ITEM #10
Proposal for Group Employee Insurance Benefits Consulting Service
BOMA
3/22/11

SHERRILL MORGAN

February 16, 2011

Mr. Brian Wilcox, Purchasing Manager
City of Franklin Purchasing Office
Franklin City Hall, Suite 107
109 3rd Ave. South
Franklin, TN 37064

Dear Mr. Wilcox:

Thank you very much for the opportunity to respond to your Request for Proposals for Group Employee Insurance Benefits Consulting Services. We have enclosed our response, along with supporting documents.

We specialize in Tennessee and Kentucky governments, representing over seventy-five governments throughout both states. Because of our familiarity with Tennessee governments, our office, in conjunction with the Tennessee Personnel Management Association (TPMA), conducts an annual survey of government employee benefits.

Our proposal illustrates the types of services we provide. The foundation of these services is development of a three-year plan for employee benefits based on the City of Franklin's financial goals. Plan designs would be tailored to achieve these goals, with consumer-driven programs like health reimbursement arrangements, wellness programs, and coverage of over-the-counter drugs being incorporated into a comprehensive program. Access to our on-staff attorney and C.P.A., as well as independent pharmacy and hospital network consultants are included in our services.

Because of our expertise with Tennessee governments, we believe that we are uniquely qualified to represent the City of Franklin. We look forward to the opportunity to further demonstrate how we might be able to serve you.

Sincerely,

Mark T. Morgan, President
Sherrill D. Morgan & Associates, Inc.
DBA SHERRILL MORGAN

525 W. Fifth Street · Suite 310 · Covington, KY 41011 · (859) 291-6600 · (800) 291-4222 · (859) 291-7805 Fax · www.sherrillmorgan.com

Exhibit 11	Smoking Cessation Information
Exhibit 12	Pharmacy Evaluation
Exhibit 13	Plan Design Recommendations
Exhibit 14	RFP Evaluation Forms
Exhibit 15	Disclosure Statement

supports the needs of its clients and their employee benefits programs. SHERRILL MORGAN and pertinent personnel are licensed as Health and Life Agents and/or Consultants. SHERRILL MORGAN staff includes a licensed attorney and certified public accountant.

In addition to fulfilling all of their respective continuing education requirements, these staff members regularly participate in conferences and training sessions held by the Kentucky Public Human Resources Association (KPHRA), the Kentucky Municipal Clerks Association (KMCA), the Tennessee Personnel Management Association (TPMA), The Tennessee Public Risk Management Association (TnPRIMA), the Tennessee City Management Association (TCMA), and the National Association of Insurance and Financial Advisors. Staff attend annual update meetings held by the Department of Labor, and keep abreast of state legislative activity on a regional basis through the departments of insurance of those states, and of federal legislative activity through the Employee Benefits Institute of America.

SHERRILL MORGAN represents over seventy-five public sector clients, a number of which have 150 employees or more and $1,500,000 in group health insurance premiums. Most of these public sector clients have been SHERRILL MORGAN clients for over 3 years. (Please see Exhibit 1 for partial listing of SHERRILL MORGAN government clients.)

Benefits Surveys:

SHERRILL MORGAN conducts three major annual surveys of employee benefits. The first is the Kentucky Government Benefits Survey, which is a survey of the employee benefits of over 5,200 Kentucky government employees. The second is the Tennessee Personnel Management Association Benefits Survey, which is a survey of over 28,000 Tennessee government employees. SHERRILL MORGAN also conducts the Greater Cincinnati Health Benefits Survey, a survey of private industry companies in the Greater Cincinnati area with 100 or fewer employees. (A copy of the TPMA Survey is included.)

SHERRILL MORGAN regularly sponsors educational seminars for its clients, including annual budget seminars for its government clients and periodic updates on regulatory issues, especially the new federal health care reform laws and regulations. SHERRILL MORGAN provides sponsorship and facilitation of meetings regarding new industry concepts, including consumer-driven health plans and wellness programs. (Please see Exhibit 2 for sample invitations.) SHERRILL MORGAN also provides all clients with a monthly newsletter to keep them up-to-date on employee benefit news. (Please see Exhibit 3 for sample newsletters.)

In addition to the services listed in Section 2 - Work Plan/Technical Approach, SHERRILL MORGAN also assists clients in the following ways:

Health Care Reform Assistance:

Consultation on the financial aspects of health plans

Shannon Mason, RHU, REBC, MBA
A primary Consultant for the client

Kristen Fields, Customer Service Director
Dedicated to assisting the client with enrollment and claims issues and assisting members with individual claims issues with carriers

(Please see next section for more detailed staff qualifications.)

Qualifications

Mark Morgan, President, SHERRILL MORGAN
With over 20 years' experience in the health and life insurance industry, Mark specializes in managing and establishing employee benefit plans. He is a licensed Agent and Consultant experienced in working with private, non-profit and governmental entities throughout the country and has been involved in numerous collective bargaining negotiations. He also works with hospital and provider organizations, and is one of the industry's leading proponents of transparency in health care financing, particularly in the area of pharmacy benefit management. He is regularly invited to speak at human resources conventions on health benefits and health care reform. Mark is an advocate for senior citizens, and has served as President of Senior Services of Northern Kentucky.

Michael Williams, Senior Vice President, Licensed Consultant
Mike joined SHERRILL MORGAN in 1998. A graduate of the University of Cincinnati, he has a diverse background in the health insurance industry as a marketing representative and service specialist. Mike also has experience as a billing representative, enrollment specialist, and a divisional trainer and has held positions with Humana and United Healthcare. He has extensive health insurance knowledge of claims issues, state laws and guidelines, and customer service. Mike is responsible for preparing analysis for all client renewals and new business quotes and is a primary consultant for SHERRILL MORGAN concerning any client service issues. Mike is a licensed Agent and Consultant. Mike also serves on several insurance company advisory boards and on several state advisory panels, including the Insurance Coverage Affordability and Relief program. Mike stays abreast of state legislative issues regarding health care and has served on various health committees. He also serves on the advisory board for Humana, CHA, and the Dental Care Plus Group.

Lisa Stamm, Esq., Vice President, Consulting Services
Lisa is a graduate of Northern Kentucky University and the University of Cincinnati College of Law. She has been with SHERRILL MORGAN since 2005, and assists with the management of health and welfare benefit plans. As a licensed attorney, she is able to give consultation regarding applicable state and

The City of Columbia has recently retained SHERRILL MORGAN to conduct Requests for Proposals for all services for their health plan and other employee benefits and to provide general consultative services regarding the City's employee benefits programs.

City of Springfield, Tennessee

The City of Springfield has retained SHERRILL MORGAN for consulting services regarding its employee health benefits. The mutually established goal is a reduction in the health care budget of $600,000 over a period 12-month period.

City of Kingsport, Tennessee

The City of Kingsport has retained SHERRILL MORGAN to conduct a Request for Proposals for administrative services for its health plan and to provide general consultative services regarding the City's employee benefits programs. SHERRILL MORGAN assisted in the City's GASB analysis of their retiree benefits.

The City of Bowling Green, Kentucky

The City of Bowling Green has approximately 450 employees and has been a SHERRILL MORGAN client since 2007. The City reduced its cost by nearly 20% by instituting a consumer-driven health plan with an HRA and by implementing a new spousal eligibility policy. This policy requires spouses who have coverage available at their place of employment to enroll in that coverage. The policy also offered a one-time waiver benefit for spouses who left the City's plan to enroll in other coverage. Contract and network changes recommended by SHERRILL MORGAN have also contributed to the City's savings. For example, in 2009, SHERRILL MORGAN was able to negotiate an approximate 25% savings on stop loss premiums for the City. The following bar graph illustrates the City's trend in cost per employee unit since 2002. Since SHERRILL MORGAN began representing the City in January of 2007, the City's unit cost was reduced from $8,763 to $7,339.

adopted a Medicare Advantage fully insured program for its Medicare-eligible retirees.

The City added a new plan design with a Health Reimbursement Arrangement for its active employees in 2009. The City's cost per unit decreased approximately 16% in 2009-2010 when compared with 2008-2009.

The City of Covington, Kentucky

The City of Covington has approximately 400 employees, and has been a client since 2004. SHERRILL MORGAN helped the group to achieve a savings of approximately $250,000 in administrative and stop loss expenses, and also assisted in union negotiations. In 2007, the City was able to reach agreements with all three of its unions, in part because of changes to the prescription drug program developed by SHERRILL MORGAN in conjunction with its pharmaceutical consultant, Allan Zaenger.

