CITY OF AURORA

Results achieved by the City of Aurora and Group Alternatives over the past three years:

- OAP plans covering active employees, pre-65 retirees, & post-65 retirees have a -1.4% annual compounded trend from 2015-2018.

- Converted post-65 retirees to Aetna Medicare Advantage January 1, 2018, resulting in the following:
    a. 2018 reduction in city funding of $3,946,924
    b. Reduced long-term health care liability ≈ 25,000,000
    c. 2019 renewal is a 9.2% decrease for savings of $166,533

- HMO premiums have remained flat since 2015 when Group Alternatives performed their first audit.

Accomplishments for 2019 renewal negotiations:

- 2019 HMO renewal negotiation with BCBSIL resulted in a 2.4% decrease or $258,482 in annual savings.

- 2019 OAP renewal negotiations with Cigna resulted in the following:
    a. 5-month admin credit of ≈ $123,965
    b. $100,000 Wellness Fund
    c. 100% Rx rebate pass through
    d. Stop Loss renewal negotiated $40,324 off initial offer
    e. Adding Cigna One Guide & Motivate Me programs at no cost, worth approximately $50,000

Additional services provided to the City of Aurora for the 2018 contract period:

- Added Data Analytics in 2018 at no cost to the city. The solution identifies cost drivers, engages members with tailored strategies and predicts future spending.

GROUP ALTERNATIVES

CITY OF AURORA

CONTRACT FOR SERVICES

This contract is entered into between City of Aurora and Group Alternatives, Inc. to maintain the services of Group Alternatives, Inc. in accordance with the terms included in the Scope of Services.

City of Aurora retains Group Alternatives, Inc. for Continuing Services for the three-year period beginning January 1, 2019 and ending December 31, 2021.

- The cost from January 1, 2019 through December 31, 2019 is $43,500. Payments of $3,625.00 are due the first of each month beginning January 1, 2019.

- The cost from January 1, 2020 through December 31, 2020 is $50,000. Payments of $4,166.67 are due the first of each month beginning January 1, 2020.

- The cost from January 1, 2021 through December 31, 2021 is $50,000. Payments of $4166.67 are due the first of each month beginning January 1, 2021.

This contract may be terminated without penalty by City of Aurora or Group Alternatives, Inc. at any time with 60 days advance notice in writing.

This agreement is entered into this _____ day of _____, 2018.

Signed By,

Michael J. Baker
President
Group Alternatives, Inc.

Alisia Lewis
Director of Human Resources
City of Aurora

Executive Summary:

Group Alternatives, Inc. was founded in 1989 as a boutique, fee-based benefit consulting company. Our core principle is to provide unbiased advice to the mid to large employer as well as deliver the highest level of customer service. Our success and expertise has established strong and lasting relationships with our clients, resulting in an average retention of 97.5% annually.

Our company's growth and industry complexities have led to many strategic partnerships over the years. Our clients benefit from additional expertise through our partners, including the following:

- Seyfarth Shaw, LLP – Legal and Compliance Services
- EmployeeTech – HR and Benefit Technology Consulting
- Springbuk – Data Analytics Reporting
- Consulting Advisory Councils – Aetna, Blue Cross, CIGNA, CHC Wellness

Our approach uses a five-step process to thoroughly evaluate your current benefit package and to provide both strategic and practical recommendations. ***Our process has resulted in 85% of our clients having a 2.9% 5-year compounded trend versus industry average of 7.5%.*** These steps include:

- ***DISCOVERY:*** Each benefit plan is evaluated from a design, historical, and financial perspective to understand the complete nature of the benefits and how they align with our client's overall business goals. This is an annual process; however, it will be performed multiple times in a given year if legislation is passed that affects the benefit programs.

