COUNTY OF MILWAUKEE
DAS – DIVISION OF EMPLOYEE BENEFITS
INTER-OFFICE COMMUNICATION

DATE : September 7, 2011

To : Chairman Lee Holloway, County Board of Supervisors

FROM : Matthew Hanchek, Interim Director – Employee Benefits Division

SUBJECT: **Report from the Interim Director, Employee Benefits Division, requesting authorization for a 3-year contract for the administration of Milwaukee County's medical plan coverage.**

Issue/Background

Milwaukee County's contract with UnitedHealthCare (UHC) expires as of 12/31/2011. As a result, the Employee Benefits Division has been tasked with identifying a vendor for medical services, excluding prescription drugs, effective 1/1/2012.

With the assistance of our health care benefits consultants, Cambridge Advisory Group, Milwaukee County issued a Request for Proposal (RFP) for a third party administrator (TPA) to address the following objectives:

- Provide effective administration for Milwaukee County's self-funded medical plans for active employees and retirees.
- Provide claims data, clinical support, and cost management recommendations to the Employee Benefits Division.

The RFP responses were to include the following components:

- Administration of Milwaukee County's PPO and Managed Care Plan Designs;
- Administration of Coverage for Active Employee, Pre-Medicare Retiree, Medicare-eligible Retiree, and COBRA groups;
- Clinical Services (e.g. Utilization Review, Acute and Large Case Management);
- Provider Network Contract Management.

Four responses to the RFP were submitted. Responders to the RFP included: United Health Care (UHC), Anthem, Humana, and WPS. All responses were reviewed independently by Cambridge Advisory Group. WPS withdrew their response upon clarification of the process for evaluating provider networks. As a result, the three remaining responses were all included as finalists.

Finalist Review Process

On Monday, May 16th and Tuesday, May 17th, a review panel consisting of Matthew Hanchek - Fiscal Benefits Manager; Gerald Schroeder – Interim Benefits Director; Heather Giza - Health Benefits Coordinator; Rick Ceschin - County Board Research Analyst; and Justin Rodriguez – DAS Fiscal Analyst; was formed to evaluate finalist presentations.

Finalists were given one hour to present their best and final proposal to the review panel. Additional time was also allotted to each to provide time for questions and answers from the Panel. At the conclusion of all presentations, the Panel and Cambridge reviewed the results of each finalist and reached a consensus on the rankings, pending an updated financial analysis from Cambridge including each vendor's best and final offer.

Highlights of Finalist Presentations:

UnitedHealthCare

As the incumbent medical administrator, UHC offers the easiest transition to a new contract. UHC has a strong history of customer service and responsiveness to requests made by Milwaukee County. The Benefits Division is completely satisfied with the administrative performance and service provided during the 2009 through 2011 contract.

UHC utilizes a broad provider network which includes nearly all of the providers utilized by employees and retirees in the Milwaukee Metro area.

While the other vendors' bids were more financially competitive than they were in 2008, UnitedHealthCare continued to offer the deeper validated discounts and less expensive administrative fees than all other bidders. The cost advantage, coupled with the proven history of service to the County, and UnitedHealthCare's provider network access gave UHC an advantage over all the other finalists.

Anthem

Anthem, like United Health Care, offers the advantage of being able to utilize the same network for both the PPO and Manage Care plans. Anthem offered a competitive provider network in the Milwaukee area, the addition of the UW system in the Madison area, and strong nation-wide provider networks. Since the 2008 RFP, Anthem has made improvements to network access and provider reimbursement rates in the Milwaukee Market. Access to data and decision making tools were also significantly enhanced.

Anthem's response demonstrated they are a viable alternative to UnitedHealthCare, and they were able to match UHC in many of the evaluated categories. Anthem was willing to contractually guarantee a higher overall discount than the guarantee offered by UHC, however, an analysis of actual claims incurred by the County in 2009 and 2010 demonstrated that the validated discounts through Anthem still lagged behind.

Humana

Humana has significant market share in the Milwaukee area through their role as the administrator for the Milwaukee's Business Health Care Group. By utilizing a relatively narrower "Humana Preferred Network" (HPN), Humana has made significant strides in their network discounts, provider access, and support tools since the 2008.