The City of Bardstown, Kentucky

Perhaps the greatest impact SHERRILL MORGAN has had on any client was on the City of Bardstown. Bardstown has 120 employees and has been a SHERRILL MORGAN client since 2000. With proper long-term planning and coordination of all aspects of its plan, including wellness, an HRA (see above), and network discount negotiations, the City had an overall 57% reduction in costs over four years.

Kenton County Fiscal Court, Kentucky

The Kenton County Fiscal Court has approximately 330 employees and has been a client since 2003. Initially, SHERRILL MORGAN coordinated bidding of administrative services, stop loss, network discounts and ancillary services, and was able to impact fixed costs and ancillary services (disability and life) by almost $300,000. In 2006, as part of its long term plan, the County instituted a dual choice program that included wellness programs, tobacco premiums, and waiver benefits. The County realized total savings of approximately $900,000 in 2006/2007. In January of 2009, the City began offering a Health Reimbursement Arrangement.

References

1. **City of Bristol, Tennessee** *(current client)*
Contact: Belva Hale, Director of Human Resources, 801 Anderson Street, Bristol, TN 37621, (423)989-5525

Services provided: Management of health and prescription drug plans and ancillary benefits

Employers are increasingly challenged to find ways to control costs while maintaining a level of employee benefits that enables them to attract and retain a strong workforce. Understanding the client's goals in this regard and helping to define those goals is SHERRILL MORGAN's first priority. SHERRILL MORGAN uses a detailed process called the "long term plan" in order to identify and achieve the client's goals. Ultimately, the goals are translated into a long term plan document. (Please see Exhibit 7 for long term plan documents.)

The following topics are discussed with the client as part of the long term planning process:

- **Financial Goals:** What are the client's *Financial Goals*? What does the client want plan costs to be over the next three years, and what share do they want employees to pay during that period? The client's historical costs are examined to determine the rate at which plan costs have inflated. (Please see bar graph in Exhibit 7.)

- **Retiree Benefits:** SHERRILL MORGAN can examine the costs of the client's retiree benefits programs and make recommendations to the client on how to manage these programs and the resulting current and future financial liability associated with them, including GASB and OPEB liability. (Please see sample Client Memoranda in Exhibit 8.)

- **Wellness and Consumer-Driven Goals:** This is the area with the greatest potential for employee involvement and also involves how the plan is conceptually conveyed to employees. Numerous federal and state regulations apply in the area of Wellness Programs. SHERRILL MORGAN's on-staff attorney can provide guidance to the client on the regulatory implications in this area.

- **Pharmacy Goals:** This is a major consumer-driven area of health plans. For instance, health plans can cover over-the-counter substances in order to move members from more costly prescribed drugs. (Please see below for more information on over-the-counter drug coverage.) This, along with other programs, can greatly impact prescription drug costs. We also recommend transparent and pass-through contracting for the client's pharmacy program to ensure that drugs are purchased at the best possible discount and that all rebates come back to the employer.

- **Plan Design Goals:** Deductibles and copays are evaluated to make sure they coordinate with the client's goals in other areas.

All of the information above is put on a timeline on which meeting dates and goals, such as the renewal process, are given future action dates. (Please see timeline in Exhibit 7.) SHERRILL MORGAN meets quarterly with clients in order to facilitate the long term planning process.

b. ***Consumerism and Wellness***

After helping the client to select a wellness program vendor, such as a national firm or local hospital, SHERRILL MORGAN works with the client to determine what type of incentive program will best fit its workforce. SHERRILL MORGAN also helps the client in designing employee educational formats that will convey the goals of the wellness programs to employees. The cost of the programs range from a per employee per month cost, to a cost per meeting. Measurements of return on investment (ROI) are calculated in the reporting, but an industry standard for monetary ROI is a minimum of two to three years. Many of the programs that SHERRILL MORGAN has implemented have had an immediate ROI, such as being able to detect minor and major health conditions of which employees were previously unaware. Lisa Stamm, Esq., is experienced in developing wellness programs in which the employer can track certain health conditions, such as high blood pressure, and then reward or penalize employees for their actual success in managing their conditions. (Please see wellness information in Exhibit 9.)

iii. Over-the-Counter Drug Coverage

The Over-the-Counter (OTC) Drug program enables both individual members and health plans to save money by covering over-the-counter substances under the prescription drug card. It enables members to substitute less expensive allergy, stomach, and cold sore medications for more expensive prescription substances. A special, reduced copay is established for these over-the-counter substances in order to encourage members to participate. For instance, some employers with $5 or $10 generic copays charge $1 or no copay at all for a thirty-day supply of the OTC substances. SHERRILL MORGAN will help to educate employees regarding the benefits of this program. (Please see Exhibit 4 for a sample of employee educational information on the OTC program.)

Vendor Evaluation and Selection Services

SHERRILL MORGAN uses the long term planning format, discussed previously, for implementation of new vendors and programs in order to meet the client's goals. (Please see Exhibit 6 for an example of a Request for Proposal that SHERRILL MORGAN used to help select and install a new third-party administrator for a client.) Once pertinent vendors have been selected, SHERRILL MORGAN provides customized presentations for each client, including presentations to employees, and will prepare employee materials in the format the employer chooses. The involvement of networks and vendors is crucial to this process, and SHERRILL MORGAN will facilitate their involvement. SHERRILL MORGAN can also facilitate online enrollment with vendors, as well as enable both employer and employee to access online benefit information.

Pharmacy Analysis

The following implementation, planning, and evaluation services are provided by SHERRILL MORGAN as part of its regular services:

1. Installation or Examination of Current Bids or Providers

   - Evaluating and negotiating vendor contracts
   - Monitoring installation timelines for new programs and monitoring vendor performance
   - Employee meetings

2. Future Plan Evaluation & Recommendations

   - Understanding of client goals
   - Plan compliance with applicable regulations
   - Plan costs and trends
   - Provision of written recommendations to reduce plan costs (e.g., Rx benefits) (Please see Exhibit 13 for an example of written recommendations for a client.)
   - Recommendations regarding retiree benefit programs and associated financial liabilities (Please see sample Client Memoranda in Exhibit 13.)
   - Recommendations for LTD, STD, life, dental, and vision benefits

3. Future Bid Requests & Evaluation

   - Understanding what the client desires to achieve from bidding process
   - Preparing bid documents, establishing goals, parameters for election criteria of bids
   - Distribution of bid requests
   - Fielding questions from respondents
   - Receiving and evaluating bids, measuring election criteria, and presenting results to client (Please see Exhibit 14 for forms used to evaluate RFP responses.)
   - Interviewing and awarding contracts to successful respondents
   - Monitoring installation timelines for new programs and monitoring new vendors

4. Plan Monitoring & Ongoing Evaluation

   - Mid-year Review of plan costs, containment measures, and possible plan change recommendations
   - Third Quarter Review of current plan, plan provider, plan costs, and preparation of possible plan changes and contract renewal
   - SHERRILL MORGAN staff available for claims issues and general consultation
   - Development of long-term plan (3 to 5 years) and comparison of Client information to other government data available to SHERRILL

Proposal Submittal Form

a form required of Bidders and Proposers on purchases of supplies, materials, equipment and services for the

City of Franklin, Tennessee

Purchasing Office Solicitation No.: 2011-016

Vendor's name, street address, and mailing address:	SHERRILL MORGAN 525 W. 5th Street, Suite 310 Covington, KY 41011
Vendor's contact person's name (printed), title, and telephone number:	Mark T. Morgan, President 859-291-6600
Does the proposer take any exceptions to the City's requirements (yes, see enclosed / no, proposer takes no exceptions)?	Yes, see enclosed
Are exceptions, if any, to the City's requirements listed separately, described, compared to the City's intention as expressed and implied by the City's requirements and submitted (yes, see enclosed / no, proposer takes no exceptions):	Yes, see enclosed
City's preferred payment terms (net 30 days from date of invoice) are acceptable to proposer (yes/no; if no, proposer to indicate its preferred payment terms):	Yes
Last date (no sooner than April 30, 2011) that proposal and associated pricing is valid and may be accepted by the City:	July 1, 2012
Are the following included with this Proposal Submittal Form in the proposal submittal (yes/no)? • Detailed vendor-supplied description of proposed service(s); • Identification, listing and description of any exceptions to the City's requirements as per the instructions; • Contact information for minimum of three references; • Standard Procurement Terms and Conditions of the City of Franklin, with the vendor's contact information inserted; • Vendor terms and conditions, if any, that are not inconsistent with the City's Standard Procurement Terms and Conditions; • Affidavit of Non-Collusion, executed in full; • If proposer employs not less than five employees, then the City's Affidavit of Drug-Free Workplace, executed in full; and • Affidavit of Title VI Compliance, executed in full.	No

