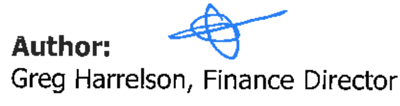
SUPP.# 294

Hardee County School Board
Agenda Analysis

19.03

Author: 
Greg Harrelson, Finance Director

Date:
June 6, 2017

Subject:
Aetna as medical insurance provider effective October 1, 2017

Background Information:
Florida Blue has provided our medical insurance since July 2009. In March 2017, the School Board's insurance committee and Albritton Insurance representatives met to discuss issuing a request for proposal (RFP) for "fully insured" medical insurance for 2017-18. The RFP asked insurance carriers to propose insurance plans as close/ identical to the School Board's current copay and H.S.A. plans.

In May, insurance committee voting members scored the proposals on 15 areas including similar clients, comparison of benefits, network discounts, network and prescription coverage, wellness, pricing, etc. Aetna's proposal was ranked #1. Insurance committee members and advisors included- Paul Samuels, George Kelly (chair), Greg Harrelson, Heather Lane, Angela Spornraft, Chad Douglas and Jim Demchak.

Albritton Insurance prepared the attached *Medical Benefits Request for Proposal HCSB2017-01 Aetna Final Offer Summary* which summarizes the process and highlights Aetna's negotiated proposal for year 1 (17-18), year 2 (18-19) and year 3 (19-20).

Aetna recently provided the attached documents for their proposal- cover page (1 page), rate quote (1 page), programs and services (3 pages), wellness programs (2 pages), caveats/ stipulations (4 pages), Aetna recognitions (1 page), year 2 medical rate cap guarantee (2 pages) and year 3 medical rate increase guarantee (4 pages).

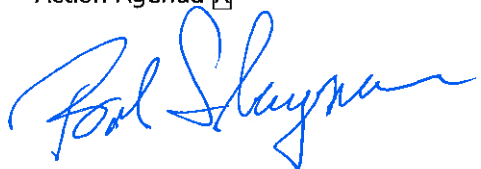
Administrative Consideration:
Section 287.057, Florida Statutes. Procurement of commodities or contractual services- specifies requirements for requests for proposals.

Fiscal Impact:
(based on 601 employees and retirees under 65 in specified plan levels as of May 2017)

Aetna annual premium for 2017-18	$7,024,285		
Florida Blue annual premium using 16-17 rates	$7,638,224	savings	$613,939
Aetna maximum premium increase 18-19	6%		
Aetna wellness participation funding in 17-18 and 18-19	$150,000 per year		

Proposed Recommendation to School Board:
Recommend approval of Aetna to be our medical insurance provider effective October 1, 2017

Action Required: Action Agenda ☒



BOARD ACTION
6/8/17
Approved

Hardee County School Board

Medical Benefits Request for Proposal HCSB2017-01

Aetna Final Offer Summary

Background:

On March 27, 2017, Hardee County School Board advertised publicly for proposals from "Fully Insured", Florida licensed insurance companies for employee group health insurance. Proposals were received from carriers (Aetna, Cigna, Florida Blue, Humana, and UnitedHealthcare) on April 21st, 2017. The Hardee County School Board Insurance Committee (Committee) met, reviewed, discussed and ranked the proposals. Proposers were ranked as follows on May 4th, 2017:

1. Aetna
2. Cigna
3. Florida Blue
4. UnitedHealthcare

The Committee then began direct negotiations with Aetna. The following offer was proposed by Aetna and accepted by the Committee on May 25th, 2017.

Year 1 (2017-2018):

- Aetna proposed to offer $50,000 "Premium Holiday" credit (year 1 only).
- Aetna proposes a rate reduction of approximately 7.9% below the current total premium being paid to Florida Blue.
- Wellness and Preventative participation goals:
  - 30% Biometric Screenings participation amongst HCSB employees
  - 45% Online Health Assessments participation amongst HCSB employees
- Aetna proposes $150,000.00 in Wellness Participation Reimbursement Fund
- $50/EE and/or covered Spouse ($50) Gift card for Online Health Assessment and participation in (1) Online Health Coaching Program Journey.

Year 2 (2018-2019):

- Aetna proposes a rate cap maximum increase of 6%
- Wellness and Preventative participation goals:
  - 60% Biometric Screenings participation amongst HCSB employees
  - 70% Online Health Assessments participation amongst HCSB employees
- Aetna proposes $150,000.00 in Wellness Participation Reimbursement Fund
- $50/EE and/or covered Spouse ($50) Gift card for Online Health Assessment and participation in (1) Online Health Coaching Program Journey.

Year 3 (2019-2020):

- Aetna proposes a Medical Benefits Ratio (MBR) Table with guaranteed rates if year 1 and year 2 Wellness and Preventative participation goals are met.
- $50/EE and/or covered Spouse ($50) Gift card for Online Health Assessment and participation in (1) Online Health Coaching Program Journey.

A Proposal
Presented to

Hardee County School District

by Non-Appointed Producer
October 1, 2017

Firm

Hardee County School District

Contact Information

Account Executive:	D Michael Driscoll	Email:	DRISCOLLM@AETNA.COM
Telephone Number:	(407) 670-3318	Fax:	Unavailable

Assumptions

Contract State:	FL	Lives:	598	Participation:	Acceptable
Medical Pooling Level:	$200,000	Sic Code:	9999	Contributions:	Acceptable
Producer Service Fee:	3.50%	Mem/EE Ratio:	1.69	Large Claims:	$$ Amounts/Diagnosis
Enrollment:	See Enrollment Caveat				
[1]Health Insurance Provider Fee%:	2.36%				

Proposed Rates **Effective Date:** October 1, 2017 **End Date:** September 30, 2018

The Medical Pooling Level indicated in the assumptions above represents what was used in your pricing based on company standards for your market and case size. This may be subject to change."