The review panel expressed concerns that the narrower Humana Preferred Network would create significant network access disruptions for employees by excluding the Wheaton Franciscan providers, which could be a point of contention with County bargaining groups. Further, Humana's bid was contingent on Milwaukee County joining the Milwaukee Business Health Care Group. In effect, the County would be obligated to accept fee schedules and other

terms set by the coalition, as opposed to having the ability to independently negotiate certain terms. The review panel expressed concerns over limiting the County's autonomy and flexibility.

In addition to the comments by the review panel, Cambridge Advisory Group noted that Humana presented conflicting responses to the RFP regarding the providers included in their rate guarantee and the providers cited in the network analysis. Upon request, Humana did clarify the actual network terms, but the lack of transparency was cited as a concern during the process.

Cambridge Analysis

Cambridge Advisory Group was asked to perform analysis of the bids independent of the review panel to assess the relative strength of each bid. To accomplish this, each bidder was required to complete a seven-section questionnaire where the strength of each answer was assigned a score based on Cambridge's review.

As anticipated, all three finalists were proven capable of administering the County's plans, with all three receiving the highest possible scores across several categories. However, UnitedHealthCare and Anthem distinguished themselves with an average score of 93% compared to 88% for Humana. UHC had a clear advantage in the bid assumptions, requirements, & deliverables, while Anthem was rated higher on information management.

Humana lagged UHC and Anthem in the bid assumptions, requirements & deliverables, member service, claims and eligibility sections. Areas affecting Humana's score in these sections include:

- Only a two-year fee proposal and guarantee, when 3 years were requested;
- Restrictions on audit agreement;
- Member satisfaction scores;
- Customer service turnover.

Network Analysis of Bids

In addition to evaluating the questionnaire, Cambridge Advisory Group was asked to analyze the financial terms and strength of the networks proposed by applying actual County claims history:

Provider Network Discounts*			
	UnitedHealthCare	**Humana**	**Anthem**
Proposed	51.90%	49.10%	38.40%
Guaranteed	48.30%	48 – 50%	51.80%
Repriced with County-Specific Claims	53.10%	48.80%	48.50%
Rank	**1**	**3***	**2**

*Discount analysis is based on in-network claims only

Monthly Base ASO Fees			
YEAR	UnitedHealthCare	Humana	Anthem
2012	$27.57	$31.67	$33.07
2013	$27.57	$32.63	$33.07
2014	$27.57	$32.63*	$34.06
Total Annual Base ASO Costs			
YEAR	UnitedHealthCare	Humana	Anthem
2012	$3,349,424	$3,847,525	$4,017,608
2013	$3,349,424	$3,964,153	$4,017,608
2014	$3,349,424	$3,964,153	$4,137,881
Total	**$10,048,272**	**$11,775,831**	**$12,173,097**
Difference		$1,727,559	$2,124,825
Rank	1	2	3

* Humana did not guarantee a rate for 2014. For the purpose of this analysis the 2013 rate was carried forward. The business coalition's negotiations for 2014 could increase or decrease this fee for all coalition members.

Provider Network Analysis			
	UnitedHealthCare	Humana	Anthem
Claims	95%	85%	96%
Patients	94%	86%	96%
Total Paid	95%	85%	96%
Rank	2	3	1

* Based on clarification by Humana, the Humana Preferred Network (HPN) was applied locally while the Humana PPO wrap was assumed outside of the area. HPN excludes Wheaton Franciscan.

Annual Cost Comparison:			
Repricing Discounts	**UnitedHealthCare**	**Humana****	**Anthem***
Inpatient Facility	49.6%	44.2%	40.3%
Outpatient Facility	54.6%	50.9%	53.7%
Physician	53.6%	49.4%	47.3%
Aggregate Discount	**53.1%**	**48.8%**	**48.5%**
Estimated Dollar Difference from UnitedHealthcare Trended to 2012			
Inpatient Facility	$0	$2,540,058	$4,405,806
Outpatient Facility	$0	$2,710,438	$665,201
Physician	$0	$3,877,287	$5,848,704
Total Discount Difference	**$0**	**$9,127,783**	**$10,919,710**
Administrative Fees Per Year			
Administrative Fees	**$3,349,424**	**$3,847,525**	**$4,017,608**
Difference in Administrative Cost	$0	$498,101	$668,184
Total Difference in Annual Cost vs. UHC	**$0**	**$9,625,884**	**$11,587,894**

* Humana and Anthem included Medicare Claims in their repricing file. Excluding Medicare claims would weaken the overall reported discounts

** Humana's discounts were applied to Wheaton Franciscan claims in this analysis. The exclusion of Wheaton would result in loss of discounts, mitigated by the patients who are willing to change care providers.