Affidavit of Non-Collusion

a form required of Bidders and Proposers on purchases of supplies, materials, equipment and services for the

City of Franklin, Tennessee

State of Kentucky)
County of Kenton) SS
)

Affiant, Mark T. Morgan, deposes and makes oath that:
(printed name of person signing Affidavit)

1. He or she is the President of
(Owner or Authorized Partner, Officer, Representative or Agent of Owner)
Sherrill D. Morgan & Associates, Inc.,
(legal name of entity submitting bid or proposal)
the Bidder or Proposer who has submitted the attached bid or proposal;

2. The Bidder or Proposer is fully informed respecting the preparation and content of the attached bid or proposal and of all pertinent circumstances respecting such bid or proposal;

3. Such bid or proposal is genuine and is not a collusive or sham bid or proposal;

4. Neither the said Bidder or Proposer nor any of its officers, partners, owners, agents, representatives, employees, or parties in interest, including this Affiant, has in any way colluded, conspired, connived or agreed, directly or indirectly, with any official or agent of the City of Franklin or with any other firm, person, or potential or actual bidder or proposer to submit a collusive or sham bid or proposal in connection with the contract for which the attached bid or proposal has been submitted, or to refrain from bidding or proposing indirectly, or sought by agreement, or collusion, or communication, or conference with any other firm, person, or potential or actual bidder or proposer to fix the price or prices or cost element of the bid, quoted or proposed price or the bid, quoted or proposed price of any other potential or actual bidder or proposer, or to secure through any collusion, conspiracy, connivance, or unlawful agreement any advantage against the City of Franklin or any person interested in the proposed contract;

5. The price or prices quoted in the attached bid or proposal are fair and proper and are not tainted by a collusion, conspiracy, connivance, or unlawful agreement on the part of the Bidder or Proposer or any of its agents, representatives, owners, employees, or parties in interest, including this Affiant; and

6. He or she understands that Article VIII, Section 16, of the City Charter of Franklin, and T.C.A. §6-54-107, prohibit any member of the Board of Mayor and Aldermen, or officer elected by said Board, from being interested in any contract, or work of any kind whatever, under its control and direction, and any contract in which any such person shall have an interest shall be void and unenforceable, subjecting any funds received by contractor to be returned in full to the City, in addition to any other penalties provided by law.

Mark T Morgan
(signature of Affiant)

President
(title of Affiant)

Sworn and subscribed to before me this 16 day of Feb, 20 11

Cheryl Fallen
(Notary Public)

My Commission Expires: 10-1-13

(Submitted in response to City of Franklin Purchasing Office Solicitation No. 2011-016)

Standard Procurement Terms and Conditions
City of Franklin, Tennessee

1. Assignment/Subcontracting. Neither party may assign any rights or obligations under these Standard Procurement Terms and Conditions or any Statement of Work without the prior written consent of the other party. These Standard Procurement Terms and Conditions will be binding upon and inure to the benefit of the parties and their respective successors and permitted assigns. Vendor may subcontract any portion of the work only with the prior consent of the City, but such subcontracting will not relieve Vendor of its duties under these Standard Procurement Terms and Conditions.

2. Time of the Essence. The parties agree that TIME IS OF THE ESSENCE with respect to the vendor's performance of all provisions of this procurement.

3. Taxes. As a tax-exempt entity, the City shall not be responsible for sales or use taxes incurred for products or services. Upon request, the City shall supply Vendor with a copy of its Sales and Use Tax Exemption Certificate. Vendor shall bear the burden of providing its suppliers with a copy of the City's tax exemption certificate and shall assume all liability for such taxes, if any, that should be incurred.

4. Notices. Any notice provided pursuant to these Standard Procurement Terms and Conditions, if specified to be in writing, will be in writing and will be deemed given: (a) if by hand delivery, then upon receipt thereof; (b) if mailed, then three (3) days after deposit in the mail where sender is located, postage prepaid, certified mail return receipt requested; (c) if by next day delivery service, then upon such delivery; or (d) if by facsimile transmission or electronic mail, then upon confirmation of receipt. All notices will be addressed to the parties at the addresses set forth below (or set forth in such other document which these Standard Procurement Terms and Conditions may accompany, or such other address as either party may in the future specify in writing to the other):

In the case of the City:	In the case of Vendor:
City of Franklin	SHERRILL MORGAN
Attn: Purchasing Manager	Attn: Mark T. Morgan
Re: City of Franklin Purchasing Office Solicitation No. 2011-016	
109 Third Ave. South	525 W. 5th Street, Suite 310
P.O. Box 305	
Franklin, TN 37065-0305	Covington, KY 41011
FAX: 615/550-0079	859-291-7805
E-mail: purchasing@franklintn.gov	mark@sherrillmorgan.com

11. Precedence. In the event of conflict between the provisions of these Standard Procurement Terms and Conditions and any contract, agreement or other document which these Standard Procurement Terms and Conditions may accompany, the provisions of these Standard Procurement Terms and Conditions will to the extent of such conflict take precedence unless such document expressly states that it is amending these Standard Procurement Terms and Conditions.

12. Indemnification. Vendor agrees to indemnify and hold City harmless from and against legal liability for all judgments, losses, damages, and expenses to the extent such judgments, losses, damages, or expenses are caused by Vendor's negligent act, error or omission in the performance of the services of this agreement. In the event judgments, losses, damages, or expenses are caused by the joint or concurrent negligence of Vendor and City, they shall be borne by each party in proportion to its own negligence. The terms and conditions of this paragraph shall survive completion of this services agreement.

13. Additions/Modifications. If seeking any addition or modification to the Contract, the parties agree to reference the specific paragraph number sought to be changed on any future document or purchase order issued in furtherance of the Contract, however, an omission of the reference to same shall not affect its applicability. In no event shall either party be bound by any terms contained in any purchase order, acknowledgement, or other writings unless: (a) such purchase order, acknowledgement, or other writings specifically refer to the Contract or to the specific clause they are intended to modify; (b) clearly indicate the intention of both parties to override and modify the Contract; and (c) such purchase order, acknowledgement, or other writings are signed, with specific material clauses separately initialed, by authorized representatives of both parties.

14. Applicable Law; Choice of Forum/Venue. These Standard Procurement Terms and Conditions are made under and will be construed in accordance with the laws of the State of Tennessee without giving effect to any state's choice-of-law rules. The choice of forum and venue shall be exclusively in the Courts of Williamson County, TN.

15. Termination. Either party may terminate these Standard Procurement Terms and Conditions, with or without cause, upon thirty (30) days' notice to the other. Upon termination by the vendor, the City shall be entitled to retain ownership of any and all goods and equipment purchased. Upon termination by the City, the vendor shall be entitled to receive any amounts due as a result of goods and equipment already delivered and/or services already rendered; however, the City shall maintain ownership and control of any goods and equipment purchased. Upon termination of services, whether connected or unconnected to goods and equipment, such services shall be rendered until the conclusion of the 30th day as stated in the notice or until a contractual benchmark has been achieved, or as the parties may otherwise agree.