Total Amount Due Includes 3.5% Producer Service Fee*

Coverage	Lives	Monthly Rate PEPM	Monthly Amount Due
OA MC			
Open Access Managed Choice			
EE	264	$689.04	$181,907
EE + SP	31	$1,426.27	$44,214
EE + Children	82	$1,295.35	$106,219
Family	58	$2,187.63	$126,883
Total	**435**		**$459,222**
H.S.A. HN Option 1			
HSA Health Network Option			
EE	86	$618.80	$53,217
EE + SP	8	$1,124.48	$8,996
EE + Children	23	$1,021.25	$23,489
Family	12	$1,724.72	$20,697
Total	**129**		**$106,398**
H.S.A. HN Option 2			
HSA Health Network Option			
EE	27	$551.26	$14,884
EE + SP	4	$1,060.05	$4,240
EE + Children	2	$819.71	$1,639
Family	1	$1,389.71	$1,390
Total	**34**		**$22,153**

Total Medical Lives	**598**	
Monthly Total Amount Due		**$587,774**
Annual Total Amount Due		**$7,053,283**

RX Formulary: N/A

*The proposed rates includes premium and Producer Service Fee as requested. Producer Service Fee will be removed from Total Amount Due if Policyholder and/or Producer do not elect our company to serve as billing and collection agent. Total Amount Due will reflect executed Billing & Collection Agreement.

[1]The Affordable Care Act imposes two new fees/assessments, the transitional reinsurance contribution and the health insurance provider fee. The fees were effective as of January 1, 2014. This rate quote includes, where permitted, an estimated proportionate allocation of expenses associated with these fees. Starting with January 1, 2017 effective dates, the Reinsurance Contribution no longer applies.

Hardee County School District

Programs and Services -Fully Insured **Effective Date: October 01, 2017**

Program Summary

Program/Service	OA MC	H.S.A. HN Option 1	H.S.A. HN Option 2
Aetna Health Connections - Disease Management℠	Yes	Yes	Yes
Disease Management℠	Yes	Yes	Yes
MedQuery® with Member Messaging	Yes	Yes	Yes
Aetna Navigator™	Yes	Yes	Yes
Aetna's CareEngine-Powered PHR	Yes	Yes	Yes
Beginning Right℠ Maternity Program	Yes	Yes	Yes
Chronic Kidney Disease Program	Yes	Yes	Yes
Health History Report	Yes	Yes	Yes
24/7 Nurse Line - Informed Health® Line	Yes	Yes	Yes
Enhanced Clinical Review	Yes	Yes	Yes
Simple Steps to a Healthier Life®	Yes	Yes	Yes
Teladoc®	Yes	Yes	Yes
Aetna Vision℠ Discount Program	Yes	Yes	Yes

Program Description

Programs/Services	Description	Cost
Aetna Health Connections - Disease Management℠	Unique and powerful disease management program supporting more than 35 chronic conditions. Integrated and personalized patented technology allows Aetna to tailor each member's interactions based on health and disease states, benefit plan coverage and personal preferences. The Simple Steps online health assessment and Personal Health Record are also integrated with our disease management program.	Included
MedQuery® with Member Messaging	Our program also includes MedQuery® with Member Messaging. MedQuery® with Member Messaging is a program that uses medical claims, pharmacy claims and lab result values at a member level, compares that against complex algorithms developed from evidence-based standards of care to identify potential gaps in care called Care Considerations and provides the care considerations to physicians and members to help them improve their patients' care. Members receive Care Consideration via letter by using the address provided by the health plan (or employer self-insured health plan). The letter encourages the member to call his or her doctor to discuss the Care Consideration.	
Personal Health Record	This online report combines detailed, claims-driven information gathered from across the health care spectrum - such as physician offices, labs, diagnostic treatment and pharmacies - with user-entered information such as family history or allergies. The result is a health profile that the member can access anytime online, and print to share with his or her doctor.	Included
Beginning Right℠ Maternity Program	Provides services, information and resources to help improve pregnancy outcomes. Nurse outreach to physician for high risk members. Rewards for program completion are also available: Mayo Guide to Healthy Pregnancy sent with completion of the Pregnancy Risk Survey before the 16th week; baby blanket and growth chart sent when high risk outcome is complete.	Included
Chronic Kidney Disease (CKD) Program	Aetna and Fresenius Medical Care (Fresenius) have launched a CKD program aimed at improving clinical outcomes and reducing medical costs by slowing the progression of chronic kidney disease in members and facilitating gentler, less costly transitions to dialysis or pre-transplant care. This voluntary program may include the following tools and services; telemonitoring equipment, support from a kidney health care management team, coordination with a doctor, 24-hour access to a kidney nurse and personalized information.	Included
Health History Report	The Health History Report provides a centralized summary of a member's health-related activity, such as doctor visits, tests, treatments, and prescriptions for medications. This information is preloaded and updates automatically based on claims data, without any effort by the member. It can then be organized according to health-related category, such as names of doctors, medical care, prescription drugs, dental care and health assessment. Aetna Navigator™ subscribers may also view Health History Reports of their dependents covered under their Aetna medical plan policy, subject to applicable state and federal privacy laws and regulations.	Included
24/7 Nurse Line -	24-hour nurse 1-800 support line - Members can call anytime and talk to a registered nurse	Included

Informed Health® Line	for answers to health related questions. They can also listen to information from our audio health library on thousands of topics.	
Enhanced Clinical Review	Aetna's Enhanced Clinical Review Program can limit the financial impact of high cost radiology services, diagnostic cardiology, sleep management studies, hip and knee arthroplasties and cardiac rhythm implant devices by coordinating information provided by the ordering doctor. The information is reviewed by board-certified specialists, specialized registered nurses, and physicians to maximize savings on these high cost services. Plan sponsors can expect to see an estimated savings of $1.50 to $1.90 PMPM savings with this program.	Included
Simple Steps to a Healthier Life®	A personalized online health and wellness program that begins with completing a health assessment. Upon completing the health assessment, the participant receives a Health Summary Report to keep and record their results over time, which can also be printed and shared with a health care provider. Based on information gathered in the health assessment, the participant receives a personalized HealthMap, containing online coaching program recommendations to help them achieve and maintain good health. The Health Assessment also is designed to assess participants' level of health risks, their readiness to change certain health behaviors and their impact of health on productivity. Plan Sponsors have access to aggregate results and can utilize information to design a wellness program and measure the success of the programs.	Included
Teladoc®	Teladoc® is a national network of board-certified physicians who provide quality health care to members through the convenience of phone or online video consultations. Teladoc physicians can diagnose, treat and write prescriptions for routine medical conditions. Benefits of Teladoc® include: • The convenience of 24/7 access online or by phone • Reduction in absenteeism and increased productivity • Less time spent away from work • Increased employee satisfaction • Lower claim costs Our standard implementation allows Teladoc® to verify eligibility directly with our systems. Teladoc® will submit a claim charge for each consultation. The member's coinsurance or deductible will be applied when appropriate. Charges for consults will be submitted as any other medical claim and processed through the claims system. The member's cost share is the same as a physician office visit. In some cases, a custom member cost share can be implemented. In these custom cost share cases, updated eligibility files are provided to Teladoc® at least monthly. Teladoc® operates subject to state regulations: • Not available for HMO-based plans in New Jersey Teladoc® is temporarily suspended in Arkansas due to state regulatory considerations.	Included
Aetna Vision℠ Discount Program	The Aetna Vision℠ Discount Program helps members save on many eye care services and products, including eye exams, LASIK surgery, eyeglasses, contact lenses, nonprescription sunglasses, contact lens solutions and other eye care accessories -- at no additional premium cost.	Included