Note: The analysis in this report is only intended for ranking bids. Actual financial impact will be dependent upon enrollment, provider mix, utilization and trend. A complete actuarial analysis will be required to project costs for budget purposes for 2012 and beyond.

Final Rankings

Based upon the finalists presentations, and analysis by Cambridge the review panel ranked the finalists as follows:

1. United Health Care
2. Anthem
3. Humana

Recommendation of the Panel

UnitedHealthCare has served Milwaukee County since 2009 and has consistently exceeded expectations in plan management, financial performance, and customer service. They have proven to be active and willing partners in the

County's disadvantaged business enterprise goals have demonstrated flexibility in accommodating County initiatives.

Although all bids were more competitive in 2011 than the prior RFP, the offer from UnitedHealthCare was superior in discounts and fees. United Health Care's provider networks provide the County the most comprehensive access to providers in the Milwaukee area. Additionally, UHC scored as highly for service to patients and clients, implementation, and clinical services. Because of these findings, the Review Panel considered United Health Care's bid the best total value to Milwaukee County.

Disadvantaged Business Enterprise (DBE)

After working through challenges in early 2009, UnitedHealthCare has fully complied with Milwaukee County's Disadvantaged Business Enterprise program. In 2010, UHC voluntarily exceeded their required goal. UnitedHealthCare has also been willing to accommodate Milwaukee County's preference for utilizing local DBE firms when practical, including an ongoing flu shot program and recent building maintenance projects at their facility. UHC has completed updated forms to continue their full compliance in 2012 and beyond, and will continue to work with our Community Business Development Partners to identify additional local opportunities for participation. The anticipated 2012 goal amount is approximately $570,000.00.

Collaboration with Milwaukee County Transit System

At the direction of Chairman Holloway during his tenure as County Executive, the Benefits Division sought ways to collaborate with other public entities to deliver health care savings. We identified the Milwaukee County Transit System as the most mutually beneficial opportunity to follow through with this initiative. Support for the vetting and pursuit of this approach was continued by the current administration.

The selection of UnitedHealthCare creates an opportunity to include the Milwaukee County Transit System under Milwaukee County's administrative services agreement. Under this arrangement, Transit would utilize Milwaukee County's Ceridian Benefits System to transmit enrollment and eligibility data to UnitedHealthCare. UHC would administer the Transit System's medical plan on a self-funded basis under the terms of the County's contract. The County would extend its purchasing leverage to the Transit System; however, the Transit System would still be responsible for its own claims and administrative expenses. This effort will reduce the Transit System's health care expenditures by an estimated $2,000,000, with a budget impact of approximately $1,100,000. The Benefits Division is working with Corporation Counsel and UnitedHealthCare to draft an addendum including the appropriate confidentiality and hold harmless agreements for incorporating the Transit System into this agreement.

Summary / Requested Board Action

UnitedHealthCare's response to the County's request for proposal demonstrated their commitment to being a valuable strategic partner. United Health Care's bid was evaluated by a review panel including members of Benefits, DAS Fiscal, and County Board staff. The review panel found that UHC's bid was superior to all other bids regarding administrative costs, provider discounts, and network access. These findings were supported by analysis from Cambridge Advisory Group and were shared with the Employee Benefits Workgroup. Further, UHC has a proven history of excellent service to the County and compliance with the County's DBE goals.

Based on the review panel recommendations, the Employee Benefits Division, with assistance from Corporation Council, the Employee Benefits Work Group, and the Community Business Development Partners, negotiated an addendum to the original contract extending services from January 1, 2012 through December 31, 2014. A copy of the negotiated contract addendum is included with this report.

The Employee Benefits Division requests authorization to execute the attached contract addendum with UnitedHealthCare for the administration of Milwaukee County's employee and retiree medical plans. The Employee Benefits Division also requests authorization to execute a second addendum to this contract enabling the County and UnitedHealthCare to collaborate with Transit for the administration of the Transit System's medical plans.

