	924	$ 686,759	$ 8,241,110	100%	$ 400,000	$150,000	$ 7,691,110	100%
CIGNA	924	$ 713,871	$ 8,566,455	104%	$ -	$ 50,000	$ 8,516,455	111%
AETNA	924	$ 679,287	$ 8,151,450	99%	$ -	$ 20,000	$ 8,131,450	106%
AV-MED	924	$ 724,264	$ 8,691,168	105%	$ -	$ -	$ 8,691,168	113%
UNITED HEALTH CARE	924	$ 662,983	$ 7,955,795	97%	$ -	$ -	$ 7,955,795	103%

To the left of the solid black line is a straight-up comparison of the quoted premiums before any of the other factors were brought about. These are all based on the requested plan designs. All are within 5% of the offer put forth by BCBSFL with BCBSFL sitting squarely in the middle of the pack. Below the solid black line are the two carriers that were eliminated in the first-pass, as covered earlier.

At the outset, we can happily declare that there is **no increase to premium rates for the 2011/ 2012 year.** This is extraordinarily uncommon in today's market!

In our estimation, each carrier shows sound underwriting. In other words, while we are pleased to present competitive financial terms, based on prior years claims data, we can offer assurances that no single carrier can be accused of "buying the business" and setting up NCSB for a larger rate action next year. Although there are a few caveats based on incomplete data, our underwriting evaluation shows that this current year is very favorable as compared to prior years. Our evaluation can be found on page 12 of this report.

Other cost components emerged through the RFP process and the surplus/ deficit accounting of BCBSFL. The impact of these components is shown to the right of the solid black line. BCBSFL offered to present an early settlement of the favorable year of claims representing their current estimate of NCSB's share of the expected surplus, $400,000. This is locked in by BCBSFL and a check for this amount can be presented to NCSB immediately if they are awarded the NCSB contract for 2011/2012. (Regardless of whether the claims deteriorate or improve, the $400,000 from BCBS is guaranteed. In fact, if claims stay where they are or improve for the rest of the year, then NCSB can expect an additional check from BCBSFL).

They also are willing to apply it in an appropriate manner according to the wishes of NCSB, for example to further reduce the new premium rates or apply it to a future month's premium payment. Our recommendation would be to either take a check making sure it benefits the employees since it conceivably contains a portion of employee premium monies (through contributions); or, better to apply it to future premium payments. The question as to what, if any, of a check should be rendered to employees is a matter for determination of qualified legal counsel as we are not such, nor do we practice law.

In addition, the RFP requested a grant from the carriers to support the NCSB wellness efforts. These are shown to the right of the black line in the above table.

Applying these additional components places the incumbent, BCBSFL, in a favorable position.

5. Scoring matrix

A systematic approach was applied in carefully evaluating each of the finalist proposals. The findings are summarized in the table below:

Scoring: 1. Score 0 = does not meet requirements 1 = partially meets requirements 2 = meets requirements 3 = exceeds requirements 2. Weighting: 1-2-3 3. Raw data (e.g.- # seconds to answer calls)	AETNA	BLUE CROSS	CIGNA
1. Overall compliance with RFP instructions and requests, format and presentation of proposals	34	30	37
2. Plan design	28	28	28
3. Customer Service	38	38	40
4. Account Management	85	84	79
5. Financial	48	48	45
6. Network	18	18	16
7. Cost Control Initiatives	30	30	30
8. Reporting	30	29	30
9. Renewal underwriting and processes	14	14	8
10. Administration	54	52	52
11. Implementation	0	0	0
12. Wellness initiatives	32	34	33
13. Outside vendor partners	1	2	1
14. Financial stability	6	6	6
15. General	6	4	5
	424	417	410

You will note that item #11, Implementation, shows all zeroes, as did each subcomponent relating to implementation. This was to enable a fair comparison with BCBSFL, which has no implementation issues. If BCBSFL were eliminated as a result of this comparison, the implementation items would have been used to compare the remaining finalists.

Based on our evaluation, we once again see a tight competitive cluster with BCBSFL squarely in the middle. Like we did with the financial terms, using BCBSFL's score of 417 as the standard, the percentage spread is very small at less than 2%.