Indemnification Agreement

a form required of Bidders and Proposers on purchases of services for the

City of Franklin, Tennessee

On behalf of Bidder/Proposer, Mark T. Morgan agrees that:
(printed name of person signing Agreement)

1. He or she is the President of
(Owner or Authorized Partner, Officer, Representative or Agent of Owner)
Sherrill D. Morgan & Associates, Inc.,
(legal name of entity submitting bid or proposal)
the Bidder or Proposer who has submitted the attached bid or proposal;

2. The Bidder or Proposer is fully informed respecting the preparation and content of the attached bid or proposal and of all pertinent circumstances respecting such bid or proposal;

3. The Bidder or Proposer agrees to indemnify and save the Government of Franklin, the City of Franklin and individual, on or off duty, officers, and employees of the City of Franklin, harmless from any and all losses, damages and expenses, including court costs and attorneys fees, by reason of any loss, whatsoever, arising out of or relating to or in consequence of the work done in connection with the contract of which this Agreement is a part, excepting only such losses as shall be occasioned solely by the negligence of the City of Franklin; and

4. This Agreement is made on personal knowledge.

Mark T Morgan
(signature of person whose printed name appears above)

President
(title of person whose printed name appears above)

(Submitted in response to City of Franklin Purchasing Office Solicitation No. 2011-016)

Form revised 02/25/2005

Government Health Plan Budgeting: Issues, Strategies & Forecasts

Nashville, TN • February 10, 2011 • 8:30 a.m. – 11:30 a.m.

~ Program Overview ~

8:30 a.m.
Registration and Continental Breakfast

8:45 a.m.
Opening Remarks & Introductions
Mark Morgan
President, Sherrill Morgan

8:55 a.m.
TPMA/MTAS Update
Richard Stokes
Executive Director, TN Chapter IPMA-HR
HR Consultant, University of TN – MTAS

9:05 a.m.
Government Rx Trends & Benefit Strategies
Allan Zaenger, R.Ph., MS
President & CEO, Pharmaceutical Horizons

9:50 a.m. – 10:00 a.m.
Break

10:00 a.m. – 10:15 a.m.
Actuarial View of Tennessee Health Plans
Randy Gomez, FSA, EA, MAAA
Principal & Chief Health Care Actuary, Nyhart

10:15 a.m. – 10:45 a.m.
Compliance Issues
Lisa Stamm, Esq.
VP Consulting Services, Sherrill Morgan

10:45 a.m. – 11:00 a.m.
Benchmarking, Forecasts, and Strategies
Mark Morgan
President, Sherrill Morgan

11:00 a.m.
Breakout Sessions

Are you ready for your next plan year? Sherrill Morgan is pleased to invite you to an exclusive client budget workshop where you will receive all of the tools and strategies you need to prepare for your upcoming budget year.

You'll have the opportunity to learn about important regulatory issues, benefit trends and plan strategies that will help you improve your plan's performance.

Self-Funded Clients
During the breakout session, you will receive a customized claims analysis with year-end cost projections. You'll have an opportunity to review your analysis with a benefits expert as well as discuss budget projections.

Fully Insured Clients
During the breakout session, representatives from the fully insured carriers will discuss benefit trends for their organizations.

Please join us for this informative, invitation-only program at:

Gaylord Opryland
Resort & Convention Center
2800 Opryland Drive
Nashville, TN 37214

To register, contact Michelle Middendorf at 800-291-4222 or michelle@sherrillmorgan.com.

This event is sponsored by:

SHERRILL MORGAN

Crisis in the economy: Implications for your health plan in an era of furloughs and layoffs

Employer Benefits Seminar

Metropolitan Club, Covington, KY
March 17, 2009

~ Program Overview ~

8:15 a.m.
Registration and Continental Breakfast

8:30 a.m.
Welcome and Opening Remarks

8:45 a.m. – 9:45 a.m.
Economic Stimulus Package/ Furlough & Lay-off Considerations

Lisa Stamm, Esq., VP Consulting Services
SHERRILL MORGAN

Caroline Fraker, VP Compliance & Risk Mgt
MEDBEN

9:45 a.m. – 10:00 a.m.
Break

10:00 a.m. – 11:00 a.m.
Greater Cincinnati Health Benefits Survey

Mark Morgan, President
SHERRILL MORGAN

Mike Williams, Senior Vice President
SHERRILL MORGAN

How will the expansion of COBRA laws through the economic stimulus package affect your health plan?

Experts in the health care industry will discuss the COBRA changes arising from the American Recovery and Reinvestment Act of 2009. The Act imposes a number of new requirements for employers. Learn how to implement these changes as they relate to your health plan.

What do you need to know before furloughing or laying off employees?

Employers facing difficult decisions concerning their workforce need to be aware of the implications of their actions as they relate to their group health plan.

How are other Cincinnati-area employers weathering the storm?

Greater Cincinnati Health Benefits Survey results– local private employers in the Greater Cincinnati area and the health benefits they offer their employees.

To RSVP contact:
Michelle Middendorf
859-291-6600
michelle@sherrillmorgan.com

This free event is being co-sponsored by:

SHERRILL MORGAN

MedBen
Where peace of mind is your best benefit®

Trends In Consumer-Driven Health Plans -

taken from Health Insurance Underwriter December 2010 (article by Chris Byrd, President & COO Evolution Benefits)

News reports on the rising costs of health care seem to be endless. Unfortunately, so too are the countless stories of hardworking, insured individuals across the country who are going without necessary medical treatments and lifesaving medications because they simply can't afford it.

According to the Kaiser Family Foundation's 2010 Employer Health Benefits Survey, employees' share of premiums for family plans will rise by an average of 14% to $3,997. In the past five years, employees' premium contributions have grown 47% while overall premiums increased 27%. If these trends continue, by 2019, the average family health plan will cost over $30,000 per year.

An increasing number of major corporations have announced the need to raise employee benefits costs, while some have threatened to cut health care benefits altogether.

Many employers see consumer-driven health plans (CDHPs)—including a high deductible health plan offered with a Health Reimbursement Arrangement (HRA), Health Savings Account (HSA) or Flexible Spending Account (FSA) and a convenient benefits debit card—as a viable solution for curbing high benefit costs.

These plans offer lower premiums, empower employees to make wise decisions about how to spend their health care benefit dollars, and give them a tax break on their out-of-pocket costs.

The consumer-driven movement has a track record of holding down health care costs. Many studies have been conducted on health care consumerism and the research shows CDHPs undoubtedly have helped curtail rising health benefits costs. By switching to a CDHP, many employers have experienced meaningful reductions in the annual rate of health care cost increases.

HRAs and HSAs continue to experience strong growth. As estimated 6 to 7 million HSAs and a similar number of HRAs are in use today. Kaiser Family Foundation found that enrollment in consumer-driven plans that offered an HSA or HRA jumped form eight percent to 13% in the past year.

While the healthcare costs and reform debate continues to grab headlines, the bottom line is this: Consumer-driven health plans will occupy an even larger position in the health care landscape as employers and consumers alike realize that this approach holds costs down and stretches their health care dollars.

For more information on consumer-driven health plan options, please contact a SHERRILL MORGAN account manager at 859-291-6600 or

IRS Clarification on Over-The-Counter Drugs - per John Paul Prebish of Infinisource, Inc.

Under the Patient Protection and Affordable Care Act (PPACA), over-the-counter (OTC) drugs require a prescription if incurred on or after January 1, 2011. Previously, Notice 2010-59 delayed the effective date to January 16, 2011, for purchases made with debit cards.

Recently, the IRS issued Notice 2011-5, providing a further exception for debit cards, and outlining a procedure where a prescribed OTC drug could be reimbursed if all five of the following requirements are met:

1. Before the purchase, the FSA/HSA participant gives the pharmacist a copy of the prescription, the pharmacist provides the OTC drug and assigns an Rx number
2. The pharmacy or vendor retains a record of the Rx number, the name of the purchaser or person for whom the prescription applies and the date and amount of the purchase
3. The pharmacy retains all records for review upon request
4. The card will not work without an assigned Rx number
5. All of the other usual requirements are met

The above requirements must be met for the following types of vendors:

- Drug stores and pharmacies
- Non-health care merchants with pharmacies (i.e. Walmart)
- Mail order and web-based vendors that sell prescription drugs

The card could also be used at other vendors with a health care related Merchant Category Code, except the requirements above related to an Rx number do not apply because no pharmacy is involved.

If all of the above requirements are met, the purchase will be considered fully substantiated at the point of sale. Notice 2011-5 states that the rules for debit card purchases at "90 percent pharmacies" continue to be subject to the PPACA rules in Notice 2010-59, which was issued earlier in 2010.

Carrier Corner...

What's New...