Aetna Healthy Commitments℠ Program	**Cost**
Premier Wellness Package has been included in our offering. Please refer to the Aetna Healthy Commitments℠ Packages section included within this proposal.	Included

Medical Management Model - Aetna In Touch Care - Premier	**Cost**
The Aetna In Touch Care℠ program is an alternative to having separate case management and disease management programs. This program is an industry innovation that takes member centricity to a new level, focusing on the member's current and future needs rather than reacting to conditions. It includes three primary functions: • Find – Our algorithms identify at-risk members by comparing member data against the latest medical knowledge. Our goal is to identify potential health issues before they become a major problem. Once identified, we can reach out to offer those members with an appropriate level of support. • Engage –Our nurses connect with members using techniques, such as motivational interviewing and preference-based outreach, to engage members into taking action. • Help – Digital and nurse support options allow members to personalize the way they receive help as they strive to reach their best health. The Aetna In Touch Care model drives better engagement through: • Early and more accurate member identification through our new algorithm. • A single nurse experience addressing both acute and chronic needs. • Highly integrated virtual care support — enabling the member to choose the level of support that best meets his or her needs. Nurses can track members' online engagement, answer questions and provide motivational support. • Members with the most urgent needs are targeted early and get one-on-one nurse support. Those with less urgent needs	Included

are directed to our virtual care resources.	

NAP Flex	Cost
Your plan and your employees can save money with the Facility Charge Review (FCR) and Itemized Bill Review (IBR) components of Aetna's National Advantage™ Program (NAP). FCR provides reasonable charge allowance review for most inpatient and outpatient out-of-network facility claims. IBR's review of large facility charges which meet certain criteria (including certain in-network, inpatient claims) often results in eliminating certain types of charges prior to claim adjudication. These programs not only save money on eligible claims for your plan but also can help your employees see lower co-insurance and deductible charges. In addition, the Contracted Rate component of NAP provides similar benefits when members receive out-of-network services involuntarily (e.g., emergencies). The claim experience shown below for your quoted products also includes NAP access fees (which are a percentage of NAP savings achieved).	Included

Annual Wellness Allowance	Cost
We are including a wellness allowance of up to $150,000 that may be used towards reasonable wellness services procured by the Plan Sponsor from third party vendors to pay for wellness-related expense such as wellness fairs, biometric screenings and on-site flu vaccinations incurred during the October 01, 2017 through September 30, 2018 plan year. These funds will be available as of the effective date of the period. Our preferred method of payment of wellness-related expenses is directly to the vendor. Payment will be made once the expenses are incurred and invoice(s) are provided. In the event you request us to reimburse you directly, Hardee Schools will provide an invoice indicating which employees have qualified for premium credit based on wellness program engagement. Invoices must be submitted to us within 60 days following the close of the plan year. Expenses must be for wellness-related programs or activities that are designed to promote the health and well being of plan participants, or to educate the participants about healthy lifestyles and choices. Any expenses beyond the Wellness Allowance are the responsibility of the customer. Any balance of this allowance fund remaining at the end of the policy year will be forfeited. Any amounts ("Wellness allowance") paid by Aetna to a plan sponsor to offset or reimburse such plan sponsor for any expense or costs incurred as a result of contracting with Aetna for benefits plan administration services, shall be paid in accordance with applicable law. Plan sponsors are advised to determine appropriate accounting for these payments with their own counsel or accountant. Any plan sponsor receiving a wellness allowance or other payments from us that offset or reimburse expenses that would otherwise be paid from plan assets, should consult with their ERISA counsel to determine if such allowance must be credited to plan assets, and for additional counsel regarding the accounting for reporting of such payments. We assume the funding of any wellness budget is either at the request of your Plan Administrator acting in their fiduciary capacity to your Plan or for the exclusive benefit of your Plan.	Included

Reporting

Standard reports are produced at the customer level based on underwriting's release policy for full-risk, experienced-rated customers on a bi-annual basis if 100-199 covered subscribers or quarterly if 200+ covered subscribers. Reports are available on an incurred basis, rolling 12 months with a 2-month claims lag. The reports offer a view of the current year's and the prior year's data illustrating utilization and financial trends in a concise, graphical format.

Report	Description	Cost
Level A	Level A includes pre-run, rolling 12-month incurred claim reports produced at the plan sponsor level by funding and product (medical, pharmacy, and dental). The package of reports identifies key cost, membership, and utilization trends. A "Summary by Product" package is also produced which includes all applicable products for a plan sponsor in one package.	Included
Level B	Level B allows users to access the same Level A standard report formats for medical, pharmacy, and dental in order to easily create their own reports on demand by selecting various time periods, account structure, product combinations, network service area and claim basis (incurred or processed).	Included
Ad Hoc	For customers with 100 or more subscribers, customized reports are also available upon request from Aetna Integrated Informatics®. A business consultant will be assigned to respond to tailored information and analytic needs. Charges and delivery dates for customized or ad hoc reports are quoted in advance. 100 - 2999 subs - 5 hours free	$200 per hour

Aetna Healthy Commitments℠ - Premier Package

Hardee County School District

Aetna Healthy Commitments - Fully Insured Funding | **Effective Date: October 01, 2017**

Wellness Programs Included to Help Members Stay Healthy and Improve Productivity

We believe that a workplace wellness strategy is essential to successfully motivate subscribers and sustain engagement in their health and well being. The Aetna Healthy Commitments program is designed to help improve our members' overall health by offering easy access to an online health assessment, Online Wellness Programs, online self-help tools, onsite biometric screenings, and a variety of member incentives.