Attachments

Cc: County Executive Chris Abele
George Aldrich, Chief of Staff, County Executive's Office
Patrick Farley, Director, Dept. of Administrative Services
Kimberly Walker, Corporation Counsel
Rick Ceschin, Senior Research Analyst, County Board
Steve Cady, Fiscal and Budget Analyst, County Board
Employee Benefits Workgroup
Carol Mueller, Chief Committee Clerk
Jodi Mapp, Personnel Committee Clerk

File No.
(Journal,)

(ITEM) From the Director, Division of Employee Benefits, requesting authorization to execute a contract extension with United Health Care for Third Party Administrative (TPA) services for Milwaukee County's medical plans effective January 1st, 2012 by recommending adoption of the following:

A RESOLUTION

WHEREAS, Milwaukee County's current contract with UnitedHealthCare expires on December 31st, 2011 and that contract includes TPA services for Milwaukee County's medical coverage; and

WHEREAS, Milwaukee County, in coordination with Cambridge Advisory Group, issued a competitive request for proposal (RFP) for TPA services for Milwaukee County's group health plans for active employees and retirees; and

WHEREAS, a RFP review panel including representatives from the Employee Benefits Division, DAS Finance, and County Board Staff was formed under the direction of the Benefits Manager to evaluate finalist proposals; and

WHEREAS, UnitedHealthCare's bid was also evaluated on cost, network access, performance guarantees, patient services, client services, implementation, formulary impact, clinical services, and compliance with Milwaukee County disadvantaged business enterprise goals; and

WHEREAS, UnitedHealthCare's overall response to Milwaukee County's RFP, based on the criteria above, was deemed by the RFP review panel and Cambridge Advisory Group to be superior to the other bids submitted in the RFP process; now, therefore

BE IT RESOLVED, that the Director, Employee Benefits Division, Department of Administrative Services and the Office of Corporation Counsel, is hereby authorized execute a contract extension with UnitedHealthCare for Third Party Administrative services for Milwaukee County's group medical coverage plans for active employees and retirees commencing January 1, 2012 and continuing through December 31st, 2014.

MILWAUKEE COUNTY FISCAL NOTE FORM

DATE: July 2, 2008

Original Fiscal Note ☒

Substitute Fiscal Note ☐

SUBJECT: Request for authorization to contract with UnitedHealthCare for medical plan third party administrative services for January 1, 2012 through December 31, 2014.

FISCAL EFFECT:

☒ No Direct County Fiscal Impact

☒ Existing Staff Time Required

☐ Increase Operating Expenditures
(If checked, check one of two boxes below)

☐ Absorbed Within Agency's Budget

☐ Not Absorbed Within Agency's Budget

☐ Decrease Operating Expenditures

☐ Increase Operating Revenues

☐ Decrease Operating Revenues

☐ Increase Capital Expenditures

☐ Decrease Capital Expenditures

☐ Increase Capital Revenues

☐ Decrease Capital Revenues

☐ Use of contingent funds

Indicate below the dollar change from budget for any submission that is projected to result in increased/decreased expenditures or revenues in the current year.

	Expenditure or Revenue Category	Current Year	Subsequent Year
Operating Budget	Expenditure	0	$282,500
	Revenue		
	Net Cost		
Capital Improvement Budget	Expenditure		
	Revenue		
	Net Cost		

DESCRIPTION OF FISCAL EFFECT

In the space below, you must provide the following information. Attach additional pages if necessary.

A. Briefly describe the nature of the action that is being requested or proposed, and the new or changed conditions that would occur if the request or proposal were adopted.

B. State the direct costs, savings or anticipated revenues associated with the requested or proposed action in the current budget year and how those were calculated. [1] If annualized or subsequent year fiscal impacts are substantially different from current year impacts, then those shall be stated as well. In addition, cite any one-time costs associated with the action, the source of any new or additional revenues (e.g. State, Federal, user fee or private donation), the use of contingent funds, and/or the use of budgeted appropriations due to surpluses or change in purpose required to fund the requested action.

C. Discuss the budgetary impacts associated with the proposed action in the current year. A statement that sufficient funds are budgeted should be justified with information regarding the amount of budgeted appropriations in the relevant account and whether that amount is sufficient to offset the cost of the requested action. If relevant, discussion of budgetary impacts in subsequent years also shall be discussed. Subsequent year fiscal impacts shall be noted for the entire period in which the requested or proposed action would be implemented when it is reasonable to do so (i.e. a five-year lease agreement shall specify the costs/savings for each of the five years in question). Otherwise, impacts associated with the existing and subsequent budget years should be cited.