Blue Cross Blue Shield of Illinois

- To comply with the Illinois Insurance Fairness Act (Public Act 96-0857) that took effect on Jan. 1, 2011, all insurers doing business in Illinois must now use the Illinois Standard Health Application for small group and Under 65 individual coverage. **Beginning Feb. 1, 2011, any applications received using the old forms will be rejected.**

Blue Cross Blue Shield of Tennessee

- Effective January 1, 2011, some prescription medications are changing classifications. The following will require "step therapy" for approval: **Analog Insulin**—Humalog will require step therapy with Novolog; **Diabetic Strips**—Lifescan (One Touch) strips will become a third-tier prescription and require step therapy; while third-tier Abbott (Freestyle) strips will also require step therapy; **Angiotensin II Receptor Blockers (ARB)**—Avapro and Avalide will move to non-preferred tier and all non-preferred ARBs (Atacand/Atacand HCT, Avapro/Avalide, Cozaar/Hyzaar, Diovan/Diovan HCT and Tevetan/Tevetan HCT) will require step therapy; **Cymbalta** will become a third-tier prescription and require step therapy.

United Healthcare

- UnitedHealthcare has entered into an agreement to renew medical insurance coverage for The Guardian Life Insurance Company of America's medical plan customers.

New Ohio Law Limits Prescription Transfers Between Pharmacies

A new Ohio law, effective January 1, 2011, limits the number of times individuals can transfer prescriptions between pharmacies to once per year. The law aims to improve medication safety by preventing people from switching pharmacies frequently to take advantage of coupons and discounts offered by many chain retail pharmacies. For more information, please visit: http://www.pharmacy.ohio.gov/index.htm

Health Insurance Survey

1. Various programs can be used as a means of controlling the costs of a health plan and keeping benefit changes to a minimum over time. The following questions are designed to determine which types of programs you would prefer to use.

How familiar are you with the concept of Health Reimbursement Arrangements?

1	2	3	4	5
Not Familiar				Very Familiar

How familiar are you with the concept of Health Savings Accounts?

1	2	3	4	5
Not Familiar				Very Familiar

How interested would you be in exploring the use of a Health Reimbursement Arrangement (HRA)? (If you're not sure what an HRA is, feel free to skip this question.)

1	2	3	4	5
Not Interested				Very Interested

2. Recognizing that all areas of the health plan are important, please indicate how important each of the following areas of the plan are to you by using this scale:

1	Not very important
2	Somewhat important
3	Important
4	Very important
5	Extremely important

Current Prescription Drug Benefits _____

Current Office Copays _____

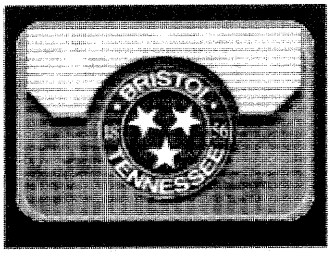
Current Emergency Room Copays _____

Current Deductible Levels _____

Current Coinsurance Levels _____

Current Out-of-Pocket Maximum Levels _____

3. Your comments/suggestions regarding future planning for the health plan:



March 8, 2007

REQUEST FOR PROPOSAL

Health Benefit Program & Associated Services

1. Overview

The City of Bristol health benefit plan has been self-funded for approximately 14 years. The City's health plan has been administered by S&S Healthcare Strategies of Cincinnati, Ohio. The City currently purchases administrative services and stop loss insurance. The City also participates in the Highlands Wellmont Health Network, as well as the USA Network. It utilizes Express Scripts, Inc. for pharmacy benefit management.

Approximately 334 employees and their families are receiving benefits under the City's plan.

Sherrill D. Morgan & Associates (SDMA) will be coordinating this request for proposal for the City.

2. Purpose and Evaluation Method

The City of Bristol is seeking general TPA/ASO services, pharmacy benefit management services, and stop loss coverage, as well as dental, life, and long-term disability coverage for its employees and their dependents. The City feels it is prudent to request proposals at this time to ensure that they are receiving the best price and service for its employees, as well as to maintain control and reduce the cost of their medical plan. The respondents' ability to demonstrate their ability to help manage health care costs will be considered. The City is also interested in obtaining exceptional customer service.
All services provided by TPAs/ASOs should be quoted separately, such as COBRA/HIPAA administration. (See attached Administrative Services Form.)

3.3 PPO Network (Point Value: 20 Points)

The City currently utilizes the Highlands Wellmont Health Network and USA PPO physician/hospital networks. The top five facilities currently utilized by the City are: Wellmont Health System, Johnson City Medical Center, East Tennessee Children's Hospital, Russell County Medical Center, and North Side Hospital. The TPA/ASO must either be able to continue the present network arrangements, or provide other network options.

TPA/ASO respondents proposing other network options should provide average discounts for the top five hospitals in the proposed network on both an inpatient and outpatient basis, and should also provide average provider discounts for the proposed network for providers in the 37621 zip code. Respondents proposing other network options should also submit a GeoAccess report with the following minimal parameters: 2 primary care physicians within a 15-mile radius; 2 specialists within a 15-mile radius; 2 pediatricians within a 15-mile radius; 2 OB/GYNs within a 20-mile radius, and 1 hospital within a 20-mile radius. A disruption report may be required of finalists.

3.4 Stop Loss (Point Value: 10 Points)

The City currently has $105,000 of specific stop loss coverage with the Gerber Life Insurance Company. The City does not purchase aggregate coverage. The City will entertain proposals with higher stop loss deductibles, but a $105,000 specific deductible option must be quoted. Paid, *24/12, 18/12 are preferred, but 15/12 contracts will be considered.* Currently, medical and prescription drug claims are covered under the specific deductible and the City is requesting that this remain the same with the new stop loss coverage.

If necessary, further negotiation with successful respondents regarding stop loss will be permitted after the deadline. **Stop loss should be quoted net of commissions.**

3.5 Utilization Review/Medical Management (Point Value: 10 Points, 5 allotted to UR/Medical Management, 2.5 allotted to disease management, 2.5 allotted to predictive modeling capabilities)

Highlands Wellmont presently provides utilization review and medical management for the City. If you wish to propose using a different arrangement, please identify if your utilization review is a part of the TPA/ASO service and whether it is an in-house service or provided by an outside vendor. Also, please describe how individuals are reported to UR/medical management and the procedures involved. Additional points will be given for TPAs/ASOs offering disease management programs and/or predictive modeling capabilities.

4. Specifications

4.1 Criteria

All proposals will be submitted in writing and will specifically address all of the requirements that are listed above. Criteria that will be used to determine award of the contract will include but will not be limited to the following:

a. **The cost per employee per month for all services. Cost quoted must be guaranteed for at least a one-year period following acceptance.**
b. **References provided. Government agencies will receive significant regard. (Point Value: 5 Points for 2 or more government references, 10 Points will be awarded if 1 reference is a government in Tennessee.) At least four references in total should be provided.**
c. The qualifications and experience of the TPA/ASO, staff, and associated vendors.
d. The scope and degree of services provided.
e. Thoroughness and usefulness of reports provided to the City on a monthly basis.
f. Demonstrate competence and compliance with HIPAA Privacy regulations.
g. On-line services.
h. The ability to work with related vendors.
i. Demonstrated customer service.
j. Claims turnaround time.
k. Thoroughness of the response to the RFP
l. Completion of Attachment to RFP

4.2 Consequence for Unsatisfied Requirements

Failure to meet specifications as outlined or failure to provide any of the information asked for or addressed in this request in a manner which will permit thorough assessment of a provider's program may be grounds to reject any proposal.

4.3 Contract Term and Effective Date

The TPA/ASO contract for the City will cover a one-year period and will commence on JULY 1, 2007 and will end on JUNE 30, 2008. The contract may be renewed for like terms on the anniversary date upon written notice by the City. The contract can be terminated by the City with at least thirty (30) days' prior written notice of termination. It is anticipated that the contract will be renewed for consecutive years. Multi-year contracts will be considered if offered.

5. ADDITIONAL QUOTE REQUIREMENTS FOR TPA/ASO & ASSOCIATED VENDORS

1. How long has your TPA/ASO provided services?
2. Where are your headquarters?
3. Where are claims processed?
4. How are you owned?
5. What are your office hours/customer service hours?
6. Do you offer any other services other services? (not already discussed)
7. Stop-loss providers most commonly used and what are their ratings?
8. What routine reports will you provide and how often? Please include an example of reports.
9. Are reports available online?
10. **Please provide copy of your EOB.**
11. How often do you audit claims? What methods/procedures do you use for auditing? Are you audited by an outside organization?
12. Please state your average claims turnaround time.
13. Please provide a minimum of four references. (See section 4.1, item b. for specific requirements.)