Healthy Lifestyle Coaching	
Outreach Telephonic Coaching focused on all categories covering areas such as tobacco cessation, stress management, exercise & weight management	Telephone coaching and support from professional Health Coaches. Healthy Lifestyle Coaching (HLC) is a high-touch, all-inclusive, unlimited-session coaching program delivered by experienced, highly trained wellness coaches. It helps all members from low to high risk quit using tobacco, manage their weight, deal more effectively with stress, learn about proper nutrition and physical fitness, high risk reduction and preventive health. High risk members receive weekly phone appointments with a coach for 12 months, moderate risk up to 8 calls and low-risk up to four calls. Included are educational materials and if the member's goal is to get tobacco-free, we provide an 8-week supply of Nicotine Replacement Therapy (NRT).
Onsite Biometric Screenings	
Quest Diagnostics	We work with Quest Diagnostics to bring health screenings directly to the worksite to help employees decrease their risk for health concerns. Fingerstick or Venipuncture options are available as well as Fasting or Non Fasting screenings; all screening options offer a convenient online scheduling system. Additional options for testing include Home Test Kits, Primary Care Physician Results Forms, and Patient Service Centers (venipuncture only). **Fingerstick** Results are generated by a single fingerstick test at the time of the event. A nurse will discuss results and health risks to the participant at that time along with an online report through the Quest scheduler. A minimum of 30 participants are required per event location. **Venipuncture** Blood draw performed on-site or at a patient service center and sent to the lab for processing. Results are available online and mailed to the participant's home. The onsite Venipuncture screenings require a minimum of 20 participants per event location.
Health Assessment (Supported by Incentives)	
Simple Steps To A Healthier Life® (SSHL) Aetna's Health Assessment	A personalized online health and wellness program that begins with completing a health assessment. Upon completing the health assessment, the participant receives a Health Summary Report to keep and record their results over time, which can also be printed and shared with a health care provider. Based on information gathered in the health assessment, the participant receives a personalized HealthMap, containing online coaching program recommendations to help them achieve and maintain good health. The Health Assessment also is designed to assess participants' level of health risks, their readiness to change certain health behaviors and their impact of health on productivity. Plan Sponsors have access to aggregate results and can utilize information to design a wellness program and measure the success of the programs
SSHL Health Assessment Completion/Update & Completion of One Online Health Coaching Program	Subscribers and their spouses can each earn a $50 gift card after completing both the Health Assessment and a minimum of one Online Health Coaching Program Journey.
Online Wellness Programs	The Online Health Coaching Programs ("Journeys") will personally invite subscribers who complete their Compass Health Assessments to join the program most likely to appeal to them, based on the information provided in their Health Assessments. Your subscribers will embark on a Journey that is tailored to their unique needs & preferences. Journeys are developed to maximize engagement and positive outcomes through use of: • Adaptive Technology • Gaming Mechanics • Proven behavior science methodology Available programs include: Be Tobacco Free, Blood Pressure in Check, Diabetes Life, Eat Healthier, Get Active, Healthy Back, Heart Healthy Cholesterol, Living Well with Asthma, Sleep Well, Stress Less, Weigh Less, and Health In A Hurry
Advocacy & Outreach Programs	
24/7 Nurse Line - Informed Health® Line	24-hour nurse 1-800 support line - Members can call anytime and talk to a registered nurse for answers to health related questions. They can also listen to information from our audio health library on thousands of topics.
Neighborhood Well-being Services	Provides members easy access to face-to-face lifestyle and preventive coaching support in their neighborhood CVS MinuteClinics.
Communications Campaigns and Toolkits	
Member Wellness Message Program	Electronic communications for employees that address general health and wellness topics, available in English and Spanish.
Fitness Challenge with Social Networking	
Get Active℠	Get Active℠ is an online health and wellness program with a unique social approach that encourages employees to connect with one another to reach their health goals. Plus, it's powered by ShapeUp, Inc., a leader in global social wellness solutions.

	Get Active℠ is based on a year-round curriculum of fun team challenges. It uses online tools to help participants chart their progress. By motivating each other, employees get healthy together, and your company can save money on health care costs. Get Active℠ has three main components: 1. Self-assessment and goal setting: The Get Active℠ platform and online tools help participants identify and set achievable health goals. Whether employees are seasoned athletes or first-time exercisers, we help them define and reach their particular goals. 2. Healthy challenges: Employees are invited to join quarterly team-based fitness challenges focused on walking, exercise, nutrition and weight loss. Challenges use the latest medical research and social gaming mechanics. Friendly competitions focus on fitness, nutrition, lifestyle balance and preventive care. Weekly bonus challenges focus on well-being. User-generated challenges keep engagement high among participants. 3. Progress tracking and milestones: Our intuitive tracking interface allows participants to chart progress towards healthy goals. Tracking is convenient and accessible to all employees.
Online Self-Help Tools	
Aetna Navigator™	A secure member website that is an online resource for personalized health and financial information. Subscribers can access their personal health benefits, find claims status and details, find cost of tests and medical visits, view health history report, receive wellness discounts, take the health assessment, participate in the Online Wellness Programs, locate a doctor, and self refer into available disease management programs and much more.
Health Decision Support	Health Decision Support is an online training tool that helps members understand their conditions, treatments, procedures and surgery options.
Healthwise® Knowledgebase	This feature on Aetna Navigator™ is a decision-support tool that gives members access to powerful information resources in order to make better health decisions. Members have access to clinical information on 1,900 health topics, 600 medical tests and procedures, 500 support groups, and 3,000 medications.
Preventive Health Care Schedule	This informational schedule will guide members according to age and gender of preventive screenings needed and steps to take to live a long and healthy life.
Aetna Discount Programs	
	Our discount program helps members save money on a wide variety of products and services for themselves and their family. Members can save on gym memberships, weight loss programs, eyeglasses, LASIK laser eye surgery, massage therapy and much more!
Reporting	
	A variety of reports are available to plan sponsors via Navigator and Simple Steps, and may vary based on participation levels.

This material is for information only. Health information programs provide general health information and are not a substitute for diagnosis or treatment by a physician or other health care professional. Health benefits and health insurance plans contain exclusions and limitations. Not all health services are covered. See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by location and are subject to change. The Aetna Personal Health Record should not be used as the sole source of information about the member's health conditions or medical treatment. Discount programs provide access to discounted prices and are NOT insured benefits. The member is responsible for the full cost of the discounted services. Information is believed to be accurate as of the production date; however, it is subject to change.

For information about Innovation Health plans, refer to: www.innovation-health.com.