D. Describe any assumptions or interpretations that were utilized to provide the information on this form.

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[1] If it is assumed that there is no fiscal impact associated with the requested action, then an explanatory statement that justifies that conclusion shall be provided. If precise impacts cannot be calculated, then an estimate or range should be provided.

A. Approval of this request would enable the Division of Employee Benefits to contract with UnitedHealthCare for the administration of Milwaukee County's medical benefit plan coverage.

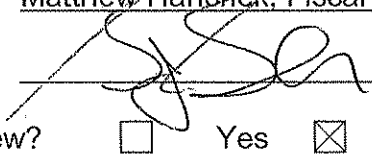
B. There is no direct cost impact to the 2011 budget.

C. There is no budgetary impact to the current year, aside from the time of existing staff. Based on current enrollment, the annual administrative fees paid to UnitedHealthCare would increase by $282,500 in 2012. There will be no further increases in 2013 and 2014.

   The increase in administrative fees is expected to be more than offset by improvements to provider discounts. Based on current enrollment and historical utilization, provider discounts are expected to improve by 2%, yielding savings of approximately $2,000,000 per year compared to current provider discounts. However, inflationary health care trend will still apply to the County's medical costs during contract period, offsetting any projected savings directly attributable to this contract. Consequently, the savings due to improved provider discounts are not reflected as a reduction in overall costs in this fiscal note.

D. The estimated impact to administrative cost is based on current enrollment. The estimated impact of the improved provider discounts referenced above assumes enrollment and health care utilization will remain similar in 2012 and beyond. Changes to enrollment, provider mix, or utilization could positively or negatively impact the estimates in this fiscal note.

Department/Prepared By Matthew Hanchek, Fiscal Benefits Manager

Authorized Signature  6/6/11

Gerald J. Schroeder

Did DAS-Fiscal Staff Review? ☐ Yes ☒ No

FINANCIAL RENEWAL AMENDMENT

This Amendment is effective for the period beginning on January1, 2012 and ending on January 1, 2013 unless otherwise specified.

"Our", "Us" and "We" mean United HealthCare Services, Inc. and/or its affiliated companies, unless indicated otherwise and "You" and "Your" mean Milwaukee County. Any other capitalized terms used have the meanings shown in the governing agreements and/or policies. These terms may or may not have been capitalized in prior contractual documents between the parties but will have the same meaning as if capitalized.

The agreements that are being amended include any and all amendments, if any, that are effective prior to the effective date of this Amendment.

Nothing shown in this Amendment alters, varies or affects any of the terms, provisions or conditions of the agreements other than as stated herein.

The parties, by signing below, agree to amend the agreements contained within Exhibit A herein.

Milwaukee County	**United HealthCare Services, Inc.**
By _____ Authorized Signature	By _____ Authorized Signature
Print Name _____	Print Name _____
Print Title _____	Print Title _____
Date _____	Date _____

50119829 (06/11)

EXHIBIT A

THE AMENDED FINANCIAL TERMS ARE AS FOLLOWS:

This Exhibit A shall not alter, vary, or affect any previously agreed to financial terms that are not amended by this Exhibit A.

Administrative Services Agreement

Contract No.: 714852
Contractholder: Milwaukee County
The following financial terms are effective for the period January 1, 2012 to January 1, 2015.

Adjustments to Fees

The fees for standard medical service fees described below, excluding optional and non-standard fees, are adjusted as set forth in the applicable performance standards.

The Standard Medical Service Fees are the sum of the following:

- $27.57 per Employee per month.

Average Contract Size

Your Average Contract Size is 1.92.

The optional and non-standard fees are the sum of the following

Service Description	Fee
Fraud and Abuse Management	Fee equal to thirty-two and five-tenths percent (32.5%) of the gross recovery amount
Hospital Audit Program Services	Fee not to exceed thirty-one percent (31%) of the gross recovery amount
Credit Balance Recovery Services	Fee not to exceed ten percent (10%) of the gross recovery amount.
Third Party Liability Recovery (Subrogation) Services	Fee equal to thirty-three and one-third percent (33.3%) of the gross recovery amount
Facility R&C Bill Management -- We will bill You for the amounts You owe Us. The bill will reflect reductions obtained during the preceding month and adjustments, if any, from previous months	Fee for Our services, equal to thirty percent (30%) of the amount of reductions obtained through Our efforts
Shared Savings Program	You will pay a fee equal to thirty-five percent (35%) of the "Savings Obtained" as a result of the Shared Savings Program. "Savings Obtained" means the amount that would have been payable to a health care provider, including amounts payable by both the Participant and the Plan, if no discount were available, minus the amount that is payable to the health care provider, again, including amounts payable by both the Participant and the Plan, after the discount is taken.