STOP LOSS CARRIER/MGU QUESTIONNAIRE

Sherrill D. Morgan and Associates, Inc. (SDMA) requests that each Stop Loss Carrier/and or MGU confirm its stance on the following contractual and administrative issues. **If you offer more than one carrier's contract, please complete one of these forms for each of the contracts you offer.**

Please Insert the Name of Carrier:

1. Claims

a. Please define a "paid claim"?

b. Does this contract cover either or both of the following fees associated with a prescription drug program?
Dispensing Fees ☐Yes ☐No Administration Fees ☐Yes ☐No

c. If you are an MGU, do you have any claims paying authority? ☐Yes ☐No
If yes, to what extent?

d. Does this contract cover either or both of the following surcharge taxes and assessments? ☐NY ☐Mass.

2. Specific Coverage

a. Do you offer advance funding on specific claims? ☐Yes ☐No
If yes, please describe any limitations of this option. Is advance funding available during the entire contact year or are there special provisions for the end of the contract year?

b. What is the average turn-around time for reimbursement?

3. Aggregate

a. Do you offer a monthly rolling aggregate option? ☐Yes ☐No
If yes, is there a per employee per month cost or an initial charge at the beginning of the contract? Please describe. PEPM charge;
If yes, does the aggregate have to be exceeded by a certain dollar amount to receive reimbursement?
☐Yes ☐No
If Yes, when is the payback of the advance expected?
☐Immediately ☐End of the contract

b. What is the average turnaround time for reimbursement of all aggregate claims?

4. Plan Document

a. Does this carrier have a specific set of exclusions that are required? ☐Yes ☐No
If yes, SDMA requests that you provide this list as soon as possible.

b. What is the expected turnaround time for approval of the plan document and amendments?

5. Additional Questions

a. If you are an MGU, do you assume any risk for this carrier? ☐Yes ☐No
If yes, how much?

b. Does this carrier assume 100% of the risk (minus the MGU risk, if any)? ☐Yes ☐No
If no, please list and describe the other parties assuming risk.

PHARMACY BENEFIT MANAGER (PBM) QUESTIONNAIRE

Sherrill D. Morgan and Associates, Inc. (SDMA) requests that each Pharmacy Benefit Manager confirm its stance on the following contractual and administrative issues.

Proposals must be transparent with regard to all fees, rebates, and spread.

Please Insert the Name of PBM:

1. Corporate Capabilities

a. Identify the staff that would be directly involved with the City's contract, along with their titles and responsibilities with respect to the group.

b. Identify three references of clients similar to the City of Bristol.

2. Provider Network Management

Describe your MAC program including discounts and maintenance procedures.

3. Rebate Management

a. Please provide your proposal for providing a rebate for every paid claim including, as applicable, mail service and specialty pharmacy. Include among other items the following:

- Guaranteed rebate per EVERY paid drug claim
- Sharing of rebate amount in excess of the per claim guarantee

b. The City of Bristol requests the access and right to audit all records regarding rebates with drug manufacturers as it pertains to the City. Please describe your current policy and scope for outside audit procedures.

c. Describe the process for recommending formulary changes in conjunction with rebate contracts in order to obtain the most cost effective net per member per month costs.

4. Price Proposal

a. Identify the administrative services fee per employee per month (PEPM). Identify all of the administrative services included in this fee. If there are any other charges that will be assigned to other services please identify these services and the associated fee. Any fees not identified will be assumed to be part of the administrative services included in the PEPM service fee.

b. Identify proposed retail provider network reimbursement fees (ingredient cost discount and dispensing fee).

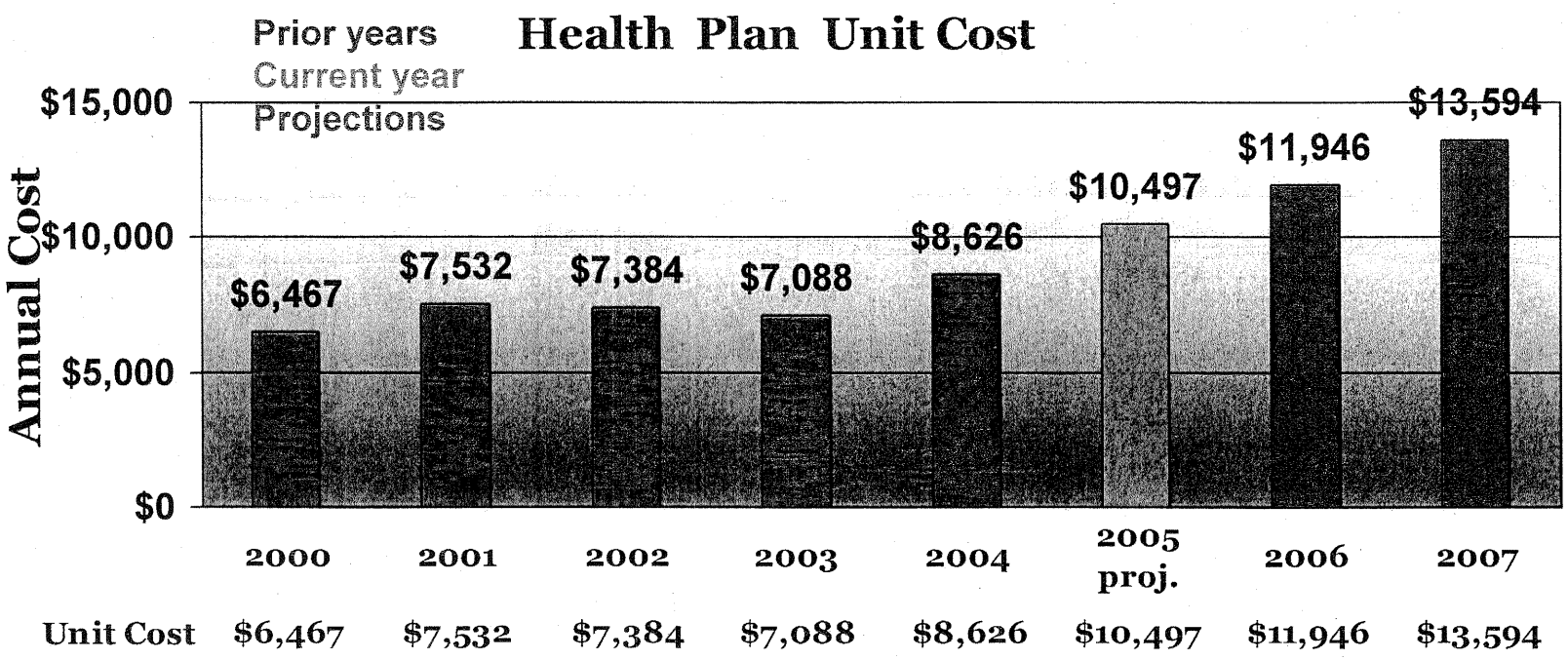
SHERRILL MORGAN

Sherrill D. Morgan and Associates, Inc. Three-Year Plan Components:

****

- Goal-setting and Timelines
- Consumer-Driven Health Plans
  HRA, FSA, HSA, etc./ Pharmacy Benefits (OTC)
- Wellness Programs
  Information Gathering / Employee involvement
- Predictive Modeling
- TPA/Provider & Other General Services

Health Care Plan Liability and Projection



	2000	2001	2002	2003	2004	2005 proj.	2006	2007
Unit Cost	$6,467	$7,532	$7,384	$7,088	$8,626	$10,497	$11,946	$13,594

Plan Goal $_____

2005/2006 based on 6 months of claims

13.8 % used for future projections. Average inflation for current and prior years shown is 13.8 % per year from 1999.

At this rate plan cost would double in less than 6 years

SHERRILL MORGAN

SHERRILL MORGAN

To: City Manager
From: Mark Morgan
Date: October 14, 2008
Re: Three-Year Planning Objectives

The following are recommendations for the City's employee health and related benefits plan through July of 2010.