Hardee County School District

Caveats - Fully Insured Funding | **Effective Date: October 01, 2017**

Documentation needed from current carrier(s)
Current Rates Current rates/fees and plan designs.
Renewal Rates Renewal rates/fees and plan designs.
Billing Statement Complete copy of the most recent billing statement, within one month of the effective date.
Monthly Claims Updated monthly claims on incumbent carrier letterhead on a rolling 12-month basis with corresponding exposures up to 150 days prior to the effective date.
Demographics Census data on incumbent carrier letterhead for all subscribers eligible for coverage, including: each subscriber's date of birth, insurance status, dependent coverage, gender, and home zip code. Census should also identify whether each subscriber is active, COBRA, part-time, union, early retiree, retiree or waiver and the plan/product in which the subscriber is currently enrolled. Additional information may be required if union members, retirees or part-time workers are eligible.

Assumptions
Prospective Quoting The quoted insured medical rates are offered on a prospectively rated basis. No policy year accounting balance will be calculated for these coverages.
Billing and Payment of Premium Amount due is payable on the first day of the month covered by the invoice. If the amount due is not paid in full within 30 days, we reserve the right to terminate the contract and/or assess late premium payment charges.
Commissions Commissions have been excluded from our quoted rates.
Producer Service Fee • Producer Service Fee of 3.5% of the total amount due as defined in the Billing and Collection agreement. • Negotiated directly between Policyholder and Producer for services provided in connection with the Group Medical benefit plan. Producer Service Fee is not a component of the premium but is included in the total amount due. Producer Service Fee will be removed from Total Amount Due if Policyholder and/or Producer do not elect our company to service as billing and collection agent. Total Amount Due will reflect executed Billing & Collection Agreement.
Financial History Plan Sponsor must have been in business at least three years.
First Year Renewal The first year renewal will be delivered 60-90 days prior to the anniversary date.
HCR Dependent Age to 26 Source documentation of the dependent limiting age is required for plan installation. In the absence of documentation from the current carrier(s), these rates assume that the dependent limiting age is as mandated by the contract situs and federal law. The rates contemplate a change to a dependent limiting age up to 26/26 student/non-student based on health care reform legislation and may be amended to a higher limiting age upon receipt of the dependent eligibility documentation.
High Deductible Health Plan We reserve the right to change the quoted rating for coverage, or to decline to offer coverage if the Plan Sponsor funds the deductible in excess of 50%.
Mandates Benefit provisions are subject to state, local, and federal mandates. Future mandates will be incorporated in the plan(s) as of the date required by law and may require rate adjustments.
SPD Modification Our premium includes our standard Summary Plan Description language and any customization may require an additional cost.
Total Replacement This proposal assumes we will be the sole carrier for the quoted lines of coverage. In the event alternative carriers or Minimum Essential Coverage plans are to be offered, we reserve the right to reassess our rates.
Underlying Plan

Our quoted rating assumes that there are no underlying plans in effect that will either partially or completely subsidize any member cost sharing including but not limited to co-pays, deductibles, and/or coinsurance balances. We reserve the right to change the quoted rating or decline coverage if we have not been notified of the existence of an underlying plan.

Network Re-Contracting

In addition to standard fee-for-services rates, contracted rates with network providers may also be based on case and/or per diem rates and in some circumstances, include risk-adjustment calculations, quality incentives, pay-for-performance and other incentive and adjustment mechanisms. These mechanisms may include payments to organizations that may refer to themselves as accountable care organizations ("ACOs") and patient-centered medical homes ("PCMHs"), in the form of accountable care payments (ACP) and incentive arrangements based on clinical performance and cost-effectiveness. The ACP amount is based upon an assessment for each member who is already accessing providers in an ACO, and is assessed retrospectively on a quarterly basis and collected through established claim wire. Each ACO will have a different ACP based on the clinical efficiencies targeted and network negotiations. The ACP assists the ACO in funding transformation of the health care system to improve quality, reduce costs and enhance the patient experience by:

- Identifying and engaging patients at risk for health crises sooner through more data-sharing
- Increasing patient engagement in best-in-class care management programs through doctor-driven outreach
- Delivering better health outcomes through increased collaboration between the health plan and ACO providers

The following conditions also allow us to assess the potential financial impact and may result in a modification of the terms of the offer:

Member/Subscriber Ratio

The enrolled member to subscriber ratio increases or decreases by more than 10% from the 1.69 ratio assumed in this quote.

Enrollment

The actual enrollment in total or by plan changes by more than 10% compared with what was proposed.

The plan sponsor offers coverage to employee previously not covered under the plan without prior notification.

Contract Provisions

The final benefit provisions, account structure, claim payment requirements or services change from those proposed.

Information Accuracy/Demographics

The information provided is inaccurate and/or the demographics of the quoted group change resulting in +/- 5% premium difference.

Quoted Benefits

A material change in the plan of benefits offered, or a change in claim payment requirements or procedures, or a change in state premium taxes or assessments, or any other changes affecting the manner or cost of providing coverage that is required because of legislative or regulatory action.

Additional

Federal Mental Health Parity

The Federal Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) applies to fully-insured Traditional and HMO Middle Market (MM) & National Accounts (NA) commercial plans as well as self-funded Traditional and HMO MM & NA commercial plans for plan years beginning on or after October 3, 2009. Please speak to your Account Manager if you would like additional information.

Medical EOBs

We make EOBs available through our secure Navigator website for subscribers who have registered to use Navigator and for whom we have a valid email address. We send members an email when a new EOB is available. All other members receive paper EOBs. If a member receiving EOBs electronically prefers paper EOBs, they can get them by telling us that is their preference. Please note that unless required by state law we do not produce EOBs for claims when there is no member liability.

Medical Disclosure Information

At the time of annual enrollment, your plan participants should be provided with the Medical Disclosure information related to their plan of benefits. Go to our corporate website and enter the state followed by the word 'Disclosure' in the search field Please provide the applicable Medical Disclosure document and any required Addendum to your plan participants. If you have any questions, please contact your broker or account management team.

Premium Holiday

Aetna is willing to offer a Premium Holiday of $50,000 to offset the costs of contract termination with Florida Blue.

Health Care Reform Caveats

Healthcare Reform Disclosure

This new business proposal is intended to be compliant with health care reform.