- ***ANALYSIS:*** Benefit Plan areas that are analyzed include:
    - Financial/funding arrangements
    - Benefit, cost and contribution benchmarking
    - Data Analytics – detailing the cost drivers to the plan
    - RX claims repricing and contract analysis
    - Provider Network Analysis
    - Health and well-being strategies
    - New technologies that improve cost and members' experience

- ***STRATEGY:*** Strategic and practical recommendations are provided and prioritized for action based on our client's direction. The strategic plan ranges anywhere from 1 to 5 years depending on the objectives of the client.

- ***REVIEW:*** Each actionable item is tested in the market for cost, quality, and the best match with your goals. We also facilitate finalist interviews, aid in the decision process and finalize any new arrangements.

- ***IMPLEMENTATION:*** Client's decisions are implemented in a timely manner, including any change in carrier or vendor. Group Alternatives manages this process and oversees any transitions in partnership with the client's HR team.

SCOPE OF SERVICES

I. Review the existing benefits and provide a factual, concise summary of the current plans along with observations and suggestions for future changes.

II. Analyze the claim experience and other costs, including financial projections and implications of maintaining the existing benefits and funding arrangement.

III. Analyze the financial implications of ACA on your current benefit programs, such as the pending Cadillac Tax for 2022 and beyond. In addition, analyze benefit options and financial implications of Repeal and Replace Legislation.

IV. Market the existing benefit plans, which includes:

- Writing specifications for the Request for Proposal
- Marketing to no less than 10 markets for medical and up to 6 additional markets for each of the other benefits
- Preparing and presenting a concise Marketing Report
- Evaluating offers and negotiating pricing
- Developing a selection strategy for finalists, if desired

V. Evaluate current and alternative Preferred Provider networks, including:

- Tax ID number match-up based on physician usage and charges
- Repricing of medical claims, if obtainable from current carrier

VI. Data Analytics – Monthly aggregated medical / Rx claims, as well as biometric screening results and payroll data. The solution unifies employer data into a single system for employee health, allowing employers to **identify** cost drivers, **engage** members with tailored strategies, **predict** future spending and model plans and program recommendations. Capabilities include:

- Health HQ – An updated monthly dashboard is accessible to the client, providing a "real time" view of plan performance with focus on key health service areas and underlying conditions. Health HQ illustrates year-over-year plan costs, as well as a 12-month projection using client-specific predictive modelling.
- Gaps-In-Care – Provides comprehensive list of top disease states and that population's adherence to treatment plans. Predicts future spend at both the client and member level based on risk score, compliance and motivation to change. Adds a level of accountability to the tracking of wellness initiatives and their effectiveness.
- Claims – Tracks Top 10 medical diagnoses and Rx medications. Provides a current two-year medical/Rx trend by month.
- Reporting – Option to create and furnish customized executive summaries: Risk Stratification, Financials, Gaps-In-Care, and Data Summaries.

VII. Benchmark the current benefits and employee contributions to a real time database of other employer's benefit plans. Comparative information from this database (over 5,000 employers) may be selected by industry, number of employees and/or geographic region.

SCOPE OF SERVICES

VIII. HR Technology Consulting:
- Evaluation of current HR process, technology and requirements
- Process improvement with current platforms
- Marketing for new solutions
- Management of RFI process
- Coordination of vendor demos
- Recommendations – scored based on client evaluation
- Calculation of return on investment
- Final vendor negotiations
- Implementation oversight

IX. Customize, develop and launch a virtual benefits counselor.

X. Provide information and a proven strategy for using Consumer Driven Health Plans to reduce benefit costs, including a 2-3 year flat budget approach.

XI. Review the Prescription Drug benefit and provide cost control strategies.

XII. Provide employee behavior modification strategies, including:
- Wellness
- Disease Management
- Large claims/chronic co-morbidity

XIII. Review all benefit plan documents and master contracts for accuracy, as well as consistency with each other and with benefit regulations, such as COBRA, HIPAA, FMLA and ACA.

XIV. Review/update current employee communication materials for compliance with the Summary of Benefits and Coverage requirements.

XV. Provide assistance/resolution in difficult claim situations. Be available for meetings and questions as needed.

XVI. Provide assistance with coverage changes and enrollments.