EXHIBIT B

PERFORMANCE STANDARDS FOR HEALTH BENEFITS

The Standard Medical Service Fees (excluding Optional and Non-Standard Fees), (hereinafter referred to as "Fees") payable by You under this Agreement will be adjusted through a credit to your Service Fees in accordance with the performance guarantees set forth below unless otherwise defined in the guarantee. Unless otherwise specified, these guarantees apply to medical benefits and are effective for the period beginning January 1, 2012 and ending on January 1, 2013 ("Guarantee Period"). With respect to the aspects of our performance addressed in this exhibit, these fee adjustments are your exclusive financial remedies.

We reserve the right from time to time to replace any report or change the format of any report referenced in these guarantees. In such event, the guarantees will be modified to the degree necessary to carry out the intent of the parties. We shall not be required to meet any of the guarantees provided for in this Agreement or amendments thereto to the extent Our failure is due to Your actions or inactions or if We fail to meet these standards due to fire, embargo, strike, war, accident, act of God, acts of terrorism or Our required compliance with any law, regulation, or governmental agency mandate or anything beyond Our reasonable control.

Prior to the end of the Guarantee Period, and provided that this Agreement remains in force, We may specify to You in writing new performance guarantees for the subsequent Guarantee Period. If We specify new performance guarantees, We will also provide you with a new Exhibit that will replace this Exhibit for that subsequent Guarantee Period.

Claim is defined as an initial and complete written request for payment of a Plan benefit made by an enrollee, physician, or other healthcare provider on an accepted format. Unless stated otherwise, the claims are limited to medical claims processed through the UNET claims systems. Claims processed and products administered through any other system, including claims for other products such as vision, dental, flexible spending accounts, health reimbursement accounts, health savings accounts, or pharmacy coverage, are not included in the calculation of the performance measurements. Also, services provided under capitated arrangements are not processed as a typical claim; therefore capitated payments are not included in the performance measurements.

Implementation -- Applies to First Year Only			
A formal implementation plan, which defines key tasks, dependencies and completion dates will be developed and			
Initial ID Cards Issuance			
Definition	ID cards will be postmarked within the parameters set forth after the final eligibility data has been system loaded and passed a system load test.		
Measurement	Percentage of cards delivered		99%
	Delivery time frame, business days or less	business days	10
▪ Criteria	Calculated on a pro-rated basis, based on the actual number of late cards as a percent of the total number of cards. ID card turnaround time guarantees are based on Our performance during the implementation process.		
▪ Level	Customer specific		
▪ Period	Initial implementation timeframe		
Payment Period	Annually		
Fees at Risk	**Dollars at Risk** for this metric		$22,200
Payment Amount	Of the Dollars at Risk for this metric, percentage at risk for each gradient		N/A
Gradients	Not applicable		
Claim Ready Date			
Definition	Ready to pay electronic claims by the later of the effective date or within the designated number of days following the completion of key implementation tasks: (i) Account structure and benefit plan details are defined and written approval has been provided by the customer; (ii) final eligibility has been received and successfully tested by Us; and (iii) if so negotiated, deductibles and lifetime maximums from the previous carrier received in a mutually agreed upon format, accurate, and loaded electronically.		
Measurement	Electronic claim ready by effective date or the later of business days or less	business days	18