March 23, 2010, the Federal government released regulations related to grandfathering of health plans in existence under

the health care reform legislation, health plans existing prior to the enactment of the legislation may be "grandfathered" and not subject to some of the mandated benefits and reform provisions. Changes in your benefit design as well as your contribution strategy may affect grandfathering. Plan sponsors are required to notify us if their contribution rate changes for a grandfathered plan at any point during the plan year.

This new business offer assumes your plan is not grandfathered.

Except for specific and limited scenarios described as transitional rules in the health care reform legislation, if a plan's grandfathered status has been lost, it cannot be regained. If, after reviewing the grandfathering rules with your benefit consultant or counsel, your determine that your coverage could be or is grandfathered, and you want to retain grandfathered status, please contact us for further instructions.
We reserve the right to treat an insured plan as non-grandfathered.

The Affordable Care Act (ACA) prohibits insured group health plans that are not grandfathered from discriminating in favor of highly compensated employees as to benefits and eligibility. This rule will become effective after additional regulatory guidance is issued in the future. Employer penalties for violating the rule include a $100 per day penalty multiplied by the number of those individuals "discriminated against." If you think your plan may be discriminatory under ACA, we urge you to monitor the rulemaking process and contact your benefits attorney or tax counsel for further guidance. We do not conduct discrimination testing and are not responsible for an employer's compliance with this ACA non-discrimination rule.

The benefits and rates within this proposal are subject to change pending any required approvals or future guidance from state or federal regulatory agencies. If you have questions, please contact your Account Executive.
We reserve the right to modify its products, services, rates and fees, in response to legislation, regulation or requests of government authorities resulting in changes to plan benefits and to recoup any material fees, costs, assessments, or taxes due to changes in the law even if no benefit or plan changes are mandated.

Retiree Only Plan Status Certification
Guidance issued by the Internal Revenue Service ("IRS"), Department of Labor ("DOL"), and Department of Health and Human Services ("HHS") has indicated that "retiree only" plans are exempt from the benefit mandates under ACA including Medical Loss Ratio ("MLR") and rebate requirements for insured plans (Retiree only plans are subject to certain ACA fees and assessments). In order to demonstrate the establishment of a retiree only plan, a plan should maintain, separately from the plan for current (i.e., active) employees, a separate plan document and Summary Plan Description (SPD) and file a separate Form 5500. If you have a retiree only plan, and want to be considered exempt, please provide the required documentation to us. We have the right to treat insured plans as subject to ACA without an executed certification document.

Affordable Care Act – fees and assessments
The Affordable Care Act (ACA) imposed several fees/assessments, including the Health Insurance Provider Fee, the Transitional Reinsurance Contribution and the Patient-Centered Outcomes Research Institute Fee.

- Health Insurance Providers Fee (HIF) is a recurring, annual, industry fee assessed based on each insurer's share of the fully insured market, as determined by the IRS. A total of $11.3 billion will be collected across the industry for 2016. The total assessment will increase each year, to an estimated $14.3 billion in 2018 and will then increase at the rate of industry premium growth thereafter. The Omnibus Bill, signed into law on 12/18/15 includes a one year suspension of the HIF for calendar year 2017. HIF will be reinstated for calendar year 2018.
- Transitional Reinsurance Contribution – This assessment is in effect from January 1, 2014 through December 31, 2016 and will no longer apply as of January 1, 2017.
- Patient-Centered Outcomes Research Institute Fee (PCORI)–This fee is in effect for plans or policy year ending after September 30, 2012, and before October 1, 2019.

This rate quote includes, as applicable, an estimated proportionate allocation of expense associated with the Health Insurance Provider Fee and the Patient-Centered Outcomes Research Institute Fee. We reserve the right to modify these rates, or otherwise recoup such fees, based on future regulatory guidance, subsequent state regulatory approval, or if estimates are materially insufficient.

Member Out of Pocket Limit
For non-grandfathered plans renewing on or after January 1, 2014, all in-network medical, behavioral health, and pharmacy member cost sharing, which includes all copays, coinsurance and deductibles, must apply to a member's out-of pocket (OOP) maximums. The OOP maximum limit cannot exceed the limits set by the Department of Health and Human Services, or under the tax law for high deductible health plans paired with Health Savings Accounts (HSAs).

For non-grandfathered plans renewing on or after January 1, 2016, an individual members OOP maximum cannot exceed the individual limit set by the Department of Health and Human Services. This is regardless of whether the individual is enrolled in self-only coverage or non-self only (family) coverage.
A plan may maintain separate OOP maximums for different benefit categories, as long as the combined totals do not exceed the statutory limit. For plans renewing on or after January 1, 2015 plans will have two options to maintain compliance:

- Integrated medical and pharmacy OOP maximum that does not exceed the statutory limit
- Non-integrated medical and pharmacy OOP maximums that collectively do not exceed the statutory limit – this option is not available for high deductible health plans paired with HSAs

We recommend that you review your pharmacy OOP maximum to ensure compliance. Please contact your Aetna Account Executive to inform us of any required changes that you will make to these plans to ensure compliance or with questions on this requirement.
High deductible health plans paired with HSAs are still required to integrate all accumulators for medical, behavioral health and pharmacy benefits. Integration support is not available for fully insured business.

The rates provided may include an adjustment in order to bring your plan into compliance with the member payment limit requirements.

Waiting Period Requirement
When renewing your plan(s) with us, you represent that:

- You will give us effective dates for your employees and their dependents that take into account all state and federal eligibility conditions and waiting period requirements, including a reasonable and bona fide orientation period.
- If this information changes, you will inform us immediately.

Essential Health Benefits
The ACA prohibits the application of annual dollar limits for any Essential Health Benefits for all plans effective on or after January 1, 2014 (the prohibition of lifetime dollar limits on Essential Health Benefits has been in effect since 2010). To the extent that your current benefit plan includes such limits, this renewal includes the removal of those limits.

Summaries of Benefits and Coverage (SBC)
For applicable plans and policies with effective dates of January 1, 2014, and later, the SBC must include statements about whether the plan or coverage provides minimum essential coverage (MEC) and if the coverage meets minimum value (MV) requirements.

Under the Affordable Care Act (ACA), minimum value and minimum essential coverage determinations are associated with the employer shared responsibility provisions. We will review the minimum value standard for each plan based on the MV calculator criteria provided by the Department of Health and Human Services (HHS) and will indicate within the SBC whether the plan meets or does not meet the MV standard based on this review. We do not provide legal or tax advice, and recommend that plan sponsors consult with their own legal and tax counselors when reviewing MEC and MV determinations. We have no responsibility or liability regarding the minimum value or minimum essential coverage evaluation, regardless of the role we may have played in reviewing/producing the SBC documents. To the extent you disagree with our evaluation, we will make changes to reflect your determination, as you are responsible for the final determination of these SBC elements.