Plan Design Recommendations (January 1, 2009):

Active Employees

The City currently offers two health plan options, the Maroon and the White Plan, with the Maroon Plan having the richer benefits. In 2007-2008, the Maroon Plan's total costs were $1,235,919 with a total average enrollment of 161. This equates to a cost per employee unit of $7,677. For the same time period, the White Plan had a total cost of $860,598 with a total average enrollment of 178. This equates to a cost per employee unit of $4,835. The Maroon costs on an employee unit basis are approximately 59% higher than the White Plan. For this reason, we recommend elimination of the Maroon Plan effective January 1, 2009.

We then recommend that the City adopt one of the following options: (1) The White Plan with higher deductibles and a Health Reimbursement Arrangement; or (2) The White Plan as it currently exists and a second plan with higher deductibles and a Health Reimbursement Arrangement, as shown here:

HRA EXAMPLE *

White Plan	**Current**		**HRA Plan**		**HRA Reimbursement**	
	Single	**Family**	**Single**	**Family**	**Single**	**Family**
Deductible	**$700**	**$1,600**	**$1,000**	**$2,000**	**$1,000**	**$2,000**
Out-of-Pocket Max. (not including ded.)	**$1,500**	**$4,500**	**$2,000**	**$6,000**		

Estimated Claims reduction from plan design changes	$ 185,618
Maximum HRA funding level (including admin. fees**):	$ 537,238
Minimum recommended HRA funding level (including admin. fees**):	$ 118,838
Estimated net savings if HRA funded at Minimum level:	$ 66,780

*Assumes elimination of the Maroon Plan
**Administrative fee from NAA for HRA: $3.50 pepm

If Option (1) is adopted, the City's estimated net savings would be $67,000 in 2009. If Option (2) is adopted, the savings will be dependent on how many employees enroll in the White Plan versus

Prescription Drug Benefit (January 1, 2009):
Our pharmacy consultant, Allan Zaenger, has recommended the following copay structure for 30-day supply at retail prescriptions: $10 generic/25% to $150 preferred brand/25% plus $25 to $200. He also recommends limited coverage of the smoking cessation drugs Chantix and Zyban, and coverage of the following over-the-counter medications: Abreva, Alavert, Alaway, Claritin, Prilosec OTC, Zaditor, Zyrtec, and Zyrtec-D and any alternative brand or generic names for these medicines. We recommend that the over-the-counter substances be available at a reduced copay of $1 or for zero copay.

Disease Management (March 1, 2009):
We recommend that the City consider adoption of some type of disease management or wellness program. These programs are often phased in over time, with participation initially encouraged on a voluntary basis but later encouraged more strongly through the use of financial incentives. A local hospital has submitted a proposal for a disease management program that the City may want to consider.

Network and Vendor Contracts (May-July 2009):
Contract with local hospitals will need to be renegotiated prior to May 1, 2009. Other vendor contracts are rate-guaranteed through June 30, 2009, so those contracts will need to be reevaluated and, if necessary, Requests for Proposals can be issued.

Mandatory enrollment of spouses in their employers' plans (July 2010):
One of the primary inflationary issues for government plans is the number of dependents they cover. We recommend that the City consider instituting a policy limiting the eligibility of spouses who have group coverage offered to them by their own employers. The City can simply make such spouses ineligible, or it can require spouses to enroll in their employers' plans but allow them to continue to be enrolled on the City plan as secondary coverage. The savings to the City would be approximately $2,880 for each spouse that left the plan entirely. If spouses are allowed to remain on the plan as secondary coverage, the savings would not be as great because the City would still incur fixed costs and claims up to the deductible/coinsurance levels. All other dependent medical claims equaled $29,172 in 2007-2008. Some reduction in these claims would likely occur because children would follow the "birthday rule" and the City plan would become secondary on some of these dependents, increasing the estimated savings. Estimating the total impact to the plan is difficult because we are not sure of coverage availability for those dependents. Numerous private employers have adopted this type of eligibility rule for spouses, and the City will need to consider a similar policy in order to prevent family enrollment from going up in response to the actions of these other employers. We recommend that consideration of this policy begin no later than July of 2010.

Pharmaceutical
Horizons

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TO: All Clients

FROM: Allan Zaenger R.Ph., MS
Pharmaceutical Horizons, Inc.

RE: Specialty Drugs - Plan Coverage and Member Copayment Issues

Issue Overview

"Specialty" Drugs are scientifically or "bioengineered" oral or injectable medicines that target and treat specific or "niche" conditions. These complex medical conditions include: anemia, cancer, hemophilia, infertility, growth hormone deficiency, multiple sclerosis, rheumatoid arthritis and the list is growing rapidly. There are more than 200 "specialty" drugs available today with more than 370 being developed or awaiting approval. The result is an increasing number of patients taking "high cost", "high tech", medicines that are more complex to use.

Specialty drugs are very expensive. The annual drug ingredient cost for a "traditional" brand name drug is about $1,200.00. The annual drug ingredient cost per patient receiving a specialty medicine is $6,000.00 to more than $350,000.00 with an average of about $18.000.00.

Specialty drugs are complex compounds and some have unique "handling" requirements. The FDA in selected situations has required dispensing from a single pharmacy or a limited set of "approved" pharmacies. Some "specialty" drugs are oral tablets or capsules, while others are self-administered injections, yet others require intramuscular or intravenous administration. The result is many drugs are distributed directly to patients, however, other medicines will be sent to physicians or home health care companies or other professional settings for administration.

Specialty drugs that patients are able to directly administer pose fewer distribution and reimbursement issues. These will fall under discounted reimbursement contracts with retail, mail order and specialty pharmacies. Specialty drugs that require intravenous, intramuscular, intra-articular or intraocular administration can be billed to the pharmacy program if dispensed from a "specialty" pharmacy and will secure reimbursement discounts for the plan or plan sponsor. However, billing for specialty drugs through a provider or provider organization under medical or ancillary contract can result in higher reimbursement or loss of available reimbursement discounts.

Most plan sponsors apply "step-edits" and/or prior authorization criteria prior to the dispensing or administration of a specialty drug. These requirements ensure appropriate use of a specialty drug; however, if the patient meets the clinical circumstances for use of a specialty drug, approval is given and the plan becomes financially responsible for this medication for as long as clinical criteria permit or until the patient no longer obtains clinical benefit from the drug.

Precaution

The simple adoption of a Tier 4 drug copay will increase the risk that members and providers will seek and obtain high cost drug therapy under an outpatient medical, physician, home health care, and/or ancillary health benefit claim due to lower member cost share under one of these benefit programs. In addition, it must be clearly understood that while the drug benefit can apply administrative procedures associated with a list of drugs due to the specific codes, these codes are not part of claims submission procedures associated with other health provides and as a result virtually impossible for any insurer or administrator to process consistently to capture the correct member cost share to these claims. With application of a "list" plans sponsors can be certain that members and providers will attempt, and if permitted, succeed in finding a "way" to work through the patient's financial limitations while "maximizing" their revenue and service fees for medication "services".

Recommendation:

Nicotine is a powerfully addicting drug that also has significant negative cardiovascular effects. Use of any form of tobacco and second hand smoke produce adverse clinical consequences. We have accumulated knowledge and recent gains in clinical understanding of how to change and diminish the addictive behaviors associated with nicotine use. As a result, I recommend that the prescription drug benefit plan for all clients cover Chantix, Zyban (and generic alternatives to Zyban) under the following clearly defined protocol:

1. The only covered drugs are Chantix and Zyban (and generic equivalents to Zyban or Wellbutrin SR). While not completely understood, these drugs work in the brain to thwart the pleasure enhancement and/or diminish the cravings associated with nicotine use. Because nicotine use is an addiction, replacement therapy with patches, gum, and inhalers, risks perpetuating the addiction and/or contributing to relapse or return to tobacco use. Nicotine replacement products (both OTC and Rx) are excluded from this benefit. No other OTC or smoking cessation products are covered under this program.
2. Coverage is limited to the first 180 tablets of Chantix or Zyban in each benefit or year. Additional therapy and associated claim charges during the benefit year will be paid entirely by the member. The first 180 tablets will provide medicine for the first 12 weeks of treatment and is consistent with the product labels for both drugs.
3. No mail order benefit will apply to this program.
4. This benefit is offered to each member once during the benefit year.
5. This benefit is offered annually.
6. Member copayment for standard Rx claims will apply. Variations to member copayment are possible to reduce the plan contribution to the benefit.

The estimated total claim charges associated with 12 weeks use of brand Zyban is $425.
The estimated total claim charges associated with 12 weeks use of generic bupropion is $230.
The total claim charges associated with 12 weeks use of Chantix is expected to be $290.