▪ Criteria	If any additional changes are received or requested after written approval is received, 10 additional business days will be required for changes affecting up to ten benefit plans (sets); 20 additional days will be required for changes affecting ten or more benefit plans (sets).		
▪ Level	Customer specific		
▪ Period	Initial implementation timeframe		
Payment Period	Annually		
Fees at Risk	**Dollars at Risk** for this metric		$44,400
Payment Amount	Of the Fees at Risk for this metric, percentage at risk for each gradient		N/A
Gradients	Not applicable		
	Eligibility Loading		
Definition	Initial implementation electronic eligibility files will be loaded within the timeframe set forth following receipt of clean eligibility file.		
Measurement	Files loaded, in business days or less	business days	5
▪ Criteria	Clean eligibility file once approved by You and/or Your designee and Us, which must be: a) error free; b) formatted per Our standards; and c) received by 12:00 p.m., EST on the scheduled date, or the guarantee period starts the following business day.		
▪ Level	Customer specific		
▪ Period	Initial implementation timeframe		
Payment Period	Annually		
Fees at Risk	**Dollars at Risk** for this metric		$44,400
Payment Amount	Of the Fees at Risk for this metric, percentage at risk for each gradient		N/A
Gradients	Not applicable		
	General Implementation		
Definition	We will meet a defined percentage of the project dates in the implementation plan.		
Measurement	Percentage of project dates met		95%
▪ Criteria	A formal implementation plan, which defines key tasks, dependencies and completion dates will be developed and agreed to by both parties. Failure on the customer's part to complete, by the agreed upon dates, the key dependent tasks associated with the project dates will nullify this guarantee.		
▪ Level	Customer Specific		
▪ Period	Initial implementation timeframe		
Payment Period	Annually		
Fees at Risk	**Dollars at Risk** for this metric		$22,200
Payment Amount	Of the Fees at Risk for this metric, percentage at risk for each gradient		N/A
Gradients	Not applicable		
	Claim Operations		
	Time to Process in 10 Days		
Definition	The percentage of all claims We receive in any will be processed within the designated number of business days of receipt.		
Measurement	Percentage of claims processed		94%
	Time to process, in business days or less after receipt of claim	business days	10
▪ Criteria	Standard claim operations reports		
▪ Level	Site Level		
▪ Period	Annually		
Payment Period	Annually		
Fees at Risk	**Dollars at Risk** for this metric		$44,400
Payment Amount	Of the Fees at Risk for this metric, percentage at risk for each gradient		20%
Gradients	11 business days 12 business days 13 business days 14 business days 15 business days or more		
	Financial Accuracy (FAR)		
Definition	Financial accuracy rate of not less than the designated percent.		
Measurement	Percentage of claims dollars processed accurately		99.3%

▪ Criteria	Statistically significant random sample of claims processed is reviewed to determine the percentage of claim dollars processed correctly out of the total claim dollars submitted for payment.	
▪ Level	Office Level	
▪ Period	Annually	
Payment Period	Annually	
Fees at Risk	**Dollars at Risk** for this metric	$44,400
Payment Amount	Of the Fees at Risk for this metric, percentage at risk for each gradient	20%
Gradients	99.29% - 99.06% 99.05% - 98.81% 98.80% - 98.56% 98.55% - 98.30% Below 98.30	
	Procedural Accuracy	
Definition	Procedural accuracy rate of not less than the designated percent.	
Measurement	Percentage of claims processed without procedural (i.e. non-financial) errors	97%
▪ Criteria	Statistically significant random sample of claims processed is reviewed to determine the percentage of claim dollars processed without procedural (i.e. non-financial) errors.	
▪ Level	Office Level	
▪ Period	Annually	
Payment Period	Annually	
Fees at Risk	**Dollars at Risk** for this metric	$44,400
Payment Amount	Of the Fees at Risk for this metric, percentage at risk for each gradient	20%
Gradients	96.99% - 96.50% 96.49% - 96.00% 95.99% - 95.50% 95.49% - 95.00% Below 95.00%	
	Member Phone Service	
Phone service guarantees and standards apply to Participant calls made to the customer care center that primarily services Your Participants. They do not include calls made to care management personnel and/or calls to the senior center for Medicare Participants, nor do they include calls for services/products other than medical, such as mental health/substance abuse, pharmacy, dental, vision, flexible spending accounts, Health Reimbursement Account, Health Savings Account, etc.		
	Average Speed of Answer	
Definition	Calls will sequence through our phone system and be answered by customer service within the parameters set forth.	
Measurement	Percentage of calls answered	100%
	Time answered in seconds, on average	seconds 30
▪ Criteria	Standard tracking reports produced by the phone system for all calls	
▪ Level	Team that services Your account	
▪ Period	Annually	
Payment Period	Annually	
Fees at Risk	**Dollars at Risk** for this metric	$44,400
Payment Amount	Of the Fees at Risk for this metric, percentage at risk for each gradient	20%
Gradients	32 seconds or less 34 seconds or less 36 seconds or less 38 seconds or less Greater than 38 seconds	
	Abandonment Rate	
Definition	The average call abandonment rate will be no greater than the percentage set forth	
Measurement	Percentage of total incoming calls to customer service abandoned, on average	2%
▪ Criteria	Standard tracking reports produced by the phone system for all calls	
▪ Level	Team that services Your account	
▪ Period	Annually	
Payment Period	Annually	