Employer Reporting Requirements
Under Internal Revenue Code (IRC) Section 6055 health insurance issuers, certain employers, government agencies and other entities that provide Minimum Essential Coverage (MEC) to individuals must report to the IRS information about the type and period of coverage and furnish related statements to covered individuals. This information is used by the IRS to administer the individual shared responsibility provision and by individuals to show compliance with the individual shared responsibility provision.

For insured group health plans, the reporting obligation under Section 6055 is our responsibility. We will report the required information to the IRS about the type and period of coverage provided to each individual member enrolled in our insured plans, and will furnish the required statements to subscribers. We will send these statements either by first class mail.
We must report the entire Social Security numbers (SSN) to the IRS for each sub-
scriber and dependent in order to complete our required reporting. However, the final rules allow the use of truncated social security numbers on statements furnished to individuals (for example, give only the last four digits of the SSN). If we don't receive the SSN through the employer, the law requires we reach out to each subscriber up to three separate times to request the information.

IRC Section 6056 requires applicable large employers (those having employed an average of 50 or more full-time employees during the preceding calendar year) to report to the IRS information about the health care coverage they have offered and also furnish applicable statements to employees. The purpose is to allow the IRS to enforce the employer responsibility provisions.

To satisfy the 6056 employer reporting requirements, an applicable large employer must file the required returns with the IRS by no later than February 28 of the year following coverage (if filing on paper) or March 31 (if filing electronically), and furnish a statement to all full-time employees by January 31st of the year following the calendar year to which the return relates (i.e., January 31, 2016 for the 2015 calendar year).

Collaborate with a strong partner

- Aetna has been recognized four years in a row as one of America's most community-minded companies in the 2016 Civic 50.
- Aetna was recognized as one the country's most innovative users of business technology in the 2016 InformationWeek Elite 100, ranking #85.
- The National Business Group on Health listed Aetna as a platinum winner on their 2016 Best Employers for **Healthy Lifestyle Initiatives** that are committed to improving employee health, efficiency and overall quality of life.
- Newsweek rated Aetna **64th among its Green 100 companies** in 2016, looking at corporate sustainability and environmental impact.
- In 2015, Aetna joined the ranks of the **top 50 companies on the Fortune 500® list**.
- Aetna was ranked **No. 15 by Barron's in its list of the Best Companies for 2016**. Barron's is a weekly newspaper that covers U.S. financial information, market developments and statistics.
- For the 5th consecutive year, Aetna in 2015 received a **ClearMark Award from the Center for Plain Language**. This year's award was received for Aetna's Consumer Tumblr Blog.
- Aetna's 11 initiative, created to encourage people to stop smoking, won almost **a dozen awards in 2015 including Modern Health-care: Healthcare Marketing Impact Award.**
- Aetna was named a winner in the **2015 IBM Mainframe Mobile App Throwdown** competition for developing an app to help nurses who conduct home visits easily manage their patient's medication.
- In 2015, Aetna received the **Corporate Angel Network Award** for providing more than 50 flights to men, women and children in need of cancer treatment to centers across the country.
- DiversityInc named Aetna once again to its Top 50 Companies for Diversity in 2016, calling Aetna "a mainstay on the top 50 list."

For More Information on Aetna Awards and Recognition

Medical Renewal Guarantee

Year 2 Medical Rate Cap Guarantee

For the first renewal period (October 1, 2018 through September 30, 2019), Aetna is willing to guarantee that the (HNO, and OA MC) per member per month plan renewal premium will not increase by more than 6.0% over the (HNO, and OA MC) per member per month plan premium that is effective October 1, 2017 through September 30, 2018, subject to the conditions below.

Each HNO, and OA MC plan will be renewed separately but will be reviewed in aggregate against the maximum 6.0% overall rate increase. Aetna's renewal for the October 1, 2018 through September 30, 2019 period will be produced using claims through March 1, 2018.

Aetna Inc. reserves the right to review and possibly modify or terminate the guarantee arrangement if any of the following occur during or prior to the guarantee period:

Conditions

a) The Patient Protection and Affordable Care Act (PPACA) prohibits insured group health plans that are not grandfathered from discriminating in favor of highly compensated employees as to benefits and eligibility. This rule will become effective after additional regulatory guidance is issued in the future.

   Employer penalties for violating the rule include a $100 per day penalty multiplied by the number of those individuals "discriminated against." If you think your plan may be discriminatory under PPACA, we urge you to monitor the rulemaking process and contact your tax counsel for further guidance.

   Aetna does not conduct discrimination testing and is not responsible for an employer's compliance with this PPACA non-discrimination rule.

   The benefits and rates within this proposal are subject to change pending any required approvals from state or federal regulatory agencies. If you have questions, please contact your Sales/Account Executive.

   Aetna reserves the right to modify its products, services, rates, and guarantees, and to recoup any costs, taxes, fees, or assessments, in response to legislation, regulation or requests of government authorities.

b) Since the above guarantee is partially based on the prior carrier claims, Aetna must receive complete mature incurred claims experience for all current plans including enrollment by month by plan through October 1, 2017 plus 4 months of run out.

Medical Renewal Guarantee

c) Aetna Inc. reserves the right to review and possibly modify or terminate the guarantee arrangement if Hardee County School District fails to make required premium payments in accordance with contract provisions.

d) A total of 598 employees are expected to be enrolled in the quoted medical product. Aetna may revisit the structure or conditions of this guarantee if there is a change of greater than 10% of the assumed enrollment during the contract year; or if the assumed enrollment by plan changes by more then 10% during the contract year.

e) It is assumed that the current plan designs will remain in place during the 2017 and 2018 policy years. If plan changes are initiated during the 2017 or 2018 policy years, Aetna reserves the right to modify the increases agreed to in this guarantee.

f) Aetna is the full replacement medical and pharmacy vendor for Hardee County School District including any self-funded plans that are offered by Hardee County School District.

g) Aetna Inc. reserves the right to review and possibly modify or terminate the guarantee arrangement if there is enactment of legislation (either state or federal) which impacts the ability of Aetna Inc, to contract for efficient, cost effective medical care.

h) It is assumed that the contribution structure will remain consistent from 2017 to 2018. Aetna may revisit the structure or conditions of this rate guarantee if there is a change of greater than 10% of the current employee contributions.

i) This guarantee applies to any site which is fully credible, Aetna is allowed to experience rate and is filed to exercise underwriter judgment.

j) Any other material change under which the plan operates.

k) The guarantee will be terminated if the medical plan is put out to bid for the first renewal period.

l) Year 2 includes a $150,000 Wellness Allowance that will adhere to same parameters as the year 1 allowance.