It is recommended that members follow product instructions and enroll in the behavior modification program sponsored by the manufacturer of the medicine. These programs improve the likelihood that members will quit and remain nicotine free.

Estimated Annual Benefit Cost

I've prepared the following assumptions and estimated plan amount paid based on the estimated claim charges above and a Tier 1 member copayment of $10 and a brand drug copayment of $30 per claim:

1. 1,000 covered lives;
2. 25% of covered lives currently smoke (250 covered lives);
3. 16% of smokers (40 covered lives) would make a decision within the calendar year to quit;
4. Total claim charges less member copayment - plan cost for 1,000 covered lives in one plan year = $8,000 (40 covered lives x $200) or $0.67 PMPM or $8.00 PMPY. If the plan amount paid PMPM is $40.00 this additional benefit would increase plan amount paid by 1.6%.

Clinical data indicates that the number of members who will successfully quit without any help is 5-16%. With the use of medications and behavior modification, the 12 month abstinence rates increase to 20%-25%. Of the 40 members who attempt to quit using the benefit 8-10 will be smoke free after 12 months following completion of the treatment. Many people require more than one attempt to quit.

I am available to speak with you about this recommendation further at your convenience.

Section 2. Member Copayment

Member Copayment is the amount contributed per prescription claim by members. The chart below details member copayment for all City groups for Jul 06 - Dec 06. The percent indicated below the dollar amount is the percent of member copayment to total claim charge.

MEMBER COPAYMENT	Jul 06 - Dec 06
City	$24.13 (37.1%)
PBM Benchmarks	$14.88 (22.4%)

- Jul 06 - Dec 06 Co-payment was **$9.25 or 62.2% greater than** the PBM Benchmark, and as a percent of total claim charge **14.7% greater.**

Section 3. Generic Dispensing

Generic Dispensing refers to the ratio of prescriptions dispensed with generic drugs compared to all dispensed prescriptions. The chart below details the rate of Generic Dispensing for all City groups.

GENERIC SUBSTITUTION	Jul 06 - Dec 06
City	53.7%
PBM Benchmarks	54.8%

- Jul 06 - Dec 06 Generic Dispensing was **1.1% less** than the PBM Benchmark.

Section 4. Drug Ingredient Cost

Average Drug Ingredient Cost refers to just the average drug ingredient cost per prescription and excludes dispensing fees and member co-payments. The chart below details the Average Drug Ingredient Cost for all City groups for Jul 06 - Dec 06.

DRUG INGREDIENT COST	Jul 06 - Dec 06
City	
Brand	$104.87
Generic	$26.18
Average	$62.66
PBM Benchmarks	
Brand	$117.10
Generic	$20.77
Average	$64.31

- Jul 06 - Dec 06 Drug Ingredient Cost was **$1.65 or 2.6% per Rx less** than the PBM Benchmark.

- **Factors Contributing to Increased Drug Cost.** Drug cost per prescription is determined by product selection and the demographics associated with each group. In general, the rate of generic substitution remains the greatest predictor of drug cost. The higher the rate of generic substitution the lower the drug cost per prescription. In addition, inflation in the cost of individual drugs, changes in drug mix and changes in benefit design significantly impact drug cost. Changes in drug mix occur when higher cost drugs within a drug class are used or when higher doses of the same drug are used (dosage creep). Changes in benefit

- provided a member contribution to total claim charge equal to the current copayment (37%);
- greater of generic dispensing;
- more equitable member contribution to generic and brand name drugs;
- plan amount paid reductions due to lower ingredient cost from generic drugs by 5% or more.

2. Retail – Tier 1 = $10, Tier 2 = 40% of Total Claim Charge ("TCC"), Tier 3 = 40% of TCC + $20
Mail – Tier 1 = $10, Tier 2 = 40% of Total Claim Charge ("TCC"), Tier 3 = 40% of TCC + $20

This copayment structure coupled with a more aggressive drug formulary during the reporting period would have produced:

- member contribution to claim charge of nearly 40%;
- greater rate of generic dispensing;
- more equitable member contribution to generic and brand name drugs;
- plan amount paid reductions of 5-10%

38% of the employee population has incurred 62% of the claims. High claimants are also predominantly enrolled in the Traditional plan. This means that movement to the Standard plan would not cause a dollar for dollar reduction in claim costs; however, the elimination of the Traditional plan should cause a claim reduction of approximately 7% to 9%, or savings in excess of $97,000, without taking into account any reduction in savings because of medical inflation. We therefore recommend that the "Client" consider the elimination of the Traditional plan effective January 1, 2008. The Standard plan was originally designed to be in line with the Standard offering put forth for by Kentucky governments as described in the Kentucky Public Human Resource Association Survey. (Please see attached survey grid.)

Changing the Standard plan into a HRA program: If the above recommendations are instituted, then the necessity to change the Standard plan into a consumer driven Health Reimbursement Arrangement could be postponed to January of 2009. Because HRAs can cause employee disruption, having more time elapsing from the changes of a year ago would be beneficial, particularly since the more urgent and effective plan matters are the elimination of the Traditional plan and having fewer dependents on the plan, and both of these cause significant disruption to the employee population. The above recommendations should cause the costs for the "Client" to continue to reduce or at worst to remain flat. Having acknowledged that an HRA program is the direction the "Client" should ultimately take, we are still waiting for the underwriter to provide what the financial impact to plan costs will be under an HRA; however, savings estimates are typically in the low teens and tend to have multiple-year reductions. They will give the "Client" more plan flexibility in the future as well. A grid of what an HRA program could look like for the "Client" is attached.

Mandatory enrollment of dependent spouses in their employers' plans: The primary inflationary issue for most government plans is the number of dependents covered on the plan. Most private industry plans have enrollment percentages of approximately 50% single and 50% family. The "Client"'s enrollment is 37% single. This means that the "Client" is covering more bodies for an employer its size than the average plan. Total claims paid by the "Client" for spousal coverage in the 06/07 plan year were $781,531. If the "Client" covered fewer spouses under the plan by mandating that a spouse with other group coverage must elect that coverage and disenroll from the "Client" plan, this would reduce spousal claims by approximately $100,000. If the "Client" prefers, it can require spouses to enroll in their employers' plans but continue to be on the "Client" plan as secondary coverage. Additionally, all other dependent claims equaled $439,386. Some reduction in these claims would occur as well because children would follow the "birthday rule" and the "Client" plan would become secondary on some of these dependents, increasing the estimated savings. Estimating the total impact to the plan is difficult because we are not sure of coverage availability for those dependents. A "Spousal Coverage Options" document is attached that illustrates various ways employers can elect to administer this plan. We recommend that the "Client" institute such a program because numerous private employers have done so and the "Client" will need to do this in order to prevent the family enrollment from going up. SDMA recommends that this policy begin on January 1 or July 1 of 2008 because it usually takes a full plan year for the eligibility or enrollment dates of the spouses' plans to take place and for the spouses to enroll in their respective plans. If employees also decide to leave the "Client" plan and take their spouse's coverage, they would receive the waiver benefit described above, which would help mitigate the medical expenses not paid for by the spouse's plan.

Employee contribution to the plan: Employees and dependents covered by the plan paid $308,244, or 11%, of medical costs from co-pays, deductibles, and co-insurance in the 06/07 plan year. For the pharmacy plan, employees paid approximately 25% of prescription plan costs, or $23,681. In employee premiums, approximately $360,000, or 11%, was contributed to total medical and prescription plan costs. The net effect of these employee contributions is that employees paid, in either premium and other forms of cost-sharing, approximately 20.5% of total medical and pharmacy plan costs, versus 7% in the prior budget year. This is a significant increase and falls much closer to government industry standards. As far as using premium to help control plan costs, no change in employee contribution would be necessary for the 07/08 period as long as the other recommendations above were instituted.

SHERRILL MORGAN

Disclosure Statement
Regarding
SHERRILL MORGAN Compensation

For managing the health plan and other general services, SHERRILL MORGAN will receive no form of compensation other than that which is paid by the Client. SHERRILL MORGAN will not receive overrides of any kind from vendors in connection with these services.

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Client

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Mark T. Morgan, President
SHERRILL D. MORGAN AND ASSOCIATES, INC.
DBA SHERRILL MORGAN