Fees at Risk	**Dollars at Risk** for this metric	$44,400
Payment Amount	Of the Fees at Risk for this metric, percentage at risk for each gradient	20%
Gradients	2.01% - 2.50% 2.51% - 3.00% 3.01% - 3.50% 3.51% - 4.00% Greater than 4.00%	
	Call Quality Score	
Definition	Maintain a call quality score of not less than the percent set forth	
Measurement	Call quality score to meet or exceed	93%
▪ Criteria	Random sampling of calls are each assigned a customer service quality score, using our standard internal call quality assurance program.	
▪ Level	Office that services Your account	
▪ Period	Annually	
Payment Period	Annually	
Fees at Risk	**Dollars at Risk** for this metric	$44,400
Payment Amount	Of the Fees at Risk for this metric, percentage at risk for each gradient	20%
Gradients	92.99% - 91.00% 90.99% - 89.00% 88.99% - 87.00% 86.99% - 85.00% Below 85.00%	
	Satisfaction	
	Employee (Member) Satisfaction	
Definition	The overall satisfaction will be determined by the question that reads *"Overall, how satisfied are you with the way we administer your medical health insurance plan?"*	
Measurement	Percentage of respondents, on average, indicating a grade of satisfied or higher	80%
▪ Criteria	Operations standard survey, conducted over the course of the year; may be customer specific for an additional charge.	
▪ Level	Office that services Your account	
▪ Period	Annually	
Payment Period	Annually	
Fees at Risk	**Dollars at Risk** for this metric	$22,200
Payment Amount	Of the Fees at Risk for this metric, percentage at risk for each gradient	N/A
Gradients	Not applicable	
	Customer Satisfaction	
Definition	The overall satisfaction will be determined by the question that reads *"How satisfied are you overall with UnitedHealthcare?"*	
Measurement	Minimum score on a 10 point scale	score 5
▪ Criteria	Standard Customer Scorecard Survey	
▪ Level	Customer specific	
▪ Period	Annually	
Payment Period	Annually	
Fees at Risk	**Dollars at Risk** for this metric	$22,200
Payment Amount	Of the Fees at Risk for this metric, percentage at risk for each gradient	N/A
Gradients	Not applicable	

EXHIBIT C

NETWORK PROVIDER DISCOUNTS

Adjustment to Standard Service Fees

The Standard Medical Service Fees (excluding Optional and Non-Standard Fees), (hereinafter referred to as "Fees") for Employees covered under the UnitedHealthcare Choice portion of the Plan, payable by You under this Agreement, will be adjusted through a credit to your Fees in accordance with the Network Provider Discount Guarantee set forth in this Exhibit. Unless otherwise specified, these provider discounts are effective for the period from January 1, 2012 to January 1, 2013. The settlement of provider discounts will be performed on an annual basis at the time of the year end reconciliation.

Choice Network Discount Guarantee	
Actual Network Discounts	**Percentage Adjustment to ASO Fees**
Less than 44.3%	-10.0%
44.3% to 45.3%	-8.0%
45.3% to 46.3%	-6.0%
46.3% to 47.3%	-4.0%
47.3% to 48.3%	-2.0%
48.3% or Greater	0.0%

Assumptions

- Target in-Network Provider Choice Discount Percentage 51.3%.
- The target discount percentage is based on the current distribution percentage of in-network employees by market. The current distribution for the larger markets is illustrated below. The distribution of smaller markets is combined into the All Other market.
- Savings are defined as the sum of the difference between the covered billed charges (excluding ineligible and not covered charges) submitted by the Network Provider and the amount based on the negotiated rate with that provider. This may also include specially negotiated discounts with Network Providers in outlier claim situations.
- We reserve the right to exclude claims billed utilizing billing software, showing billed charges (excluding ineligible and not covered charges) equal to the negotiated rate from this guarantee.
- Claims where We are the secondary payor are excluded from the Network Savings and Network Savings Factor determination.
- Mental Health/Substance Abuse claims are excluded.
- Medicare and Out of Area subscribers are excluded.
- We reserve the right to revise the target discount percentage should there be a significant change in this Employee distribution (+ or - 10% change in any of the markets identified below). The figures above are based upon the following markets and Employee counts:

Market	Employee Distribution
Milwaukee County	5,655
Other	243
Total/Average	5,898