Medical Renewal Guarantee

Year 3 Medical Rate Increase Guarantee

For the second renewal period, October 1, 2019 through September 30, 2020, Aetna is willing to guarantee the Hardee County School District per member per month plan renewal premium rate increase over the per member per month plan premium that is effective October 1, 2018 through September 30, 2019, per the chart below.

Year Two (2018-2019) Experience MBR	Year Three (2019-2020) Maximum Increase
77% or less	5.3% or less
77.1% - 78.0%	6.3%
78.1% - 79.0%	7.3%
79.1% - 80.0%	8.3%
80.1% - 81.0%	9.3%
81.1% - 82.0%	10.3%
82.1% - 83.0%	11.3%
83.1% - 84.0%	12.3%
84.1% - 85.0%	13.3%
85.1% - 86.0%	14.3%
86.1% - 87.0%	15.3%
87.1% - 88.0%	16.3%
88.1% - 89.0%	17.3%
89.1% - 90.0%	18.3%
90.1% - 91.0%	19.3%
91.1% - 92.0%	20.3%
92.1% - 93.0%	21.3%
93.1% - 94.0%	22.3%
94.1% - 95.0%	23.3%
95.1% - 96.0%	24.3%
96.1% - 97.0%	25.3%
97.1% or greater	No Guarantee

Aetna will provide a renewal for the period October 1, 2019 through September 30, 2020 in May, 2019. The Year Two (2018-2019) Experience MBR will be calculated using claims incurred March 1, 2018 through Feb 28, 2019, paid through March 30, 2019, and then

Medical Renewal Guarantee

completed and trended forward seven months to the Year Two (2018-2019) Experience period.

In addition, the pooling threshold used in the calculation of the Year Two (2018-2019) Experience MBR will not be any higher than ($200,000), provided that the plans/program remain the same and the enrollment in total and by plan remains similar to current; we will also apply our standard pooling charges in the calculation.

Rates for products, which require filing with the state, will be consistent with applicable approvals. This guarantee assumes that our current experience-rating renewal methodology for groups with at least 300 subscribers will continue to be the accepted and approved methodology for renewals effective 10/01/2019. If this is not the case, this guarantee will be reviewed and may require revision.

Aetna Inc. reserves the right to review and possibly modify or terminate the guarantee arrangement if any of the following occur during or prior to the guarantee period:

Assumptions

a) Aetna is offering their Premier Wellness program. Biometric screenings are included in this offer. 30% of employees are expected to complete this screening in Year 1, and at least 60% of employees should complete this screening in Year 2.
b) Online health assessments are available through our Premier Wellness program with incentives for employees. Aetna anticipates that Hardee Schools will promote the participation of online health assessments and that 45% of employees will complete their online health assessment in year one, and 70% of employees will complete their assessment in year two.
c) Aetna In Touch Care (AITC) is our member care management and disease support program. After a first year baseline is set on participation, Hardee Schools will commit to promotion of the program that should result in an increase of 20% of AITC participation.
d) Since the above guarantee is partially based on the prior carrier claims, Aetna must receive complete mature incurred claims experience for all current plans including enrollment by month by plan through October 1, 2018 plus 4 months of runout.

e) The Patient Protection and Affordable Care Act (PPACA) prohibits insured group health plans that are not grandfathered from discriminating in favor of highly compensated employees as to benefits and eligibility. This rule will become effective after additional regulatory guidance is issued in the future.

Medical Renewal Guarantee

Employer penalties for violating the rule include a $100 per day penalty multiplied by the number of those individuals "discriminated against." If you think your plan may be discriminatory under PPACA, we urge you to monitor the rulemaking process and contact your tax counsel for further guidance.

Aetna does not conduct discrimination testing and is not responsible for an employer's compliance with this PPACA non-discrimination rule. The benefits and rates within this proposal are subject to change pending any required approvals from state or federal regulatory agencies.

Aetna reserves the right to modify its products, services, rates, and guarantees, and to recoup any costs, taxes, fees, or assessments, in response to legislation, regulation or requests of government authorities. Such costs, taxes, fees, and assessments are not included in the quoted guaranteed cap and will be added to the quoted guaranteed rates or otherwise recouped.

Sections 1341 and 9010 of The Patient Protection and Affordable Care Act impose new fees and assessments "hereinafter Fees" effective January 1, 2014. The methodology for determining the Fees will be based on future regulation. As such, the quoted rate cap herein does not include such Fees. When the amount of Fees allocable to your plan is determined, we will add such amount to your guaranteed rates or otherwise recoup such Fees.

f) Aetna Inc. reserves the right to review and possibly modify or terminate the guarantee arrangement if Hardee County School District fails to make required premium payments in accordance with contract provisions.

g) A total of 598 employees are expected to be enrolled in the quoted medical product. Aetna may revisit the structure or conditions of this guarantee if there is a change of greater than 10% of the assumed enrollment during the contract year; or if the assumed enrollment by plan changes by more then 10% during the contract year.

h) It is assumed that the current plan designs will remain in place during the 2018 and 2019 policy years. If plan changes are initiated during the 2019 or 2020 policy years, Aetna reserves the right to modify the increases agreed to in this guarantee.

i) Aetna is the full replacement medical [and pharmacy] vendor for Hardee County School District including any self-funded plans that are offered by Hardee County School District.

Medical Renewal Guarantee

j) Aetna Inc. reserves the right to review and possibly modify or terminate the guarantee arrangement if there is enactment of legislation (either state or federal) which impacts the ability of Aetna Inc, to contract for efficient, cost effective medical care.

k) It is assumed that the contribution structure will remain unchanged from 2018 to 2019. Aetna may revisit the structure or conditions of this rate guarantee if there is a change of greater than 10% of the current employee contributions.

l) This guarantee applies to any site which is fully credible, Aetna is allowed to experience rate and is filed to exercise underwriter judgment.

m) Any other material change under which the plan operates.

n) The guarantee will be terminated if the medical plan is put out to bid for the second renewal period.