6. Recommendations to Board

Keeping focused on the end decision from the RFP process being the selection of the optimal group health carrier partner for NCSB for at least the 2011/ 2012 year, our recommendations are as follows:

- Retain BCBSFL
    - Before even considering wellness grants or the early sharing surplus guarantee of $400,000, all carriers were clustered within 5% and the finalists within 4%. The lowest rated premium was from Aetna (who had to increase their initial premium rating by 2.5% to offer surplus/ deficit accounting) and it is 1% below BCBSFL's offer.
    - We evaluated the cost components:
        - BCBSFL has the undeniably deepest, most favorable provider discounts.
        - While one carrier (CIGNA) presented the lowest guaranteed retention (expense) factor for 2011/ 2012, it was greatly offset by a much higher pooling charge for large claims over $150,000. Including BCBSFL, all carriers were below the PPACA regulated expense share of 15%.
        - The wellness grant from BCBSFL was by far the most generous.
        - We would insist that BCBSFL continue the wellness grant each year and show the same level of cost development transparency as they did this year.
        - We would insist on the continuation of the BCBSFL Pro-Share Agreement, which allows the sharing of a portion of the surplus.
    - Immediately accept the $400,000 from BCBSFL. Depending on legal counsel's recommendation, rather than further reduce the new rates, either apply it to future payments or accept a check.
        - BCBSFL guarantees this $400,000 and there are no contingencies beyond renewing the contract for the 2011/ 2012 year.
        - If claim experience continues favorably, then another check could potentially be due NCSB. If claims are not favorable and a deficit results, this does not jeopardize or reduce the $400,000 to NCSB.
    - Service, cost control, and wellness initiatives were also evaluated through scoring. The outcome was close enough to be considered a virtual tie with three strong contenders in place.
    - Transition direct and indirect costs can be avoided in the face of little financial or other beneficial trade-off by moving from BCBSFL.
        - Disruption of transitioning to new plan designs that have subtle but noticeable differences beyond the Schedule of Benefits.
        - Disruption of the significant health care in process in the period leading up to and immediately following any such transition.

- Intangibles:
  - BCBSFL reputation:
    - With NCSB employees and families.
    - In the group health market as the major player in the Florida market at large, nationally, and in the public sector market.
    - Stability in the face of PPACA and other market exigencies.
  - Leaving intact a positive and productive working relationship between the staff at NCSB and BCBSFL.

7. Other concepts considered:
   a. "Gap plans" and other worksite products: A few smaller employers have embraced the concept of adopting a high deductible plan as NCSB did through one plan option offered to employees. Instead of offering an HSA or HRA benefit funding, these employers adopt "gap plans" with a different carrier, which underlie the high deductible plan. This has been viewed as a reasonable approach for certain small plans that are "manually underwritten", but with an experience rated program like NCSB has, the advantage is not clear. Further, some carriers specifically reject such plans and specifically included a caveat in their proposals, like those we approached did.
   b. Self-funding: This was discussed above and dismissed in favor of the stability of the fully insured arrangement while still enjoying the benefits of favorable claim experience through the surplus sharing Pro-Share approach. Further, there is concern about the additional oversight, cash management, and work needed for a self-funded plan.

NASSAU COUNTY SCHOOL BOARD
Underwriting Evaluation: Group Health Plan
May-11

	From	To	Average EEs	Premium	Claims	Loss Ratio	Claims PEPM	Trend Months
1	Apr-10	Mar-11	979	$ 8,847,008.00	$ 6,268,671.00	71%	$ 533.59	18
2	Jan-10	Dec-10	974		$ 6,558,742.00		$ 561.15	21
3	Oct-09	Oct-10	968	$ 8,397,163.00	$ 6,804,537.00	81%	$ 585.79	24
4	Jan-09	Dec-09	960	$ 7,853,591.00	$ 7,242,365.00	92%	$ 628.68	33

	Trended Claims PEPM	Include Pool, Retention	Current Annual Premium	Current Premium, PEPM	Est. Rate Action
1	$ 629.64	$ 777.34	$ 9,229,726.00	$ 839.68	-7%
2	$ 678.99	$ 838.26		$ 839.68	0%
3	$ 726.38	$ 896.76		$ 839.68	7%
4	$ 836.14	$ 1,032.27		$ 839.68	23%

Caveats:

a Pooled claims not removed.
b Estimated trend: 1% per month.
c Estimated retention & pooling: 19%.